STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mississippi Valley	500 Messenger Road Keokuk, IA 52632

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 observations, clinical record review, policy review, resident and staff interviews, the facility failed to provide staff with clear resident specific directions for the level of assistance a dependent resident required for repositioning and the use of a bed pan for 1 of 4 residents (Resident #1) who experienced a fall with fracture when assisted with the use of a bed pan. The facility reported a census of 56 residents.Findings include: Review of the Minimum Data Set (MDS) assessment, dated 12/18/25, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. The list of diagnoses included hereditary motor and sensory neuropathy (a progressive disorder damaging peripheral nerves causing muscle weakness, atrophy (loss of muscle tissue) and sensory loss), chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. The assessment identified the resident non-ambulatory with the use of a wheelchair for mobility, and dependent to roll left and right and chair/bed-to-chair transfer. Review of an Event Report for a Safety Event - Fall Investigation for Resident #1, dated 12/21/25 completed by Staff C, Licensed Practical Nurse (LPN), revealed, in part:a. The fall occurred in the resident's bedroomb. Fall witnessedc. No adaptive equipment in use at the time of the falld. Description of Fall - see nurse notes. Review of the electronic health record (EHR) revealed the same nurses note entered in the Note section of the Event Report. The Notes section, documented At 11:20 am Called to room per CNA (Certified Nursing Assistant) upon entering the resident [Resident #1] was on floor on his back beside bed. Left leg with external rotation and a visible deformity of outer mid-thigh. Unable to move left leg. Resident was not moved from floor. He states he did not hit his head.Ambulance called at 1130 (AM).then at 1605 (4:05 PM) resident was being admitted with a left knee FX (fracture).Review of the Self Report, submitted on 12/22/25, Incident Summary revealed, in part: The resident is [name redacted, Resident #1]. The issue is a fractured knee cap that occurred on 12/21/2025. Scenario: Nurse was called to the resident's room. Upon arriving, the nurse observed the resident laying on the floor, on his back by his bed. Left leg was observed with external rotation and visible deformity on outer mid-thigh. Resident was observed unable to move his leg. Resident denies his head being hit or injured. Resident was not moved by facility staff. Physician notified and EMS (emergency medical services) was summoned to the facility. The acting DON (Director of Nursing) was notified as was the resident representative, of this event. EMS arrived, transferred resident to gurney and transported resident to hospital, where eventually he was admitted for further evaluation upon his diagnosis and any necessary follow up medical treatment. Scenario Review- The acting DON reviewed the event that occurred. The CNA, [name redacted] that was involved with the incident was questioned about what her role and/or observation was in the event. [CNA name redacted] identified she was in the resident's room and was assisting him off a bed pan and was going to help position him from that. She indicated she requested the resident to turn on his side. She observed the resident attempting to grab the assistance rail to assist himself in moving off the bed pan and, in that process, his legs slid off the bed. She observed that this caused the rest of his body to move also as a result. [CNA name redacted] when realizing the body movement was continuing, did attempt to stop the body movement from continuing by holding onto the resident's gown to stop it, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Mississippi Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Messenger Road Keokuk, IA 52632	

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	but was not successful. The resident slid off the bed and made contact with the floor involving the left side of his body. [CNA name redacted] then summoned additional staff assistance to the resident's room. It should be noted at that time of this event, only one (1) staff was required for assisting the resident by re-positioning within his bed. Therefore, the care expectations for the resident were being followed by [CNA name redacted] and the facility believes no staff culpability is evident.Review of hospital progress notes for the hospitalization from 12/21/25 to 12/26/25 revealed Resident #1 had a left femur fracture as result of a fall out of bed while at the facility.Review of a Progress Note in the EHR revealed the following ADL (activities of daily living) charting entries:a. On 12/11/25 at 21:05 (9:05 PM), revealed: Thursday ADL Charting: Bed Mobility Resident is an extensive two person assist with bed mobility and lifting BLE into bed. Resident requires staff assistance for repositioning and is offered Q2hrs. Pressure reduction mattress utilized as well as side rails. Pillows utilized per request with no wedges being used. Resident A/O x4 and able to communicate needsb. On 12/16/26 at 20:10 (8:10 PM) revealed, in part: Toileting and Continence: include maximum number of staff assisting, bowel and bladder, use of continence supplies, frequency of toileting or incontinence cares: Utilizes bed pan for bowel movements. Assist X 1-2 (one to two staff assistance) with toileting needs.c. On 12/19/26 at 00:14 (12:04 AM) revealed, in part: Bed mobility: include maximum number of staff assisting, include how resident lifts legs into bed and side rail use (left, right, bilateral, 1/2 or 1/4): Assist x2. Does not lift legs. Bilateral 1/4 side rails. Turning and repositioning: do they need assist, how often are they being repo'd (repositioned) etc. Use of pillows and wedges, how often being repo'd, effectiveness: Independent with repo. Calls when he needs boosted up in bed. Pillows for comfort. Effective. Pressure reducing device for bed: low air loss, scoop mattress, roho etc: n/a.Review of the Care Plan for Resident #1 revealed a problem area, start date 3/31/21 to address I am at risk for falls. Approaches included:a. Implement exercise program that targets strength, gait and balance. Start Date: 7/3/24.b. Increased staff supervision with intensity based on resident need. Start Date: 7/3/24. After the fall on 12/21/26 the approach Ax2 (Assist of 2) in bed for rolling and repositioning with a start date of 12/22/26 added to the Care Plan. The Care Plan also included a Problem area, start date: 3/31/21 to address I am limited in physical mobility and requires assist with ADL's. Approaches included, in part:a. I require assist with all ADLs. Ax2 Hoyer (a brand name of a mechanical lift). Start Date: 7/3/24.After the fall on 12/21/26, the following approach added to the Care Plan: I am aware that I can assist staff when I am being rolled in my bed for positioning purposes which I can use assistance rails to help manage rolling motion, I will now require two (2) staff to assist me with bed roll/positioning with start date of 12/22/25 and an end date: 3/18/26. During an observation on 3/10/26 at 8:38 AM, Staff D, CNA, and Staff E, CNA assisted Resident #1 to reposition by moving him towards the head of the bed. The resident was dependent on staff during the repositioning. During an interview immediately after the repositioning, Resident #1 stated he remembered the fall from his bed in December 2025, but did not remember which staff had assisted him. Resident #1 explained he needed help with rolling side to side, and staff assisted him to reposition. He recalled the staff person pushed him instead of flipping him over and pushed him out of the bed. Resident #1 explained that he had a narrower bed at that time. Resident #1 reported that he thought he tried to help, but the CNA moved him too quickly for him to grab the bed rail. Resident #1 reported before the fall in December 2025, he had either one or two staff that assisted him with repositioning and had never had problems before.During an observation on 3/10/26 at 11:30 AM, the CNA Trainer and Staff F, CNA, assisted Resident #1 with dressing. They assisted the resident with rolling from side to side two times while they pulled up his pants. The resident did not assist.During an interview on 3/10/26 at 10:58 AM, Staff C, Licensed Practical Nurse (LPN) stated she assessed Resident #1 after his fall on 12/21/25. Staff C stated Staff A, CNA, was in the room and told her the resident just slid. Staff C recalled Staff A reported the fall happened when she assisted the resident to reposition. Staff C reported she had worked at the facility for 2 years, and had helped to reposition Resident #1 during this time. Staff C stated that she had tried to put the resident on the bed pan by (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Mississippi Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Messenger Road Keokuk, IA 52632	

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	herself, and explained the resident was stiff, really hard to move and did not assist when repositioned for the bedpan. Staff C stated the resident had shorter quarter rails, and the mattresses on the beds were slick. Staff C explained she tried to use two staff, as the resident would slide on the mattress when trying to turn him. During an interview on 3/10/26 at 12:36 PM, the Restorative Nurse stated he had been in his position since 2015 and had the responsibility of oversight for the safe handling and transfer of residents. The Restorative Nurse reported the facility made sure new orientees received training related to safe transfers and repositioning, and he occasionally trained the staff. The Restorative Nurse explained that Staff C, CNA, received training on safe handling and transfers during her orientation with the CNA Trainer and also at a recent skills fair. He reported doing training with Staff C, CNA, after Resident #1's fall. The Restorative Nurse reported that he had repositioned Resident #1 prior to his fall. He reported the resident had been care planned for use of either one or two staff, and he would have to see documentation in the record that would indicate the resident required 2 staff to place him on a bed pan. The Restorative Nurse reported he heard Resident #1's fall occurred with the assistance of one staff, and after the fall the facility changed the level of assistance to two staff for ADL's. The Restorative Nurse added the facility changed the policy after Resident #1's fall to a mandatory assist of two staff for all paraplegic, quadriplegic or non-responsive residents. During an interview on 3/10/26 at 12:59 PM, the MDS Registered Nurse (RN) stated she had been in her position since September 2024 and had the responsibility of completing all resident MDS assessments and Care Plans. The MDS RN confirmed the MDS assessed Resident #1 dependent on staff for all ADL care with the exception of eating/oral hygiene. The MDS RN explained that the night shift nurses reviewed the resident's ADL needs including toileting, transfers and bed mobility during the seven-day assessment period of each MDS. During a second interview on 3/11/26 at 10:59 AM, the MDS RN explained the use of dependent meant staff did all of the ADL tasks without the resident assisting. The MDS RN reported she added the intervention to Resident #1's Care Plan for two staff to assist with all ADLS on 12/22/25 after the resident's fall. She explained Resident #1 did not have a change in ability, rather she added the intervention to ensure two staff assisted the resident, which clarified direction to staff.During an interview on 3/10/26 at 1:40 PM, the CNA Trainer stated she had provided care and repositioned Resident #1 prior to the fall on 12/21/25, but it had been some time since she last assisted. The CNA Trainer reported she trained Staff C, CNA, and Staff C passed competency skills which included bed mobility on 8/7/25. The CNA Trainer explained she had not specifically trained Staff C on how to assist Resident #1 with ADL's. The CNA Trainer explained communication care cards (also known as a Kardex, a quick reference tool to summarize a residents current ADL needs) are posted above the residents' bed, and the cards direct how many staff were needed to transfer/assist with ADLs. The CNA Trainer stated the Restorative Nurse and Therapy staff kept the Kardex information updated. She explained for bed mobility and use of the bed pan she always used two staff for Resident #1. She added prior to the fall, putting Resident #1 on the bed pan would be the same as repositioning and required 2 staff. During an interview on 3/10/26 at 2:25 PM, Staff E, CNA stated she had provided care to Resident #1 prior to his fall in December 2025. Staff E reported that she had never repositioned the resident by herself, and had always had two staff. Staff E explained staff had to reposition the resident to put him on the bed pan, and when staff rolled him, they needed two people. Staff E reported she knew the number of staff that were needed to assist residents by looking at the Restorative Communication form kept on a clipboard at the nurse's station. Staff E obtained a document titled Restorative Therapy to Nursing Communication dated 2/27/26. The document identified Resident #1 by name. The document directed Transfer w/Hoyer min BID (two times) for lunch and supper. Use caution with LLE (lower left leg extremity), support throughout transfer. Resident should remain up in w/c (wheelchair) 30 min after meals. During a follow up interview on 3/11/26 at 11:53 AM, Staff E, CNA, stated she used the Kardex posted in the residents' rooms to know whether or not one or two staff were needed to assist residents with their ADLs. She explained she also looked at the Restorative Therapy to Nursing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Mississippi Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Messenger Road Keokuk, IA 52632	

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	Communication form. During an interview on 3/10/26 at 2:30 PM, Staff G, CNA, stated she had worked at the facility for 3 years. Staff G stated Resident #1 had always been a two assist for everything including repositioning, putting him on/off a bed pan and transfers. Staff G explained she looked at the Restorative Therapy to Nursing Communication clipboard for direction.During an interview on 3/10/26 at 2:56 PM, Staff F, CNA, reported she had provided care to Resident #1 prior to his fall in December 2025. Staff F explained that the resident used to be more independent and could assist with repositioning, but that changed about 6 months before his fall. Staff F explained the resident gained weight, had become more frequently short of breath, and wasn't able to help. Staff F stated it was tougher to reposition him, especially if staff was going to put the bedpan under him. Staff F stated one person couldn't do it, because it wasn't safe. Staff F reported one person would need to pull up on the chuck (an incontinence pad placed under a resident), while the other person rolled the resident over and positioned the bed pan under him. Staff F added Resident #1 used a larger bed pan making it more difficult. During a follow up interview on 3/11/26 at 11:58pm, Staff F, CNA, stated she learned how staff assisted a resident with ADLs by word of mouth. She explained she would ask other CNAs for direction, or she would go to either the CNA trainer or a nurse. Staff F stated she did not look at the residents' Care Plans. Staff F reported she would also look at the Restorative Therapy to Nursing Communication form on the clipboard. Staff F explained that prior to Resident #1's fall, she would use her own judgement or word of mouth. During an interview on 3/10/26 at 3:55 PM, Staff B, RN confirmed she completed ADL assessments on Resident #1 during the MDS assessment period, which included assistance for toileting. Staff B confirmed she completed an assessment on 12/16/25 that identified the resident needed one to two staff assistance with toileting. Staff B explained that the resident needed the assistance of one staff to empty his urinary catheter, but needed the assistance of two staff to place him on the bed pan. Staff B explained prior to Resident #1's fall, he was a good roller. At times, the resident had been able to roll with the assistance of one staff, but it might take two staff to get the resident off the bed pan. Staff B explained that it depended on the day and how the resident was doing prior to his fall. The resident had been able to grab the quarter bed rails and help with rolling. Staff B reported that the resident rolled better to the left, and would use his right arm to grab the left rail. During an interview on 3/11/26 at 8:43 AM, Staff A, CNA, reported she had provided care to Resident #1 prior to 12/21/25, which included repositioning and transferring. Staff A reported she utilized the Kardex posted in the resident's room for instruction on toileting, repositioning and transfers. Staff A did not remember the instructions on Resident #1's Kardex. Staff A reported staff helped Resident #1 to roll over, but he helped hold himself by grabbing the bed rail. Staff A reported she had not repositioned the resident by herself, but she had previously put the resident on the bed pan by herself and had never had any problems before. Staff A explained for repositioning the resident, he needed to be pulled up in bed and she always had two staff for that. Staff A reported that on the day of the fall, the resident requested to use the bed pan. Staff A stated she got his bed pan, and asked the resident to roll over. Staff A explained he can't do it himself, and we have to assist. Staff A reported she stood on the right side of the bed (near the window), about mid bed and with the quarter rails near the top of the bed in an upright position. Staff A stated that she went to roll Resident #1 over on the left side and he had grabbed the rail, but his legs swung over the end of the bed on left side. Staff A explained that she tried to reach for the resident, but he slid off the bed and landed on his left side. Staff A reported the resident had a smaller bed then (when he fell). Staff A explained, he's a bigger guy; I had a hard time turning him. She reported Resident #1's Kardex stated two people assist for everything. She stated she couldn't remember if the Kardex in the room identified the number of staff needed for ADLs prior to the resident's fall. Staff A stated during training she was told she could use one or two staff for toileting Resident #1. Staff A denied being instructed that one staff emptied the urinary catheter and two staff were needed to place the resident on a bed pan. During an interview on 3/11/25 at 9:46 AM, the DON reported that either the MDS RN or Restorative Nurse updated the Kardex located in the residents' rooms, but mainly the Restorative (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mississippi Valley	500 Messenger Road Keokuk, IA 52632

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	Nurse had the responsibility of updating the Kardex. The DON reported at the time of Resident #1's fall in December 2025, she was the interim DON. She reported she was very new at the time, and maybe in the first couple weeks of taking over. The DON reported staff were expected to follow the Kardex located in each resident's room. The DON reported the Kardex stated the resident was a staff assist of one for bed mobility and toileting prior to his fall, and Staff A, CNA, followed the Kardex in the room. The DON reported she was not sure what the MDS assessment meant when the assessment identified a resident was dependent versus max/substantial assist for ADLs. The DON explained staff usually could get by with one staff for Resident #1 for the bed pan, but it depended on the bowel movement amount and consistency on whether or not two staff were needed. The DON explained that staff reported to her that the resident helped to roll himself. The DON provided a copy of resident's #1 current Kardex located in his room.Review of the Kardex from Resident #1's room revealed Transfer status: Hoyer; Ambulation: N/A; Side Rails: Quarter checked and x2 checked; Toilet: Bedpan handwritten and checked; Tubigrips - blank; [NAME] Hose - blank; Special Devices: blank. A handwritten date of 4/8/25 noted in right hand corner of the Kardex. During an interview on 3/11/25 at 11:26 AM, the Restorative Nurse confirmed the current Kardex, dated 4/8/25, did not identify the number of staff Resident #1 needed for assistance with ADLs. The Restorative Nurse then stated the Restorative Therapy Communication to Nursing provided specific instruction to staff. The Restorative Nurse provided the current Restorative Therapy to Nursing Communication form for Resident #1, dated 2/27/26, which instructed staff to transfer with hoyer min BID for lunch and supper, use caution with LLE, support with transfer; Resident should remain up in w/c 30 min. The Restorative Nurse explained that some staff had the ability to turn a resident safely with one staff, and staff had different physical abilities. The Restorative Nurse reported that while it was now mandatory for two staff to assist Resident #1 with ADLs, the resident was previously an assist of one or two staff, and the residents Care Plan would have told staff more specifically what the resident needed. The Restorative Nurse was unaware Resident #1's Care Plan did not specifically address the number of staff persons the resident needed to assist him with repositioning and toileting prior to his fall on 12/21/25. During an interview on 3/11/26 at 12:04 PM, the Restorative Nurse provided a copy of the Restorative Therapy to Nursing Communication form for Resident #1 that was in place at the time of the 12/21/25 fall. Review of the form, dated 9/17/25, revealed Per Therapy: Ensure Resident is up in w/c BID and check skin integrity before and after. Report any refusal or adverse conditions to the nurse for documentation. The form lacked any specific instructions regarding the number of staff need to provide ADL assistance to Resident #1. During an interview on 3/11/26 at 12:17 PM, Staff D, CNA, stated she worked as a contract staff and had worked at the facility a couple of months ago and recently returned. Staff D stated the facility did not have a place to go and look to find out whether a resident required the assistance of one staff or two for ADLs. Staff D denied that she had received any direction from management staff, and reported no one had told her what to do. Staff D reported she used her judgement to determine whether or not she needed the assistance of another staff person to assist residents with ADL tasks. During an interview on 3/11/26 at 1:07 PM, the DON reported CNAs do not conduct assessments, nurses do. The DON reported that CNAs knew how to assist residents with ADLs through verbal report, the Kardex in the residents' rooms, and orientation. The DON reported contract staff are informed of the level of assistance during shift report. The DON stated Resident #1's Care Plan should have identified the amount of staff assistance needed to complete ADL tasks. The DON reported that for the safety of Resident #1 and for staff safety, they made it mandatory for two staff to assist him with all ADLs after his fall.During an interview on 3/12/26 at 7:38 AM, Staff H, RN, confirmed that she completed the ADL assessments associated with the MDS, including an assessment of Bed Mobility, dated 12/19/25. Staff H reported Resident #1 needed staff assistance of two on night shift due to his size. Staff H explained that staff would roll the resident, push him so he could reach the bed rail and then he would hold on to the rail. Staff H stated Resident #1 did not have a good grip on the rail due to contractures on both hands, and only (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Mississippi Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Messenger Road Keokuk, IA 52632	

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	able to use his right thumb and index finger. Staff H stated the resident had better bed mobility on the left side. Staff H reported she assessed Resident #1 required the assistance of two staff for everybody's safety, both the resident and the staff. On 3/12/26 at 11:24 AM, during an interview, Staff I, CNA, reported she had worked 4 years at the facility and provided care throughout that time to Resident #1. When asked if she had repositioned or put Resident #1 on the bed pan by herself, she replied, Not so much. He had gotten harder to do. Staff I reported Resident #1 had gained weight and needed a second aide for all of his ADLs except emptying the catheter, Staff I explained this had been the case for quite some time prior to the fall in December 2025. Staff I reported that she would use her personal judgement to determine if a resident needed the assistance of two staff. She reported she was using the Kardex in the room, but did not realize the it did not identify the number of staff needed to complete ADL tasks. Staff I reported she also utilized the Restorative Therapy to Nursing Communication clipboard. Review of the facility's policy, titled Safe Resident Handling, dated 2/2024, revealed, in part, resident handling tasks would be carried out in accordance with care plans specific to the resident. If a level of assistance changed, staff would immediately communicate the change in status to the supervising nurse and Care Plan Coordinator.Review of the facility's policy, titled resident Pre-admission Screen/Resident Review (PASRR) Care Plan and MDS Care Plan, dated 5/22/23, revealed, in part.The MDS care plan shall also be developed by the facility's care team with resident/resident representative involvement. The MDS care plan shall be reflective of assessment results from the MDS and/or current clinical functioning of the resident. The care plan will identify the potential problems, goals to be achieved, and intervention strategies to be employed (by whom or by when) to meet the goals, alleviate problems and determine if new problems are occurring in order to be addressed by the overall care team.