STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115492	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare FT Oglethorpe	2403 Battlefield Pkwy Fort Oglethorpe, GA 30742

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on interviews, record review, and facility policy review titled, Skin Integrity Manual, the facility failed to implement pressure injury interventions, including the removal of a resident's walking boot to perform daily skin checks, to prevent the development of unstageable pressure ulcers for one of three Residents (R) (R172) reviewed for pressure ulcers. This failure caused harm to R172 who developed three avoidable facility acquired unstageable pressure ulcers on her right foot, right heel, and right calf. Findings included: A review of the facility's policy titled Skin Integrity Manual, with a review date of January 2024, indicated, Steps in Prevention of Pressure Injuries Identification of patient at risk . Interventions and Strategies . Prevention Strategies Monitor for pressure when splints, casts, or braces are used Approach Inspect skin around and under splints and braces daily. Inspect skin around edges of cast daily. Report odors emanating from under cast or complaints of pressure or pain to physician. Additional Guidelines Teach CNA [Certified Nurse Aide], patient, and family techniques to observe/monitor when possible. 1. A review of R172's Face Sheet, located in the Resident tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses which included major depressive disorder, dementia with anxiety, and fractures of her right tibia, right fibula, and the third, fourth, and fifth right metatarsals which were diagnosed on [DATE].The resident was discharged from the facility on 9/15/2023. A review of R172's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/03/2023, provided by the facility, revealed a Brief Interview for Mental Status (BIMS), was not conducted for this assessment. The MDS specified R172 had short-term and long-term memory problems, severely impaired cognitive skills for daily decision making, had not rejected care, required extensive assistance with two or more persons physical assist with bed mobility, required extensive assistance with one-person physical assistance with dressing, experienced a fall with major injury since her prior MDS assessment, was at risk of developing ulcers/injuries and had one or more unhealed pressure ulcers/injuries. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115492	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare FT Oglethorpe	2403 Battlefield Pkwy Fort Oglethorpe, GA 30742

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 0686 Level of Harm - Actual harm Residents Affected - Few	A review of 172's Care Plan, provided by the facility, revealed a Problem, with a start date of 5/24/2021, which specified, I am at risk for pressure ulcers and currently have a stage III pressure injury on my coccyx R/T [related to] incontinence, weakness, decreased mobility, and poor intake, declining health, incontinence. The care plan's goal specified My skin will remain intact and my current pressure ulcers will show signs of improvement. Care plan approaches, with a start date of 5/24/2021, specified Report any signs of skin breakdown (sore, tender, red, or broken areas) and Avoid shearing resident's skin during positioning, transferring, and turning. A review of R172's Braden Scale for Predicting Pressure Sore Risk, dated 7/30/2023, completed by Licensed Practical Nure (LPN)4 and provided by the facility, indicated, R172 was at High Risk for pressure sores. During an interview on 4/25/2024 at 10:33 am, R172's family member voiced concerns that R172 developed wounds on her right leg and foot in September 2023 which were acquired while she was a resident at the facility. A review of R172's Orthopedics consultation, dated 8/18/2023, provided by the facility, indicated, Order Information . Displaced [NAME] fracture of right tibia, subsequent encounter for closed fracture with routine healing *Instructions to Assisted Living Home* Note to provider: Daily wound checks. Padding over bony prominences. Patient is to wear cam walker boot for support. A review of a Progress Note, dated 8/21/2023 at 4:50 pm and written by LPN4 located in R172's EMR, specified, Patient out for follow up with ortho on 8/18/2023 for fractures of right foot. Non removable splint removed, and removable boot applied. Boot removed and foot assessed by this nurse. Wound that was present to heel has healed. Foot, ankle, and lower leg are very dry. No other wounds noted. NP [Nurse Practitioner] notified of wound healing. [R172's family member], notified of wound healing. A review of R172's physician's orders, provided by the facility, revealed an order dated 8/22/2023, which indicated, Pt (patient) to wear CAM walker boot for support as tolerated. Assess skin integrity when donning [putting on]/doffing [taking off]. A review of R172's EMR revealed no documentation of the staff's assessment of the resident's skin integrity when donning and doffing the resident's walking boot. During an interview on 4/25/2024 at 9:50 am CNA3 stated she cared for R172 when she had the walking boot applied to her right foot in September 2023. CNA3 stated R172 was dependent on staff for Activities of Daily Living (ADL) care. During further interview on 4/25/2024 at 1:00 pm, CNA3 stated staff did not remove R172's walking boot daily to perform skin checks on the resident's right leg and foot. CNA3 explained R172's walking boot was removed and the skin on her right leg and foot was checked three times per week on the resident's bath days. CNA3 stated she did not recall observing any concerns with the skin integrity of R172's right leg and right foot that needed to be reported to the nurse prior to 9/08/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115492	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare FT Oglethorpe	2403 Battlefield Pkwy Fort Oglethorpe, GA 30742

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 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/25/2024 at 12:35 pm, LPN2 who cared for R172 stated the resident wore a walking boot, but it was not removed daily to check her skin on her right leg and foot. LPN2 explained the CNAs removed R172's walking boot three times per week on her bath days and were to observe the skin on her right foot and leg on these three days. LPN2 stated no concerns regarding the skin integrity on R172's right leg and foot were brought to her attention prior to 9/08/2023. During an interview on 4/25/2024 at 1:48 pm, the facility's current Director of Nursing (DON) stated on 8/22/2023 a physician's order was written for R172 to wear a walking boot on her right leg and the order specified for staff to perform skin integrity checks when donning and doffing the boot. The DON confirmed the physician order did not specify when staff were to remove the boot to perform skin checks and there was no documentation in the resident's EMR of skin checks to resident's right leg and foot when staff donned and doffed the boot. The DON stated the staff did not perform daily skin checks on R172. The DON explained the staff would have removed the walking boot from R172's right foot three times per week on the resident's bath/shower days and performed skin checks on these dates. The DON stated R172's skin checks were completed and documented weekly by the facility's treatment nurse. A review of R172's Weekly Skin Observation, dated 9/01/2023, provided by the facility, indicated, the resident did not have any Wounds, Open, or Red Areas on her right leg or foot. A review of R172's Weekly Skin Observation, dated 9/08/2023, provided by the facility, indicated, the resident had wound/opened/red area to right leg and right foot. The skin observation specified, Wound back of R [right] leg and R foot. A review of R172's Progress Note, dated 9/08/2023 at 2:22 pm, located in the EMR and written by the facility's former DON, indicated, This nurse, wound care nurse and MD called and spoke with [R172's family member] via phone. Informed [R172's family member] of wounds caused by Boot. MD not happy with Boot, new wounds and general current resident condition. [R172's family member's name] agrees with IDT [Interdisciplinary] team about leaving boot off per MD recommendation. MD recommending hospice, r/t poor nutritional intake and overall resident decline. [R172's family member's name] agreed with need for hospice as resident has been on hospice previously . A review of R172's Wound Management Detail Report, dated 9/08/2023, completed by LPN4 and provided by the facility, indicated the resident had an unstageable pressure ulcer on the top of right foot which measured 4.5 centimeters (cm) (length) by 4.2 cm (width), an unstageable pressure ulcer on the right calf which measured 3 cm (length) by 1.5 cm (width), and an unstageable pressure ulcer on the right heel which measured 15 cm (length) by 6.5 cm (width). The report specified, Wound assessed at this time after cam boot removal. Area appears to be from rubbing against inside of cam boot. Noted dry eschar. No bogginess noted. No soft areas noted . No c/o pain or discomfort. Foot elevated on pillows. Poor intake noted. Remains non weight bearing to RLE [right lower extremity]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115492	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare FT Oglethorpe	2403 Battlefield Pkwy Fort Oglethorpe, GA 30742

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 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/25/2024 at 11:57 am, LPN4 stated she was familiar with R172 and was the facility's treatment/wound care nurse in September 2023 when R172 developed pressure sores on her right foot, heel, and calf. LPN4 explained in September 2023, R172 wore a hard-shelled walking boot on her right foot which had Velcro straps which made it removeable. LPN4 stated on 9/08/2023 R172's right foot walking boot was removed, and she observed new unstageable wounds on the resident's right calf, right heel and right foot which contained necrotic tissue and eschar. LPN4 stated she notified the resident's physician of these new wounds on 9/08/2023. LPN4 reviewed R172's EMR and confirmed on 9/08/2023the resident's right heel wound measured 15 cm by 6.5 cm, the right top of foot wound measured 4.5 cm by 4.2 cm, and the right calf wound measured 3 cm by 1.5 cm. LPN4 explained R172 did not have any wounds to her right heel, calf, and foot on her prior weekly skin assessment. LPN4 stated no concerns were brought to her attention regarding R172's skin integrity on her right calf, heel, and foot during the week prior to her performing the resident's weekly skin assessment on 9/08/2023. A review of R172's Physician Observation Detain List Report, dated 9/08/2023at 1:43 pm, provided by the facility, indicated, Acute visit to [R172]. She is a long-term resident, but I was asked to see her today in [sic] urgent basis. Present at this time with Wound Care Nurse and Director of Nursing at [sic] also present was the patient's floor nurse for the day he will also be here over the weekend. I was asked to look at her right foot. She had a recent fracture two months ago and initially was treated with casting after which she was placed in walking type boot. At the time of the removal of the cast she had a heel DTI [deep tissue injury] which had resolved completely, and the foot was nice and pink. The foot was cool but not cold. There are also new DTI's at the location between the leg and the foot and a large 1 at the heel and another 1 further up the leg medially. These were all new. It appeared that the gauze which had been used to pad the foot from the boot had migrated and caused compression and decrease in her no blood supply to the distal one third or more of the foot. A review of R172's Nurse Practitioner's (NP) Observation Detail List Report, dated 9/11/2023at 1:53 pm, provided by the facility, indicated, [AGE] year-old long term resident is seen today in follow up. She was evaluated by [MD name] on Friday for ischemia and necrosis in her right foot. I am told there was a discussion between her, the DON, and [MD's name] regarding how to proceed with potential follow-up, evaluation, treatment or remove her to hospice given her frailty, poor nutritional status . When questioned regarding pain she nods her head no. She has minimal movement of her right lower extremity, most likely due to diminished range of motion with recent fractures. She denies fever, chills, or any other constitutional symptoms at this time. Full exam as noted below. On exam right foot and toes do not appear to be tender to light palpitation. Staff report no other issues at this time. During an interview on 4/25/2024 at 1:20 pm, the NP who cared for R172 stated the resident was dependent for ADL care and she observed the wounds on the resident's right calf, heel and foot in September 2023. The NP stated when she observed the resident's wounds, they were necrotic. The NP confirmed R172's physician's order dated 8/22/2023, for donning and doffing the walking boot and performing skin checks was not specific to when staff were to perform skin checks. The NP stated she would refer to ortho regarding when staff were to remove and apply the boot and when to perform the resident's skin checks. The NP stated R172 was in and out of Hospice care, very debilitated and frail, and had very poor nutritional status which made wound healing very difficult.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115492	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare FT Oglethorpe	2403 Battlefield Pkwy Fort Oglethorpe, GA 30742

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on interview, record review, and facility policy review titled, Falls Program, the facility failed to ensure staff provided adequate supervision and assistance device to prevent falls for one of seven Residents (R) (R172) residents reviewed for falls out of a total sample of 31 residents. This failure resulted in harm to R172 who fell in the shower room, while being assisted by only one Certified Nurse Aide (CNA), and as a result she sustained fractures to her right foot, right tibia, and right fibula. Findings included: A review of the facility's policy titled, Falls Program, dated January 2024, indicated, Purpose: To identify patients at risk for falling and to implement the appropriate interventions. Objective: To reduce the patients' risk of falling and related injuries. 1. A review of R172's Face Sheet, located in the Resident tab of the electronic medical record (EMR) revealed the resident was admitted to the facility in 2018 with diagnoses which included history of falling, major depressive disorder, and dementia with anxiety. A review of R172's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 4/06/2023, provided by the facility, revealed a Brief Interview for Mental Status (BIMS), score of two out of 15 which indicated severe cognitive impairment. The MDS also specified that R172 required extensive assistance with two or more persons physical assist with transfers, requiring total assistance with bathing, and was not steady, and only able to stabilize with staff assistance when she moved from a seated to sanding position and during surface-to-surface transfers. A review of 172's Care Plan, located under the RAI 3.0 tab of the EMR, revealed a Problem, with a start date of 9/09/2019, which specified, I am at risk for falls weakness, r/t [related to] declining health, incontinence. The care plan's goal specified I will remain free from injury from fall. Another care plan indicated Problem with a start date of 11/18/2019, specified Limited ability to perform self-care tasks. A care plan approach, with a start date of 12/19/2019, specified, Assist with transfer using: Hoyer lift. A review of a Progress Note, located in the R172's EMR, written by Licensed Practical Nurse (LPN)2 dated 6/14/2023 at 10:19 am, indicated, [Recorded as late entry on 6/14/2023 10:26 pm] Approximately 9:10 am a CNA doing showers alert this nurse for assistance in the shower room. Upon entering this nurse observed the patient in the floor by the grab bar and shower chair. CNA stated, she was sliding down, and I lowered her to the floor. No apparent injuries were noted an [sic] patient denied any pain or injuries. This nurse found the other CNA's and assessed, and they assisted patient back to the shower chair. Intervention should be a Hoyer lift, due to patient not being able to help staff with the transfers. During an interview on 4/25/2024 at 10:33 am, R172's family member voiced a concern that staff dropped R172 on 06/14/23 while providing her with a shower which resulted in the resident's right foot being broken. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115492	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare FT Oglethorpe	2403 Battlefield Pkwy Fort Oglethorpe, GA 30742

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/24/2024 at 3:10 am, LPN2 stated she cared for R172 and was on duty on 6/14/2023 when R172 fell in the shower room. LPN2 stated R172 was dependent on staff for care and required two staff to assist with transfers. The LPN explained on 6/14/2023 she heard the CNA10 yell from the shower room door that R172 had fallen. LPN2 stated when she entered the shower room, she observed R172 on the floor and CNA10 was the only staff member with the resident in the shower room. LPN2 stated R172 did not exhibit any signs or symptoms of pain and she was saying Get me off the floor. LPN2 stated she assessed R172 from head to toe for injuries and the resident had no apparent injuries. LPN2 stated she worked the following week and was informed R172 was complaining of right foot pain and an x-ray was ordered. The x-ray revealed the resident had a broken right foot. During an interview on 4/25/2024 at 9:50 am CNA3 stated she cared for R172 and worked on 6/14/2023 when R172 fell in the shower room. CNA3 stated R172 was dependent on staff for care and required total assistance for transfers with two staff and a Hoyer lift. CNA3 stated when R172 fell on [DATE] she heard CNA10 yelling for help in the shower room. CNA3 explained when she entered the shower room, she observed R172 lying on the floor. CNA3 stated R172 was not exhibiting any outward signs of pain but was asking to get off the floor. CNA3 stated the next time she worked with R172 was the following week and she observed bruising on R172's right heel and reported the bruising to LPN2. During an interview on 4/25/2024 at 9:53 am, CNA4 stated she cared for R172 and worked on 6/14/2023 when R172 fell in the shower room. CNA4 stated R172 required total assistance with ADL care but could feed herself with set up. CNA4 explained R172 required two staff with a lift for transfers. CNA4 stated that R172 was at risk of falling and should not be transferred by only one staff member. CNA4 stated on 6/14/2023 she observed the emergency light in the shower room activated and when she entered the shower room, she observed R172 on the floor with one other staff present. CNA4 stated R172 was not exhibiting any signs of pain but was asking the staff present to Get me up. A review of the Progress Note, located in R172's EMR, written by LPN1 dated 6/22/2023 at 5:11 PM, indicated, Wound care nurse noted bruising to the patient's right foot and ankle during dressing change. Patient did have a previous fall on 6/14/2023 with no noted injuries at that time. This nurse reported bruising to NP [Nurse Practitioner] immediately with orders to do an X-RAY stat [immediately]. XRAY showed Tibia/Fibula FX [fracture] and three metatarsal FX's. Family notified and very upset. NP gave order to send to [Hospital] for FX's. A review of R172's 6/22/2023 Emergency Department records, located in the resident's EMR, indicated, Patient presents to the ED [Emergency Department] via EMS [Emergency Medical Services] . Patient has a history of dementia and is unable to contribute to the history. Patient was sent to the emergency room after having a mobile x-ray today that showed multiple fractures, subacute in her foot and ankle. EMS reported a fall several days ago. Patient does not know what happened. I spoke with a nurse [name] at [name is facility] and she read documentation from a fall on 6/14/2023. She states it occurred while the patient was getting a shower in the shower chair and the nurse turned around and the patient was on the floor near the grab bar. Patient is non ambulatory. X-rays reviewed. Splint placed with outpatient f/u [follow up] with center for sports medicine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115492	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare FT Oglethorpe	2403 Battlefield Pkwy Fort Oglethorpe, GA 30742

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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's investigation of R172's fall on 6/14/2023, provided by the facility, specified, On 6/14/2023, patient [R172's name] was taken to shower room by CNA. At approximately 9:10 am, [LPN 2] stated that CNA asked for assistance in the shower room. LPN stated that patient was in the floor by the grab bar/shower chair. CNA stated that she lowered the patient to the floor. Patient contact [R172's family member] contacted with no answer, voice mail left. Patient noted to have bruising/swelling to right foot on 6/22/2023, X-ray ordered. Subacute fractures noted to third, fourth and fifth metatarsal necks, Subacute fractures to distal tibia/fibula, Osteopenia and soft tissue swelling. Patient sent to [Hospital] on 6/22/2023 and returned on 6/23/2023 with splints and a follow-up at the center for Sports Medicine. A review of the Post Fall Checklist completed by LPN2 specified, Slid out of shower chair and was lowered to the floor. and Educate staff on Hoyer lift for transfers. Review of the Fall Scene Investigation (FSI) specified, Aide giving shower, attempted to stand patient for transfer. The patient could not stand and began sliding and was lowered to the floor. The FSI also specified Not enough assistance or correct assistance was the root cause of the fall. During an interview on 4/25/2024 at 11:30 am, the current Director of Nursing (DON), stated she was not familiar with R172. The DON reviewed R172's EMR and confirmed the resident experienced a fall in the shower room on 6/14/2023 when being assisted by only one CNA. The DON stated the documentation in R172's EMR reflected the resident did not experience additional falls or accidents between 6/14/2023 and 6/22/2023 when the resident was found to have fractures of her right tibia, right fibula, and right foot. During an interview on 4/25/2024 at 1:20 pm, the Nurse Practitioner (NP) stated she was familiar with R172. The NP stated R172 was dependent on staff for ADL care including mobility and did not complain of having pain. The NP specified that R172 could have experienced fractures from the fall on 6/14/2023 and not complained of pain during the following week without experiencing another incident. During an interview on 4/25/2024 at 6:10 pm, the Administrator confirmed on 6/14/2023 R172 experienced a fall in the shower room while being assisted by only one CNA which resulted in fractures.