STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145664	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of West Frankfort	601 North Columbia West Frankfort, IL 62896

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. Based on interview, observation, and record review, the facility failed to implement care plan fall interventions for 3 (R2, R4, and R13) of 5 residents reviewed for accidents in a sample of 46. This failure resulted in R2 being sent to the hospital after a fall and diagnosed with a closed fracture of left orbit and closed fracture of left side maxilla. The findings include:1. R2's admission record documents an admission date of 11/06/25 with diagnoses of Parkinson's disease, vitamin d deficiency, muscle wasting and atrophy, lack of coordination, dementia, and need for assistance with personal care.R2's MDS (Minimum Data Set) dated 02/13/26 documents in Section C a BIMS (Brief Interview for Mental Status) score of 13 which indicates R2 is cognitively intact. Section GG documents toileting and toileting transfer as dependent. Chair/bed to chair transfer as partial/moderate assistance. Section J documents has the resident had any falls since admission/entry or reentry or the prior assessment as yes. Number of falls since admission or prior assessment -no injury documents two or more. Injury (except major) documents two or more.R2's Care plan has a focus area of: I've had a recent fall that has caused a brain bleed with a date initiated of 11/24/25 with interventions of 1. administer medications per Dr. (Doctor) order. 2. Assess neurological status per facility policy and PRN. 3. Monitor for headaches, nausea, and vomiting and PEARL (Pupils, Equal, and Reactive to Light) 4. Monitor for pain per facility policy and PRN (as needed). 5. Monitor for seizures activity. Notify Dr. of any activity. 6. Monitor vital signs per facility policy and PRN. R2's Care plan has another focus area of: Risk for falls with interventions of 1. 01/16/26 Fall intervention updated to include assist resident to/from all destinations with staff attending needs before exiting. Staff to leave call light within reach. 2. 01/02/25 Fall Intervention updated to include encourage the resident to ask for help when he needs something picked up off the floor. 3. 01/2/26 Fall intervention updated to include educate resident on asking staff for assist with transfers. 4. 1/21/26 Fall Intervention updated to include new wheelchair with adjusted height for legs. 5. 01/27/26 Fall Intervention updated to include personal items within reach. 6. 01/28/26 Fall Intervention updated to include all personal items be within reach and at eye level. 7. 11/10/25 Fall intervention updated to include frequent checks when in bed. 8. 11/14/25 Fall intervention updated to include call light wrapped with yellow tape as visual reminder to ask for assist. 9. 11/24/25 Fall intervention updated to include move closer to nurse's station. 10. 12/13/25 Fall Intervention updated to include verbal reminder to use call light and wait for staff assist. 11. 12/13/25 Fall Intervention updated to include ensure bed is kept in lowest position. 12. 12/23/25 Fall Intervention updated to include 15-minute checks. (R2) continues to be seen by PT (Physical Therapy)/OT (Occupational Therapy) and a Call, don't fall sign placed in room. 13. 12/30/25 Fall intervention updated to include Call Don't fall sign place in room. 14. 02/10/26 Fall intervention updated to include continue antibiotic therapy for urinary symptoms. 15. 02/14/26 Fall Intervention updated to include PT/OT to evaluate and off frequent position changes. 16. 02/15/26 Fall intervention updated to include assist resident with transfers, utilizing therapy recommendations. 17. 02/17/26 Fall intervention updated to include activity director to assess for independent activities. 18. 02/19/26 Fall intervention updated to include to remind staff that AROM (active range of motion) can be performed PRN when (R2) wants to exercise. 19. 02/24/26 Fall Intervention updated to include (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	snacks moved within reach of (R2). 20. 02/28/26 Fall Intervention move resident into room closer to the nurse's station to allow staff to better observed resident. 21. 02/07/26 Fall Intervention updated to include continue to monitor for abnormal behavior. Notify Dr. of change in behavior. 22. 02/07/26 Fall intervention updated to include encourage water intake and continue safety checks. 23. 03/30/26 Fall intervention updated to include grippy socks/proper footwear at all times. 24. 04/03/26 Fall intervention update to include med review. 25. 04/05/26 Fall Intervention updated to include activities to reassess resident interests and provide individual engagement (TV (television), music, structed activities) to reduce boredom, confusion and misperception-related behaviors, promoting safety. 26. 04/05/26 Fall intervention updated to include schedule telehealth with (Psychiatrist). 27. Ensure call light is available to resident. 28. Evaluate fall risk on admission and PRN. 28. Fall intervention updated for activities to reassess for interest, TV, music to provide when in room. 29. Fall Intervention updated to include Flomax time change to HS (Night) to help decrease urge to void. 30. Fall intervention updated to include monitor for s/sxs (signs and symptoms) of Delirium and notify MD (Medical Doctor). 31. If fall occurs, alert provider. 32. If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. R2's fall investigation dated 01/01/26 at 3:30PM documents under incident description: Nursing Description- This nurse was walking up the hallway when this nurse observed the resident drop an item onto the floor on the south hallway before this nurse could help the resident. The resident leaned forward to pick up the item and fell onto hand and knee. This resident did not hit his head. This nurse began to assess the resident and found no injuries. The resident did not have any complaints of pain ROM (range of motion) WNL (within normal limits). Resident description- I dropped something and was trying to pick it up. Immediate action taken. Intervention- Encourage the resident to ask for help when he needs something picked up off the floor. R2's fall investigation dated 01/02/26 at 10:30PM documents under incident description: Nursing description- This nurse and CNA (Certified Nurse Assistant) were walking past resident room and noted resident on floor. Upon entering room, resident noted laying on right side on floor at foot of bed with head towards door, facing the head of bed. Resident stated he was getting out of bed when he slid. Gripper socks on, blanket noted on floor on the side he stated he got out of bed on. Resident stated he hit his right knee and right elbow on the floor. Denies any pain at current time. No apparent injuries noted. ROM WNL Neuros WNL resident assisted to bed x 2 assist per resident request. 1:1 with resident about using the call light for assist with transfers. Resident stated he forgot to use call light. Call light clipped to shirt, resident stated, thank you, I think that will help me remember. Resident description- I slid when I was getting out of bed. Immediate action taken - resident assessed, assisted back to bed, 1:1 done with resident about asking for assist with transfers. Call light clipped to shirt rather than blanket. R2's fall investigation dated 01/15/26 at 12:30PM documents under incident description: Nursing description- CNA was walking by residents' room and observed him leaning forward out of wheelchair. Resident then dropped to knees and began crawling towards bed. CNA called for nurse and this nurse, and CNA assisted resident into bed for assessment. No injuries noted. Resident description- Resident unable to give description. Immediate action taken- resident assisted into bed and assessed for injuries. No injuries noted. Resident encouraged to use call light when needing assistance and stated, That's what i was trying to do. R2's fall investigation dated 01/20/26 at 3:30PM documents under incident description: Nursing description- This nurse was made aware by the MDS coordinator of the resident's fall. This nurse was not present for the resident's fall or when he was assisted back into his wheelchair. MDS coordinator stated that she was in dining room when resident was wheeling himself forward when he slowly started to lean forward and lightly fall out of wheelchair and onto his knees. Resident description- Resident unable to give description. Immediate action taken- This nurse was made aware and this nurse then requested a full set of vitals, assessed for injuries, began a neurological assessment, and then contacted the MD and POA (Power of Attorney).R2's fall investigation dated 01/26/26 at 5:20PM documents under incident description: Nursing description- This nurse was alerted by CNA that the resident was lying (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	on the floor in his bedroom. This nurse immediately went to assess the resident and found the resident lying on his right side on the floor in the resident bedroom doorway. The resident was previously in the wheelchair. ROM WNL. Neuro checks initiated. The resident states that he did not hit his head and is not experiencing any pain. No evidence of head injury. No skin injuries observed at this time. Resident description- I was in my wheelchair trying to get my charger to plug my phone in. Immediate action taken- no intervention or action listed. R2's fall investigation dated 01/27/26 at 3:55PM documents incident description: Nursing description- This nurse was alerted by the resident that this resident (R2) was lying on the floor. This nurse went down to assess the resident, and the resident was up in the wheelchair. The resident stated that she saw the resident (R2) siting on the floor and watched the resident get back into the wheelchair. ROM WNL. No evidence of head injury. The resident declines hitting his head and declines any pain. No new skin injuries observed at this time. Resident description- The resident states that he was trying to get to his candy when his wheels on his wheelchair stopped and he fell forward landing on his knees. The resident states that he did not hit his head and he was not in any pain. Immediate action taken- intervention up at the nurse's station for monitoring. Review of R2's fall investigation dated 02/07/26 at 4:22AM documents incident description: Nursing description- This nurse was at nurses' station and heard someone down the hallway. Nurse looked and saw this resident standing outside of his door. Nurse got up to go to resident but could not get to resident fast enough. Resident fell to his left hitting the left side of his head on the door. Resident assessed. Denies pain, stated his head is a little sore. No red marks, bruising, open areas noted to left head. No apparent injuries noted. ROM WNL. Neuros WNL for resident. Wheelchair next to bed in res (resident) room. Resident assisted to wheelchair and brought to common area. Resident Description - I fell Immediate Action taken- Resident assisted to wheelchair and brought to common area. R2's fall investigation dated 02/07/26 at 6:10PM documents incident description: Nursing description- This nurse was in restroom when this nurse was made aware by nurse AM that resident was found on the floor on his knees beside the nurses' station closest to the exit. R2 stated he was trying to pull out the tubing to his catheter bag CNA's assisted resident up to his feet where they put him back in his bed. Resident description- resident unable to give description. Immediate action taken- This nurse ensured resident was helped safely to his room and placed in bed where she the instructed CNA to obtain vital signs and the nurse then began a neuro check. Following the initial neurological check, this nurse contacted the on-call provider at 1815 (6:15PM) where she instructed just to keep a close eye, continue neurological checks, and notify immediately of any changes. R2's fall investigation dated 02/14/26 at 11:30PM documents incident description: Nursing Description- Nurse at nurse's station, heard someone yelling help down south hall. This resident noted on hands and knees on floor with w/c (wheelchair) behind him in front of his door. denies pain. ROM WNL. Neuro WNL. No apparent injuries noted. Resident description- I fell out of my wheelchair 1:1 with resident to use call light if he needs anything, resident states understanding. R2's fall investigation dated 02/16/26 at 8:35PM documents incident description: Nursing description- This nurse was walking up north hall towards the nurse's station when this nurse observed the resident leaning forward with feet pulled up into the base of the wheelchair and fell onto his knees. The resident did not hit his head. The resident denies any pain. ROM WNL. No skin injuries. Resident description- I fell forward Immediate action taken- Intervention placed at nurses' station for monitoring. R2's fall investigation dated 02/19/26 at 12:10AM documents incident description: Nursing Description- Nurse heard noise down south hall. When investigating, this resident was noted on hands and knees on floor in front of his wheelchair in front of bathroom door in his room with a cup in the floor in front of him. Nurse asked resident what he was doing, resident states he needs to exercise. resident assessed, no apparent injuries noted. Denies pain. ROM WNL. Neuro checks WNL. While waiting on CNA to assist with getting resident up, resident got himself off of the floor and into wheelchair. Nurse SBA (stand by assisted), tried to encourage resident to wait for help. Resident declined to wait for assist. 1:1 with resident reminding him it is just after midnight, and everyone is sleeping. Resident agreed to go back (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	to bed and wait until morning to exercise. Resident assisted to bed with 1A (one assist) CNA, call light in reach. No further needs at this time. Resident Description- I was going to exercise out there. Review of R2's fall investigation dated 02/22/26 at 9:45PM documents incident description: Nursing Description- This nurse was sitting at the nurses' station when this nurse observed the resident propelling himself up the hallway in his wheelchair when he was leaning forward and fell out of his wheelchair onto his knees. The resident did not hit his head. No skin injuries observed. ROM WNL. Resident description- I fell Immediate action taken- Intervention placed at the nurses' station for monitoring. Review of R2's fall investigation dated 02/23/26 at 10:30PM documents incident description: Nursing description- bright red blood noted on resident floor, resident lying on his bed. Had been propelling himself in the hallway in his wheelchair on his way to his room, asked resident what happened, resident reports he fell forward out of his wheelchair and hit the floor. Bright red blood noted to chin area. No other injuries apparent, alert to self. Resident description- I fell forward out of my chair and hit my chin on the floor. Some of my teeth broke off and I just got myself up and climbed in bed. Immediate action taken- [NAME] area cleansed, bleeding subsides, BP (blood Pressure) 137/77, P (Pulse) 80, R (respirations) 16, T (temperature) 97.7, SPO2 (oxygen saturation) 97% on RA (room air), approx. 2mm (millimeter) laceration noted to chin, unable to determine if any teeth are missing from fall due to dental condition. Resident jokes saying well at least the dentist won't have as many to deal with, since they are rotten this nurse unable to find any broken teeth in room. R2's fall investigation dated 02/28/26 at 3:10AM documents incident description: Nursing description- Nurse at nurse station, heard a noise down south hall. Upon entering this resident's room, resident noted lying on his right side on the right side of the bed with head towards the bed, feet towards the door. Drink spilled on floor behind him, w/c (wheelchair) in front of him. Resident states, I was trying to get up to find you guys and I fell. Neuro checks WNL. ROM WNL. Denies pain. Denies slipping in drink, feet not wet. Resident description- I was trying to get up to find you guys and I fell. Immediate action taken- resident assisted back to bed per request. 1:1 related to using call light, frequent checks. R2's fall investigation dated 03/30/26 at 3:55AM documents incident description: Nursing description- This writer was called to residents' room by cnas who observed resident on floor beside bed. Resident reports he fell. Alert with usual confusion. No injuries noted. Denied hitting head. Resident has no footwear in place. assessed for injuries and assisted back in bed. grippy socks placed on resident at this time. Call light placed within reach. Neuro checks initiated. Resident description- resident unable to give description. Immediate action taken- assessed for injuries and assisted into bed. Grippy socks placed on resident. Neuro checks initiated. Review of R2's fall investigation dated 04/02/26 at 6:15AM documents incident description: Nursing description- CNA alerted this nurse resident was lying on floor next to his bed. Upon entering room resident lying on right side of bed on his stomach with head turned to the left side towards the bed. Resident description- Res. states he dropped a piece of cookie on the ground and was trying to pick it up. Immediate action taken- assessed for any possible injuries. VS (vital signs) obtained. Neuro checks initiated. Assisted into bed. Call placed to 911. R2's fall investigation dated 04/04/26 at 8:55AM documents incident description: Nursing description: CNA was walking by room when she noted resident was not in his bed. CNA alerted nurse. Upon entering room resident noted on his left side under his bedside table on the left side of his bed. Resident states he did not mean to get out of bed. Resident denies hitting head, denies any pain. ROM WNL. No apparent injuries noted. Resident description- I didn't mean to get out of bed. I leaned over too far and went in the floor. Immediate action taken- 1:1 with resident on use of call light. HOB (Head of Bed) lowered, resident repositioned in bed. R2's progress note dated 03/30/26 at 4:21AM by V4 (Licensed Practical Nurse) documents This writer was called to residents' room, observed resident in floor beside bed. Resident reports he fell. Alert with usual confusion. No injuries noted. Resident has no footwear in place. Assessed for injuries and assisted back in bed. Grippy socks placed on resident at this time. Call light placed within reach. Neuro checks initiated. ADON (Assistant Director of Nursing), administrator, MD (medical (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	doctor) and POA (power of attorney) notified. R2's progress note dated 03/30/26 at 6:47AM by V4 documents Resident has small amount of swelling noted to left cheek. Resident stated he couldn't remember if he hit his cheek during fall. POA called at this time and asked if she would like resident sent to hospital. She said only if resident has complaints of discomfort. Resident has no complaints at this time. Did report tooth discomfort and has several broken teeth which were like that prior to fall. Will continue to monitor and notify MD if swelling continues. Neuros continue WNL. R2's progress note dated 03/30/26 at 11:58AM (10:15) This nurse was alerted by CNA staff about the residents swelling/bruising. This nurse went down to assess the resident and found left sided facial and orbital swelling/bruising. Vital signs are as follows temp-97.3, RR (respiratory rate) 18, pulse 84, O2 97% on RA. and B/P 147/81. The resident states that he is experiencing head and neck pain. The resident is agreeable to be sent to the ER (emergency room) for further evaluation. (10:25) this nurse contacted (Local Ambulance) to have the resident transferred to (Local Hospital) (10:27) This nurse notified V1 of the resident being transferred to the ER. (10:30) this nurse attempted to contact (POA), no answer, unable to leave voicemail d/t (due to) mailbox being full. (10:35) MD was notified. (10:45) EMS (emergency medical services) arrived at the facility to transport the resident to (local Hospital) bed hold policy was sent. (10:53) This nurse called report into (Local Hospital emergency room). R2's progress note dated 03/31/26 5:23PM resident returned from hospital via ambulance with dx (diagnosis) of closed fracture of orbit. Resident very restless. New orders received and transcribed. R2's progress note dated 04/02/26 at 5:29PM CNA alerted nurse res was lying in floor next to his bed. Upon entering room, res lying on right side of bed on his stomach with head turned to the left side towards the bed. Resident reports he hit his head. Bruising r/t previous fall continues and is hard to tell if any new injuries are noted at this time. MD notified. New order: send to ER for eval and treat. POA notified. ADON here and aware of fall. EMS called and requested transfer to hospital for ground level fall. Awaiting EMS at this time.R2's progress note dated 04/02/26 at 9:53PM Spoke with (Local Hospital emergency room Nurse) at this time who stated while doing CT (Computed Tomography) scans, it did show old thoracic vertebrae fx,(fracture) that this is not new, but they do recommend spine surgery f/u. They have put in a referral. V2 and V1 aware.R2's local hospital emergency room records with a date of service of 03/30/26 documents under history of present illness facial trauma and periorbital swelling sustained facial injury after slipping and falling overnight/early morning on 03/30/26, struck L (left) face during the fall, swelling around the left eye, vision intact w/o (without) visual changes, no other visual changes and acute left sided neck pain mild left sided neck pain since fall, no shoulder pain, no difficulty moving arms. Clinical Impression documents closed fracture of let orbit and closed fracture of left side maxilla. fall encounter. R2's local hospital emergency room records with a date of service of 4/02/26 documents chief complaint fall. ED (emergency department) course documents 4/02/26 CT thoracic spine without contrast T4 spinous process fx (fracture) Pt. (patient) informed. Recommend spine surgery outpatient f/u (follow up). Clinical impression documents fall and head injury. On 04/12/26 at 9:03AM observed R2 door which was closed. Observed R2 lying in bed no staff observed in room. R2's call light out of reach of resident with no yellow tape wrapped around call light. On 04/13/26 at 10:22AM observed R2's call light which was out of reach of resident. No yellow tape wrapped around call light. Call light on top of nightstand on top of assistive devices. On 04/13/26 1:44PM observed R2's call light on nightstand on top of positioning device approximately 4 feet from where R2 was laying. R2 lying in bed. No yellow tape noted to call light. On 04/13/26 at 2:40PM observed R2's door closed and call light not in reach of resident and no yellow tape noted to call light. On 04/13/26 at 3:10PM observed R2's call light which was not in reach of resident who was lying in bed. Call light lying on nightstand on top of assistive device. No yellow tape observed on R2's call light. On 04/14/26 1:32PM observed R2's call light in reach of resident no yellow tape observed around R2's call light.On 04/15/26 at 1:02PM observed R2 wheeling himself in his wheelchair down the hallway back to his room no staff observed down the hallway or assisting R2 out of dining room. R2 was seen getting his front part of his wheelchair (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	caught on the corner of his doorway. Observed R2 get out of his wheelchair with no staff in site re-adjust his wheelchair and then sit back in his wheelchair, but the wheelchair was still stuck on the doorway. R2 then couldn't get his wheelchair to move so he stood back up and got his right foot tangled in his catheter tubing and then began walking down the hallway pushing his wheelchair with an unsteady gait and right leg still tangled in catheter tubing. R2 pushed his wheelchair all the way to the end of the hallway and almost all the way back no staff was observed in site this whole time. At 1:10PM observed V16 (Housekeeper) yelling for staff to assist R2 who was still walking with unsteady gait behind wheelchair and tubing tangled around right leg. At 1:11PM 3 staff members observed coming to assist R2 back into wheelchair. On 04/15/26 at 1:15PM, V4 (Licensed Practical Nurse) V4 stated that R2 does have a lot of falls especially on midnight shift. V4 said that she works day shift and night shift often. V4 said they try to prevent R2 from falling but he just seems like a different person at night. V4 said that some nights if they are having a bad night that R2's 15-minute checks might not get done. V4 said that the staff are very good about trying to get them done, but there are some nights that are unpredictable, and the checks might not all get done. V4 said that she was working on 03/30/26 and she said R2 was found on the floor beside his bed. V4 said R2 said he didn't hit his face or head. V4 said that later she was checking on R2 and observed swelling and she let the nurse who was taking over for her know that R2 had some swelling and a little bruising to his face. V4 said that the nurse who took over for her sent R2 out and he had a facial fracture. V4 said that several days later R2 had another fall, and she noticed some bruising on R2 hip area and couldn't tell if it was new bruising from the current fall or from the old fall on 03/30/36 so she got orders to send R2 to the hospital. V4 said that R2 did come back from the hospital, and they told them that he had an old thoracic fracture and that he didn't have any new fractures. They didn't know when the thoracic fracture happened. V4 said that even after that fall R2 had another fall several days later. V4 said that they try to prevent R2 from falling as best as they can. On 04/15/26 at 1:26PM, V2 (Assistant Director Nursing) stated that she wasn't aware of any residents being on 15-minute checks currently. V2 stated that she feels like staff should be able to do 15-minute checks on R2 if he had 15-miniute checks. V2 said that staff have a really good working relationship and can help each other out. V2 said that she would expect R2 and all residents to have their call lights in reach of them when they are in bed. V2 said that she would expect R2's door to be open when R2 is in bed unless staff is in the room providing care. V2 said that R2 was supposed to have yellow tape around his call light so he could find his call light easier. V2 said that she knew that R2 got moved closer to the nurses' station so staff could check on him more. On 04/15/26 at 1:50PM R2's door was observed closed no staff noted in room. R2's call light at the foot of his bed and no yellow tape noted to call light. On 04/15/26 at 2:00PM R2 stated that he doesn't know why he falls all the time. R2 stated that he has Parkinsons and maybe that is why he falls a lot. On 04/15/26 at 2:15PM, V7 (Minimum Data Set Coordinator) she stated that she is trying to come up with new interventions for R2 and all the residents. V7 stated that she doesn't know if the interventions she put in place are working or not. V7 said that it is hard to come up with new interventions, because R2 has had so many falls. V7 said that she tries to get more detail with some of the new fall interventions or figure out a new way to put the intervention to see if it works better. 2. R4's admission record documents an admission date of 04/30/24 with diagnoses in part of unspecified convulsions, cerebrovascular disease, muscle wasting and atrophy, lack of coordination, and need for assistance with personal care. R4's MDS (Minimum Data Set) dated 02/06/26 documents in Section C a BIMS (Brief Interview for Mental Status) score of 07 which indicates R4 has severely impaired cognition. Section GG documents toileting as dependent. Transfers as Substantial/Maximal assistance with transfers. Section J documents under has the resident had any falls since admission/entry or reentry or the prior assessment as yes. Number of falls since admission or prior assessment- no injury 2 or more. R4's Care Plan documents a focus area of Risk for falls with a revision date of 05/06/24 with interventions of 1. 01/14/26 fall intervention update to include staff to monitor position when in wheelchair. 2. 01/22/26 Fall intervention updated (continued on next page)

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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	to include Monitor Safety check 15 minutes r/t (related to) increased falls. 3. 01/05/26 Fall intervention updated to include encouraging the resident to ask for assistance during transfers. 4. 01/09/26 Fall intervention updated to include offer to lay down the resident after meals. 5. 10/13/25 Fall intervention updated to include Call Don't Fall sign in room. 6. 10/20/25 Fall intervention updated to include yellow on call light as visual reminder. 7. 10/31/25 Fall intervention updated to include proper footwear when out of bed. 8. 10/05/26 Fall intervention updated to increase visual checks when out of bed. 9. 12/30/25 Fall intervention updated to include nonskid mat on wheelchair. 10. 2/5/26 Fall intervention updated to include frequent checks when up. 11. 03/31/26 Fall intervention updated to include foam grip adaptive to regular spoon at meals. 12. 03/06/26 Fall intervention updated to include educate staff to anticipate resident needs during peak times of restlessness to provide assistance with transfers and prevent self-transfers.13. 04/05/26 Fall intervention updated to include resident be monitored at nurses' station after supper. 14. 09/12/25 Fall intervention updated to include education provided on using proper foot pedal/rest use. 15. Assist with Adl's (activities of daily living), transfers, PRN. 16. Educate on the importance of maintaining safe environment, free of potential fall hazards. 17. Ensure bed is kept in lowest position. 18. Ensure call light is available to resident. 19. Evaluate fall risk on admission and PRN. 20. Evaluate resident's environment to identify factors known to increase risk of falls, 21. Fall on 03/06/26 intervention educate staff to anticipate resident needs during peak times of restlessness to provide assistance with transfers and prevent self-transfers. 22. If fall occurs alert provider. 23. If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. 24. Review medication for drugs that increase the risk for falls.R4's Fall investigation dated 04/05/26 5:50PM documents under incident description: Nursing description- Staff observed the resident lying on the floor in the dining room. ROM WNL. No skin injuries observed at this time. Immediate Action taken- up at Nurses station for monitoring.On 04/12/26 at 9:16AM observed R4's room door closed no staff observed in room. R4 was lying in bed no call light in reach and no yellow tape noted to around call light.On 04/13/26 at 1:00PM observed R4 in a wheelchair wheeling self around facility from dining room. R4 was sitting on the edge of his wheelchair trying to propel himself around. Observed several staff going past R4. Observed R4 trying to get self out of wheelchair two times.On 04/14/26 at 1:35PM, V14 (Certified Nurse Assistant) stated that R4 is not on 15 minutes checks as far as she knows. V14 said that she is working on R4's hall today. V14 said all resident's call lights should be in reach of all residents when they are in bed, especially residents who are fall risk.On 04/14/26 at 1:37PM, V6 (Certified Nurse Assistant) stated that R4 is not on 15-minute checks. R4 said they did move R4 closer to the nurse's station, but he isn't on 15-minute checks. V6 stated that all resident call lights should be in reach of all residents when they are in bed.On 04/15/26 at 3:00PM observed R4 who was sitting in his wheelchair in foyer for over 16 minutes with no staff checking or monitoring R4.On 04/16/26 at 9:12AM, V7 (MDS Coordinator) stated that R4 is on 15 minutes checks and staff should be making sure that R4's call light is in reach of R4 at all times when he is in bed. R4 is also to have yellow tape wrapped around his call light to make it easier for R4 to find. V7 said that staff should also be offering to lay down R4 after meals and if they see R4 trying to get up or sliding out of his chair reposition him back in his wheelchair.On 04/16/26 at 9:53AM, V2 (Assistant Director of Nursing) stated that she doesn't know for sure if R4 is on 15-minute checks but if he is she would expect staff to be doing 15-minute checks. V2 said that all residents should have call light in reach of them when in bed. V2 said that if a resident is scooting out of their wheelchair, she would expect staff to assist them back in the wheelchair. V2 said that they should also be offering to lay down R4 after meals and assisting with toileting. V2 said that she would expect st[TRUNCATED