STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via of Des Moines	4911 SW 19th Street Des Moines, IA 50315

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on clinical record review, staff interviews and policy review, the facility failed to ensure staff protected and prevented resident to resident abuse for 1 of 1 resident reviewed (Resident # 3), when Resident # 2 slapped Resident #1 while in the lounge area. Resident #2 had a known history of resident to resident altercations and history of hitting staff, and the facility failed to evaluate the effectiveness of the interventions implemented to prevent harm to other residents. The facility reported a census of 72 residents. Findings include: 1. Resident #2 Minimum Data Set (MDS) assessment dated [DATE] documented a BIMS score of 3, indicating severe cognitive deficits. The MDS included diagnoses of Alzheimer's disease, anxiety disorder, and depression. The MDS documented during the look back period the resident had both physical behaviors symptoms directed toward others, and other behavioral symptoms not directed toward others, and wandering that occurred 1 to 3 days. The MDS further documented the resident behaviors of wandering that occurred 1 to 3 days. It documented the resident's current behavior status was worse the then prior MDS. The Care Plan included the following Focuses: a. Revised 4/30/24: Resident #2 is at risk for increase in mood/behaviors dx diagnoses Alzheimer's with early onset, anxiety and depression. Resident #2 will wander in the hallways, he had times of inappropriate sexual behaviors and can be easily angered and become verbally and physically abusive. He will attempt to punch, kick and slap staff and other residents. The Interventions indicated the following: -Resident #2 to have a silent type alarm placed in the resident's chair. -Resident had an altercation with his roommate. The roommate was moved for his safety. -Observe for risk for harming others, increased anger, labile mood or agitation or feels threaten by others. -Redirect Resident #2 away from female residents when he is sexually inappropriate (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	An observation on 6/12/24 at 12:35 PM revealed, Resident #2 in his wheelchair with no alarm on sitting at the table within four feet of Resident #3 (female resident) in the lounge. No staff present at this time. At 12:42 PM, Resident #3 started yelling out and staff then came up the hallway and assisted Resident #3 The Facility Investigation dated 5/23/24 reflected Staff I, Certified Medication Aide (CMA) reported concerns to Staff J, Registered Nurse (RN), regarding Resident #2 slapping Resident #3. Staff J, RN reported to the Administrator and Director of Nursing. Staff I, CMA reported she was in view of the common area and witnessed Resident #2 in the common area, self-propelling in his wheelchair toward Resident #3. When Resident #2 reached Resident #3 he slapped her on the right side of the face. Staff I, CMA reported she continued to run over and immediately separate the two residents. Staff I, CMA reported she had witnessed Resident #2 sitting by himself at the table in the common area just five minutes prior to the incident. During an interview on 6/12/24 at 9:38 AM, Staff I, CMA reported she was down the 400 hallway passing medications and needed a blood pressure cuff and so proceeded to walk by the dayroom and saw Resident #2 sitting at the table by himself and Resident #3 was against the wall in the lounge/common area (around 12 feet away). She proceeded down to the end of 300 hallway to get the blood pressure cuff from the nurse working. When she turned around to head back up the hallway she saw Resident #2 self-propelling his wheelchair toward Resident #3. She started to run up the hallway but did not make it in time and witnessed Resident #2 slap Resident #3 on the right side of the face. She continued to run until she got to them and immediately separated them. She then reported it to the nurse. During an interview on 6/12/24 at 9:50 AM, Staff K, Rehab Aide reports Resident #2 is to stay away from the women. Resident #2 had a chair alarm when in a recliner or wheelchair, bed alarm and motion sensor in is doorway. He reports Resident #2 had a history of sexually and physically abusive behaviors toward staff and other residents. During an interview on 6/12/24 at 9:54 AM, Staff L, CMA Resident #2 was to sit by himself in the dayroom and not be left in his wheelchair. Resident #2 had a chair alarm when in a recliner or wheelchair, bed alarm and motion sensor in is doorway. He reports Resident #2 had a history of sexually and physically abusive behaviors toward staff and other residents. During an interview on 6/12/24 at 9:57 AM, the DON reported Resident #2 is not to be put in a wheelchair unless he is weak and unable to ambulate. She reports he had a chair alarm when out of his room and bed alarm and motion sensor when in his room. She reported he is not to be up in his wheelchair to move around and staff are to transfer him to a regular chair when at the table. Staff are to do frequent visual checks on him when he is out of his room. He is not to be close to any women. She reports staff are aware of these interventions due to being educated on them. During an interview on 6/12/24 at 10:05 AM, the Administrator reported Resident #2 was to have frequent checks on him and not be close to any women. She reported he had a motion sensor and bed alarm in his room and when he was out to have a chair alarm on. She verbalized the staff were educated on these interventions. Review of Resident #2 Progress Notes documented on these dates and times the following behaviors: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	*1/28/23 6:10 AM Health Status Note documented as follows; This nurse noticed resident going into another female resident's room. This nurse went into room and asked resident to leave. Resident stated Well aren't you going to help her?! This nurse assured resident that I would help her but he needed to leave the room. Resident stated You better you bitch Resident then left the room and this nurse assisted female resident. I left female resident's room and went to nurses desk, resident was noted to be sitting in a chair by the wall in the dining room. After a few minutes resident got up and started walking back to his room. This nurse was leaving the med room when I heard resident back in female resident's room. I went back into female resident's room and asked him to leave again when resident got angry and yelled at this nurse You shut your fucking mouth! This nurse was standing at the foot of female resident's bed with resident standing in between me and the door. This nurse told resident that he needed to leave the female resident's room immediately. Resident then got physical with this nurse hitting me three times in the chest, hitting me one in the face and grabbing and bending my right wrist back. This nurse yelled out for help but all the Certified Nurses Aide (CNA) CNA's were in other resident's rooms and could not assist. I told the resident that he needed to stop hitting me and leave the room. Resident stated I'll leave when you help her! This nurse assured resident that I would help her but he needed to leave as I couldn't do cares on her while he was in the room. Resident left room and went back to his room. On call manager [NAME] notified. On call Dr. also notified of situation. New Order (N.O.) obtain us with culture and sensitivity may straight cath if needed. Resident currently sitting calmly in chair in dining room. Will continue to monitor *3/21/2023 Health Status Note documented as follows; res. approached med-aide stating that he wanted a knife so he could cut his face. Res. redirected. will monitor *8/3/23 7:58 PM Health Status Note documented as follows; the resident being aggressive to another resident in lounge area. Verbal disagreement between this resident and a female resident. Resident#2 stood with walker and walked past another resident and said, What you gonna do about it? and ran his walker into the other residents' wheelchair. There were words between the two residents and then staff intervened to separate the resident. The incident was witnessed by CNA staff and this nurse. *3/22/24 at 3:43 p.m., Note Text: resident walking with staff in hall way. Resident made comment regarding breasts and attempted to touch staff member over clothes on her breast. Incident reported to this nurse and DON. *3/24/24 at 3:10 a.m., Note Text: CNA reported to this nurse that resident made sexually inappropriate comments to her. This RN reported to resident to inform him that comments like that were inappropriate. Resident stated I know I'm sorry. No other behaviors observed this shift. Will continue to monitor The Nursing Abuse Prevention, Identification, Investigation and Reporting Policy dated 10/01/2019 directed staff as follows: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Policy Statement: All Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking acts that result in person degradation, including the taking or using photographs or recording in any manner that would demean or humiliate a resident, and prohibits using of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep or distribute photographs and/or recording on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. -Physical abuse includes, but not limited to hitting, slapping, pinching, and kicking. It also includes corporal punishment when used to correct or control behavior, including but not limited to, pinching, spanking, slapping hands, flicking, or hitting with an object. - Resident-to-resident physical contact that occurs, which includes but is not limited to where residents are hit, slapped, pinched or kicked and results in physical harm, pain or mental anguish is considered resident-to-resident abuse. Resident-to-resident sexual harassment, sexual coercion, or sexual assault is also considered abuse. The facility will presume that instances of abuse caused physical harm, or pain or mental anguish in resident with cognitive and/or physical impairments which may result in a resident unable to communicate physical harm, pain or mental anguish, in the absence of evidence of the contrary. An example would be a resident slapping another resident who is physically or cognitively impaired, even though the resident who was slapped showed no reaction (e.g., yelp or grimace), it is presumed the resident experienced pain. 2. Resident #3 Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 5, which indicated severe cognitive deficits. The MDS documented the resident was moderate assistance with transfers and ambulation. The Plan of Care with a revised date of 2/08/24, revealed a focus area that resident has impaired cognitive function/dementia or impaired thought processes related to Dementia, Impaired decision making. Intervention include: *Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Date Initiated: 10/25/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48003 Based on observation, clinical record review, policy review, resident and staff interviews, the facility failed to carry out safety interventions to prevent the likelihood of further abuse perpetrated by Resident #2 for 2 of 2 residents reviewed for abuse (Resident #'s 1 and #3); the facility failed to carry out interventions to prevent a fall with a major injury for 1 of 3 residents reviewed for a fall (Resident #6). The facility reported a census of 72 residents. Findings include: 1. Resident #2 Minimum Data Set (MDS) assessment dated [DATE] documented a BIMS score of 3, which indicated severe cognitive deficits. The MDS included diagnoses of Alzheimer's disease, anxiety disorder, and depression. The MDS documented during the look back period the resident had both physical behaviors symptoms directed toward others and other behavioral symptoms not directed toward others that occurred 1 to 3 days. The MDS further documented the resident behaviors of wandering that occurred 1 to 3 days. It documented the resident's current behavior status was worse than the prior MDS. The Care Plan included the following Focuses: a. Revised 4/30/24: Resident #2 is at risk for increase in mood/behaviors diagnoses Alzheimer's with early onset, anxiety and depression. Resident #2 will wander in the hallways, he has times of inappropriate sexual behaviors and can easily be angered and become verbally and physically abusive. He will attempt to punch, kick and slap staff and other residents. The Interventions indicated the following: -Resident #2 to have a silent type alarm placed in the resident's chair. -Resident had an altercation with his roommate. The roommate was moved for his safety. -Observe for risk for harming others, increased anger, labile mood or agitation or feels threatened by others. -Redirect Resident #2 away from female residents when he is sexually inappropriate The Care Plan failed to direct new interventions for safety measures following the 4/23/24 sexual abuse incident and 5/23/24 physical abuse incident to protect the residents. An observation on 6/11/24 at 8:30 AM Resident #2 sat in at the nurse's station with no staff present around at the time. All the other staff assisted residents down the hallway and six minutes passed until staff came back to the area. An observation on 6/12/24 at 12:35 PM, revealed Resident #2 in his wheelchair with no alarm on sitting at the table within four feet of Resident #3 (female resident) in the lounge. No staff present at the time. At 12:42 PM, Resident #3 started yelled out and staff then came up the hallway and assisted Resident #3. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/12/24 at 9:50 AM, Staff K, Rehab Aide reported Resident #2 was to stay away from the women. Resident #2 had a chair alarm when in a recliner or wheelchair, bed alarm and motion sensor in the doorway. He reported Resident #2 had a history of sexually and physically abusive behaviors toward staff and other residents. During an interview on 6/12/24 at 9:54 AM, Staff L, CMA Resident #2 is to sit by himself in the dayroom and not be left in his wheelchair. Resident #2 had a chair alarm when in a recliner or wheelchair, bed alarm and motion sensor in the doorway. He reported Resident #2 had a history of sexually and physically abusive behaviors toward staff and other residents. During an interview on 6/12/24 at 9:57 AM, the DON reported Resident #2 was not to be put him in a wheelchair unless he was weak and unable to ambulate. She reports he had a chair alarm when out of his room and bed alarm and motion sensor when in his room. She reported he was not to be up in his wheelchair to move around and staff are to transfer him to a regular chair when at the table. Staff are to do frequent visual checks on him when he is out of his room. He is not to be close to any women. She reported staff were aware of those interventions due to being educated on them. During an interview on 6/12/24 at 10:05 AM, the Administrator reports Resident #2 had frequent checks on him and was not be close to any women. She reported he had a motion sensor and bed alarm in his room and when he was out to have a chair alarm on. She verbalized the staff were educated on these interventions. 2. Resident #1 MDS dated [DATE] documented that Resident#1 had diagnoses which included hypertension, anxiety, depression and psychotic disorder. The MDS revealed the resident with a BIMS score of 13, for which indicated no impairments with decision making or memory problems. The MDS documented that the resident had adequate hearing, was able to make self-understood, and had the ability to understand others. The MDS documented that the resident needed partial to moderate assistance with personal hygiene. The Plan of Care with an initiated date 7/28/21, revealed a focus area that resident was at risk for cognitive deficit with impaired thought processes as evidenced by diagnosis of Bi-polar II, depression, anxiety, delusional disorder. Intervention include: *prefers to have her door kept shut at all times. Date Initiated: 03/22/2024 During an interview on 6/11/24 at 1:50 PM, Resident #1 reported she had no further interactions with Resident #2 but is worried she might due to staff are not always present in the common areas when Resident #2 is present. She reported it bothers her a lot so she stays in her room most of the time with the door shut. She reported she had told staff about it but nothing changes so she quit telling them. 3. Resident #3 Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 5, which indicated severe cognitive deficits. The MDS documented the resident was moderate assistance with transfers and ambulation. The Plan of Care with a revised date of 2/08/24, revealed a focus area that resident has impaired cognitive function/dementia or impaired thought processes related to Dementia, Impaired decision making. Intervention include: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Date Initiated: 10/25/2023 The Nursing Abuse Prevention, Identification, Investigation and Reporting Policy dated 10/01/2019 lacked safety directions to prevent the likelihood of further abuse perpetrated by a resident. 35434 4. The Minimum Data Set(MDS) assessment tool, dated 3/1/24, listed diagnoses for Resident #6 which included muscle weakness, unsteadiness on the feet and Alzheimer's disease. The MDS stated the resident required supervision or touching assistance for transfers and walking and listed her cognition as severely impaired. An 11/17/23 Incident Note stated a Certified Nursing Assistant (CNA) saw the resident open the door, walk across the hallway, and slide down the wall to sit on her bottom. The note stated she lost her balance and had a small red blood clot filling the right nostril. The resident required the assistance of 1 staff but ambulated on her own. The facility educated staff to assist the resident while she was up at all times. A 12/7/23 Care Plan entry stated the resident was at risk for falls related to impaired cognition and dementia. The Care Plan stated the resident required the assistance of 1 staff for transfers and directed staff to use Hand Held Assistance (HHA) if she refused the walker. A 1/16/24 Care Plan entry stated the resident would be free of falls through the review date and directed staff to follow facility fall protocol. A 2/7/24 Care Plan entry directed staff to encourage the resident to stay in common areas during anxiety. A 2/21/24 7:02 a.m. Incident Note stated staff walked the resident back to her room and when staff returned to the day room, they heard a crash and found the resident on the floor, having a possible seizure. The resident had no injuries. A 2/21/24 11:41 a.m. Health Status Note stated a nurse found the resident on the floor with her head bleeding. The resident transferred to the hospital. A 2/21/24 Hospitalist report stated the resident transferred to the hospital after she had a fall with head trauma with a scalp laceration(cut). A 2/26/24 Health Status Note stated the resident readmitted to the facility and had an additional fall at the hospital on 2/23/24. The note stated the resident would be an assist of 1 with hand held assist. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A 2/27/24 Health Status Note stated the resident was on the floor. The Physical Therapy Discharge Summary, dated 3/8/24, stated the resident required the assistance of 1 staff with HHA. A 3/12/24 provider Encounter Note stated the resident fell and sustained a head laceration. There was a concern for seizure activity but the work up was negative. The resident had sutures in her head. A 4/24/24 8:15 p.m. Behavior Note stated staff found the resident in another resident's room at the end of Hall 700. The resident laid on her right side in the fetal position. The resident stated she hurt but would not allow the nurse to manipulate either leg. A 4/24/24 9:20 p.m. Order Note stated the resident had increasing pain when moving the right leg and the facility received an order for a portable x-ray of the right hip. A 4/24/24 9:41 p.m. Health Status Note stated the resident had increased pain and the facility called 911. A 4/24/24 10:29 p.m. Health Status Note stated the resident transferred to the hospital. The facility Nursing Schedule for 4/24/24 revealed the following staff members worked in the resident's unit during the evening: Staff B CNA 6:00 p.m.-6:00 a.m. Staff C Registered Nurse(RN) 6:00 p.m.-6:00 a.m. Staff D CNA 2:00 p.m.-10:00 p.m. Staff H Certified Medication Aide(CMA) 2:00 p.m.-10:00 p.m. Staff G CNA 2:00 p.m.-10:00 p.m. A 4/30/24 Hospitalist report stated the resident admitted to the hospital following a mechanical fall. She sustained a right hip fracture and underwent an open reduction and internal fixation (ORIF-a surgical repair procedure). The facility's undated untitled investigation of the resident's 4/24/24 fall stated Staff B observed Resident #6 sitting on another resident's bed. Staff B began picking up trash from the floor and the resident began walking toward the door. The resident then lost her balance and fell on the floor, landing on her right side before Staff A was able to provide assistance. The resident had pain and the facility transferred her to the hospital. The investigation did not include information regarding when staff saw the resident prior to her fall. A Witnessed Fall report, dated 4/24/24, revealed the following witness statements: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Staff D witness statement. She walked down the hall and saw the resident exit another resident's room and fall to the ground. Staff B Witness statement: The resident was in another resident's room going through her trash. Staff B came in to the room and told the resident that she would show her to her room and the resident got mad that Staff B picked up garbage she put on the floor. The resident sat on the bed, then picked up a trash bag and headed out the door. She turned as she was going to say something to Staff B and fell outside the door. On 6/11/24 at 1:24 p.m. Staff A Physical Therapist(PT) walked with the resident with a gait belt and a walker. On 6/11/24 at 1:41 p.m., via phone Staff C Registered Nurse(RN) stated Staff D alerted her that Resident #6 fell and it was a hard hit. Upon assessment the resident had increasing pain and they decided to send her to the hospital. Since the fall she has had a decline. She stated the resident was a fall risk. On 6/11/24 at 1:58 p.m. Staff B CNA stated she was pulling down sheets to help other residents to bed when she found Resident #6 in another resident's room. She stated there was trash on the floor and the resident got up from the bed and Staff A made sure she would not trip on anything so she picked up the trash. She stated when the resident got up, Staff A did not touch her and she fell on her side. Staff A stated when the resident walked, they were not supposed to touch her per the family member's direction. She stated they were only supposed to follow her. Staff A stated she had just started her shift at 6:00 p.m. so she had not seen the resident prior to the fall. On 6/11/24 at 2:21 p.m., Staff A PT stated the resident required the assistance of 1 staff for transfer and if she refused a walker staff could use HHA. He stated he was not aware of a directive for staff not to make contact with her. On 6/11/24 at 2:29 p.m., Staff E RN stated prior to the resident's fall(on 4/24/24) the resident was an assist of 1. She would have used a gait belt or a hand hold. If she got up and walked on her own, staff would have rushed over to her. She stated the resident was unstable and they always needed to make contact with her and be hands on because she could fall. On 6/11/24 at 2:36 p.m. Staff F CNA stated prior to the resident's fall, staff did not use a gait belt or physical assistance with her when she walked. She explained that they just needed to stand behind her. On 6/12/25 at 6:33 a.m. Staff B clarified that when she found the resident in the other resident's room, she was sitting on the bed. Staff B started picking up the trash and asked the resident if she wanted to go to her room. The resident started walking to the door and Staff B followed behind her but not too close. Staff A reached for a piece of trash behind the door and that is when the resident turned around and fell . Staff A stated she did not know how far away she was from the resident when she fell but she was not within arms reach. She stated they could not hover over her and had to give her space. She stated when she fell she did not make contact with her because she fell too quickly. (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	On 6/12/24 at 9:33 a.m., via phone Staff D CNA stated she worked on a different unit that night but happened to come up to the area when she saw the resident fall. She stated prior to the fall, the resident was an assist of 1. She stated if the resident started to get up on her own she would absolutely want to make contact with her. She stated at the time of the fall, Staff B was the only staff member she observed around the resident. On 6/12/24 at 9:58 a.m., Staff H CMA stated on the night the resident fell she did not remember seeing the resident as she may have passed medications both downstairs and upstairs. On 6/12/24 at 12:08 p.m., the Director of Nursing (DON) stated prior to the resident's fall, she was an assist of 1. She stated the resident needed physical stabilization. She stated staff should have checked on her frequently and they should have been watching her more closely. She stated Staff B informed her she had just laid her down in bed prior to the fall. She stated safety was first and was a priority over the trash. On 6/12/24 at 12:41 p.m., via email, the Social Services Supervisor stated the facility did not have a fall prevention policy. On 6/12/24 at 2:37 p.m., Staff G, CNA stated she did not see the resident the night she fell because she worked on another hall.