STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155551	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Meadows Health Care Center	604 Rennaker St LA Fontaine, IN 46940

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 observation, interview and record review, the facility failed to implement immediate interventions to prevent future falls for 2 of 3 residents reviewed for falls. (Residents B and C). This deficient practice resulted in Resident B sustaining a right hip fracture during a subsequent fall following a fall resulting in a wrist fracture. Findings include: 1. Resident B's clinical record was reviewed on 5/30/25 at 10:55 a.m. Diagnoses included fracture of the left wrist, fracture of the right femur, dementia, muscle weakness, difficulty walking and the need for personal assistance with care. Current physician orders included bed alarm for safety 5/28/25, check placement of splint to left wrist, watch for signs and symptoms of swelling, metoprolol succinate (antihypertensive) 25 milligrams (mg) daily and Rivastigmine tartrate (dementia) 1.5 mg daily. A fall risk assessment, dated 3/20/25, indicated Resident B was at high risk of falls for reasons including intermittent confusion, previous falls in the past three months, and gait/balance problems. A current care plan, initiated on 9/23/24, indicated Resident B was at risk for falls related to poor decision making and impaired balance. Interventions included a bed alarm would be used to reminded Resident B to ask for staff assistance for bed mobility and transfers (5/27/25), hourly rounding initiated for the next 72 hours to help establish any new habits or routines resident may have (5/20/25), wearing proper footwear or nonskid footwear when Resident B was up (9/23/24), personal items within reach (4/15/25), an alternating air mattress with bolsters (5/27/25), call light within reach (9/23/24), care plan would be updated upon Resident B's return from the hospital (5/19/25), and remind Resident B to change positions slowly (4/15/25). A 4/9/25, quarterly, MDS assessment indicated Resident B was cognitively impaired. Resident B required supervision or touching staff assistance when rolling to the left and right. Resident B required partial/moderate assistance with toilet transfers. Resident B was independent when walking 10,50, and 150 feet. (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	A 5/19/25, quarterly, Minimum Data Set (MDS) Assessment indicated Resident B was cognitively impaired. Resident B required substantial/ maximal staff assistance with toileting hygiene and when rolled to the left and right. Resident B required partial/moderate staff assistance with chair/bed to chair transfer and toilet transfers. Resident B was independent when walking 10, 50, and 150 feet. A progress note, dated 5/19/25 at 2:23 a.m., indicated Resident B was in the bathroom being toileted by the CNA. The CNA turned toward the sink to grab towels, when Resident B ran out of the bathroom with her pants around her ankles. As Resident B turned to face the CAN, Resident B lost her balance and fell hitting the back of her head on the wall. The nurse assessed Resident B for injuries. Resident B was noncompliant with staff attempting to help her up off the floor. The nurse and CNA were able to assist Resident B back to her bed. The nurse was unable to obtain vital signs due to Resident B's combativeness. Neurological checks were initiated. A progress note, dated 5/19/25 at 5:43 a.m., indicated Resident B's left wrist was bruised and swollen. The DON and physician was notified. On 5/19/25 at 5:58 a.m., indicated an order was obtained for a left wrist x-ray if the resident's representative agreed. On 5/19/25 at 7:57 a.m., indicated Resident B's left wrist appeared swollen, bruised and painful. The NP was notified. A new order was placed for a left wrist x-ray and hydrocodone if the resident's representative agreed. The resident's representative was notified and indicated the facility could do what was needed including sending Resident B to the hospital. The NP was notified and advised to send Resident B to the emergency room for evaluation. On 5/20/25 at 4:30 p.m., indicated Resident B returned from the hospital. Left wrist x-ray results indicated acute left wrist fracture status post fall. Resident B was seen by orthopedics, who placed a cast on Resident B's left wrist. No immediate interventions were implemented to prevent further falls. On 5/25/25 at 2:55 p.m., indicated Resident B was found on the floor between the two beds in her room, lying on her right side. A skin tear was noted to Resident B's right elbow and a bruise was noted to her right eyebrow. Neurological checks were initiated. The NP was notified and recommended sending Resident B to the emergency room for a CT scan if Resident B's representative agreed. On 5/25/25 at 3:05 p.m., indicated Resident B's representative was notified and declined sending the resident to the emergency room at this time. On 5/25/25 at 10:18 p.m., indicated Resident B was shifting weight off her right hip while groaning and rubbing her hip. Pain medication was administered. Pain medication was effective for a short time. Resident B appeared uncomfortable when toileted a short time later. The NP was notified, and a new order was received for a right hip x-ray. Resident B's representative was notified and declined to send Resident B to the emergency room. On 5/26/25 at 3:00 p.m., indicated Resident B's right hip x-ray showed a right femur fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/26/25 at 3:30 p.m., Resident B's representative was notified of the x-ray results. Resident B's representative declined sending Resident B to the hospital for evaluation and treatment of her right hip fracture. During an interview, on 5/30/25 at 11:03 a.m., LPN 30 indicated, prior to the fall on 5/25/25, Resident B had been resting in bed. Staff found the resident between the two beds in the room maybe 45 minutes later, following shift change. A medication review was requested due to the resident recently starting taking hydrocodone (opiate pain medication). During an interview, on 5/30/25 at 11:10 a.m., RN 5 indicated CNA 35 came and notified her on 5/25/25 that Resident B had fallen. Resident B was assessed by RN 5. RN 5 and the CNA lifted Resident B off the floor and placed Resident B into bed. Resident B's immediate fall intervention was bed in the lowest position and increased supervision during neurological checks. CNA 35 was unavailable for interview during the survey on May 30 and June 2, 2025. On 5/30/25 at 11:43 a.m., RN 6 indicated after a resident experienced a fall, the immediate intervention would be put into place by the nurse. The Interdisciplinary Team (IDT) would later review the fall and update the care plan On 5/30/25 at 1:00 p.m., the DON indicated neurological checks were a nursing measure and not an immediate intervention to a fall. Immediate interventions after a fall would be documented in the residents' progress note and in a 24-hour report. The resident care plan should be updated with immediate interventions. On 5/30/25 at 1:14 p.m., CNA 7 indicated, on 5/19/25, he heard a noise and saw Resident B walking down the hallway. He assisted Resident B to the bathroom. CNA 7 turned to grab towels from the bathroom sink when Resident B ran behind him out of the bathroom with her pants and brief around her ankles. When Resident B turned around, Resident B tripped and fell, hitting her head against the wall. CNA 7 went and got RN 5. CNA 7 and RN 5 assisted Resident B into bed after the RN completed her assessment. No immediate intervention was put into place. 2. Resident C's clinical record was reviewed on 5/30/25 at 10:55 a.m. Diagnoses included Parkinson's disease without dyskinesia (abnormal, involuntary movements), unspecified dementia, muscle weakness, and need for assistance with personal care. A fall risk assessment, dated 12/5/24, indicated Resident C was at moderate risk for falls. A 3/11/25, quarterly, MDS assessment indicated the resident had moderate cognitive impairment. Moderate assistance was needed for toileting hygiene, footwear, and personal hygiene. Supervision was needed for rolling left and right, going from sitting to standing, chair/bed to chair transfers, and toilet transfers. A walker was used as a mobility device and the resident needed supervision for walking 10 feet. The resident had two falls without injury since the prior MDS assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A current care plan for falls, dated 12/20/23, indicated the resident was at risk for falls due to the resident not always using assistive devices, having impaired balance and coordination, and having an unsteady gait. Interventions included the following: additional anti-skid strips placed in front of recliner (03/24/2025), educate and remind the resident to use the call light, even for standby assistance (03/03/2025), have personal items that the resident uses frequently within his reach (12/20/23), call light within reach (12/20/23), reminder signs will be placed within view in my room to remind me to use the call light for assistance (per POA request) (12/23/24), falling leaf program (6/4/24), wear proper footwear or non-slip footwear when resident is up (12/20/23), assistive devices will be kept within resident's reach (3/24/25), and resident will sit on non-skid mat in my recliner (12/5/24). An Interdisciplinary Team (IDT) note, dated 1/7/25 at 2:51 p.m., indicated Resident C fell on 1/6/25 at 3:30 p.m. as he attempted to transfer without assistance. The resident pulled the call light cord and facility staff found him sitting on the bathroom floor. The intervention implemented was to re-educate the resident on the importance of using the call light for staff assistance with ambulation to and from the bathroom, hygiene, and dropped items off of the floor. The clinical record lacked a nurse's note for a fall on 1/6/25. A risk management form, provided by RN 3, on 6/2/25 at 10:25 a.m., indicated the immediate action taken was that Resident C was educated on the importance of call light usage. The call light was placed with personal belongings in reach of the resident while in his recliner. A fall investigation worksheet, provided by RN 3, on 6/2/25 at 10:25 a.m., indicated that Resident C was on the bathroom floor, holding onto the railing. The resident took self to the toilet and pulled the call light. The new interventions put into place were 4 P's (position, personal needs, pain, placement), educate resident on call light, and call light in reach. A 4 P's flow sheet, provided by RN 3, on 6/2/25 at 10:25 a.m., indicated a lack of documentation on 1/7/25 from 10:00 a.m. to 1:00 p.m. and on 1/8/25 from 6:00 a.m. to 5:00 p.m. A progress note, dated 3/2/25 at 11:55 p.m., indicated Resident C used his call light and was found sitting on his bedroom floor beside his bed. The resident slid from the edge of his bed as he reached to move his walker closer. Facility staff assisted the resident from the floor back into bed. No immediate interventions were implemented to prevent further falls. An IDT note, dated 3/3/25 at 11:38 a.m., indicated Resident C fell on 3/2/25 at 10:45 p.m. The resident was organizing his walker and bedside table; he leaned further than anticipated and slid to the floor. The resident indicated to IDT staff that he continues to do as much as he can on his own, but sometimes his body disagrees. The intervention implemented was call lights were to be in reach and resident education was provided about natural decline of body and encouraged to use the call light for assistance, even to have a staff member present for stand by assistance. A risk management form, provided by RN 3, on 6/2/25 at 10:25 a.m., indicated the immediate action taken was Resident C was assisted to standing position, using two staff members, and assisted back into bed. (continued on next page)

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	155551	A. Building B. Wing	06/02/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A fall investigation worksheet, provided by RN 3, on 6/2/25 at 10:25 a.m., indicated Resident C was organizing his walker and bedside table and leaned farther than expected and slid to the floor. The new interventions put into place were resident education provided on call light use, even if to have a staff member present for standby assist. A 4 P's flow sheet, provided by RN 3 on 6/2/25 at 10:25 a.m., indicated a lack of documentation on 3/3/25 from 3:00 p.m. to 9:00 p.m. and on 3/4/25 from 4 p.m. to 9:00 p.m. A fall risk assessment, dated 3/7/25, indicated Resident C was at moderate risk for falls. A progress note, dated 3/21/25 at 9:45 p.m., indicated Resident C was found lying on his back with his head facing the closet and his feet towards the bed. The resident had previously been in his recliner. His walker was beside him. Staff observed blood on the floor after assisting the resident to a standing position. The resident was found to have had two abrasions to his right buttock. No immediate interventions were implemented to prevent further falls. An IDT note, dated 3/24/25 at 3:40 p.m., indicated Resident C had a fall on 3/21/25 at 9:25 p.m. The resident had been transferring without assistance and had attempted to get up from the recliner. During a post fall interview, the resident indicated that he had Parkinson's and falling was expected. The fall intervention implemented was to add additional anti-skid strips in front of Resident C's recliner, provide education, and offer encouragement to use the call light for assistance. A risk management form, provided by RN 3, on 6/2/25 at 10:25 a.m., indicated the immediate action taken was Resident C was assessed for injuries. A fall investigation worksheet, provided by RN 3, on 6/2/25 at 10:25 a.m., indicated that Resident C had attempted to get up from recliner. The new interventions section of form was incomplete and did not list an intervention. A 4 P's flow sheet, provided by RN 3 on 6/2/25 at 10:25 a.m., showed lack of documentation on 3/21/25 through 3/25/25 until 2:00 p.m. A progress note, dated 4/30/25 at 7:45 p.m., indicated Resident C had fallen in his room. He was found lying on the floor with his head towards the door and his feet towards the window. His walker was laying on the floor beside him. The resident had two skin tears to his right arm. The immediate intervention was that the resident went to bed and he was encouraged to use the call light and ask for staff assistance. An IDT note, dated 5/1/25 at 2:06 p.m., indicated Resident C had a fall on 4/30/25 at 7:45 p.m. The resident attempted to transfer without assistance. The resident indicated that he had lowered himself to the floor and he did not fall. The intervention implemented was that staff will encourage the resident to increase fluids and have a urinal within his reach. A risk management form, provided by RN 3 on 6/2/25 at 10:25 a.m., indicated the immediate action taken was Resident C was encouraged to use call light and have staff help with transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A fall investigation worksheet, provided by RN 3 on 6/2/25 at 10:25 a.m., indicated that Resident C lost his balance. The new interventions put into place was staff would keep urinal within resident reach. A 4 P's flow sheet, provided by RN 3 on 6/2/25 at 10:25 a.m., indicated lack of documentation on 5/1/25 from 3:00 p.m. to 5:00 p.m., 11:00 p.m. to 5/2/25 5:00 a.m., and 5/2/25 from 12:00 p.m. to 5:00 p.m. During an interview, on 6/2/25 at 10:06 a.m., CNA 4 indicated staff was to offer Resident C assistance with his personal care. The facility staff was to approach and supervise when the resident was observed attempting to perform tasks independently. She was unable to recall any fall interventions that were in place for Resident C, other than to prompt resident to ask for help. She was made aware of resident falls and interventions by shift reports. During an interview, on 6/2/25 at 10:28 a.m., QMA 8 indicated the nurses documented when a resident fell and the nurses put in a fall intervention in the nurse's notes. Resident C was not considered a high fall risk. He ambulated by himself with his walker and was a one assist for toileting needs. The fall interventions Resident C had in place was using a walker and wearing non-skid socks. She had not noticed a decline in his cognitive function. During an interview, on 6 /2/25 at 10:38 a.m., LPN 9 indicated that Resident C's fall interventions were using a walker or wheelchair, non-skid socks, and proper footwear. The nurse was to implement an immediate fall intervention with each facility fall. The immediate intervention was to be documented on a post-fall note and in the risk management assessment. LPN 9 indicated she did not update the care plans with immediate fall interventions. A paper form was passed between shifts and should inform staff of any new intervention put into place. IDT usually informed staff verbally of any care plan updates. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 6/2/25 at 11:44 a.m., RN 3 indicated that the floor nurses were expected to do a post-fall assessment, obtain vital signs, assess for injuries, and implement an immediate fall intervention. A fall intervention was to prevent another fall from occurring. The nurses were to document interventions on a fall note template. She updated the care plan with new interventions after she reviewed the fall. RN 3 confirmed that Resident C's record lacked documentation of a nurses note on 1/6/25 for a fall. The immediate intervention for the 1/6/25 fall was re-education. She updated the care plan with that intervention after the 1/7/25 IDT meeting. No immediate intervention was put into place for Resident C's fall that occurred on 3/2/25 and she spoke with Resident C after the 3/3/25 IDT meeting about the natural decline of his body and his disease progression. The immediate intervention for Resident C's 3/21/25 fall was to assess for injuries and after the IDT meeting on 3/24/25 an intervention was added to place additional skid strips in front of Resident's C's recliner. The immediate fall intervention on 4/30/25 was to encourage Resident C to use his call light. RN 3 updated the care plan with a new intervention on 5/1/25. The new intervention was to increase fluids and have urinal within reach. There was no mention of Resident C and bathroom use in the post-fall note, but she felt she needed to come up with something and the resident was usually going to and from the bathroom. She considered Resident C's cognitive function when she implemented new fall interventions. Resident C's cognitive function had shown a 4-point decline since September 2024. He scored moderate cognitive impairment three months ago. New interventions were conveyed to staff by in-service papers that needed to be signed by the facility staff. RN 3 confirmed IDT usually met 24 to 72 hours after the initial fall and that an immediate intervention was to be placed prior to IDT meeting. RN 3 confirmed that the immediate interventions that were put into place at the time of Resident C's recent falls would not prevent another fall from occurring. During an interview, on 6/2/25 at 11:44 a.m., the DON indicated that the floor nurses were not using the fall template regularly and they could either use the template or enter a nurse's note. Fall packets were made to aid in the documentation processes. Floor nurses had been educated to update resident's care plan at the time of the fall. The nurses' notes regarding Resident C's falls were vague and needed to give more details. Re-education was to be done with each fall and was not considered a new intervention. A new intervention was not put into place for Resident C's 1/6/25 fall. The 4 P's form that was included in Resident C's fall packets had not completed accurately and contained missed documentation. The DON confirmed that the immediate interventions put into place at the time of Resident C's recent falls would not prevent another fall from occurring. During an interview, on 6/2/25 at 12:37 p.m., LPN 10 indicated Resident C was a high fall risk. Immediate fall interventions were documented by the nurses on the risk management form and IDT updated the care plans. During an interview, on 6/2/25 at 12:40 p.m., LPN 13 indicated the floor nurse completing the fall investigation and paperwork also determined the immediate fall intervention. The MDS Coordinator updated the care plans. New interventions were passed on during shift report. Alert paper charting was completed and stayed at the nurse's station. During an interview, on 6/2/25 at 1:10 p.m., LPN 11 indicated immediate fall interventions were relayed during shift report and documented on the risk management form. The risk management team reviewed the fall and updated the care plan accordingly. Staff inservices were provided with resident falls and their interventions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 6/2/25 at 1:35 p.m., LPN 12 indicated floor nurses were permitted to update the care plan, but usually did not and staff waited for the MDS Coordinator to update them. She relayed her immediate intervention for Resident C's 3/21/25 fall during her shift report. She was unaware of how notifications were conveyed when the risk management team or the MDS Coordinator updated the care plans. A current policy, titled Fall investigation and Risk Evaluation, provided by the DON on 6/2/25 at 11:10 a.m., indicated the following: . Policy: It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assisted devices to prevent avoidable accidents A current policy, titled Care Plan Revisions Upon Status Change, provided by the DON on 6/2/25 at 11:10 a.m., indicated the following: . The care plan will be updated with the new or modified interventions. Care plans will be modified as needed by the MDS Coordinator or other designated staff member This citation relates to Complaint IN00459934. 3.1-45(a)(2)