STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on records reviewed and interviews, for one of three sampled residents (Resident #3), whose care plan interventions included the need for two staff members to provide assistance during care, which included incontinence care, bed mobility and repositioning, the Facility failed to ensure staff consistently implemented and followed his/her care plan interventions. On 05/04/25, Certified Nurse Aide (CNA #1) provided incontinence care to Resident #3 without another staff member present for assistance, CNA #1 positioned Resident #3 on his/her side, then turned away from the resident, he/she rolled off the bed and fell onto the floor. Resident #3 was transferred to the Hospital Emergency Department (ED) and diagnosed with a closed displaced fracture (broken pieces of bone that moved away from each other) of the right femoral neck (part of the thigh bone just below the hip joint). Findings include: Review of the Facility's policy titled, Care Planning, last revised 10/18/22, indicated the Facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that include measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/09/25, indicated that on 05/04/25 around 7:45 P.M., CNA #1 was providing care to Resident #3 when he/she rolled out of the bed, was assessed to have a one centimeter (cm) laceration to the back of his/her head, pain in his/her leg, was transferred to the Hospital ED for evaluation and subsequently admitted to the Hospital with a right hip fracture. Review of Resident #3's Hospital History and Physical, dated 05/05/25, indicated he/she sustained a closed displaced fracture of the right femoral neck. Resident #3 was admitted to the Facility in April 2017, diagnoses included Dementia and Parkinson's Disease (a movement disorder of the nervous system that worsens over time). Review of Resident #3's Quarterly Minimum Data Set (MDS) Assessment, dated 02/05/25, indicated he/she was severely cognitively impaired as evidenced by a score of 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) Assessment (score of 0-7 suggest severe cognitive impairment, 8-12 suggest moderate cognitive impairment, and 13-15 suggest that cognition is intact). (continued on next page)

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Further review of the MDS indicated Resident #3 had impaired range of motion to both sides of his/her upper and lower extremities, was dependent on staff for transfers, required substantial to maximum assistance rolling left to right, and with all ADLs. Review of Resident #3's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with his/her Quarterly MDS Assessment, dated 02/05/25, indicated he/she was dependent on two staff members for dressing, toileting, bed mobility, and positioning. Review of Resident #3's Fall Prevention Care Plan, reviewed and renewed with his/her Quarterly MDS Assessment, dated 02/05/25, indicated he/she was at risk for falls and his/her bed should be low to the floor. During a telephone interview on 06/03/25 at 2:45 P.M., Family Member #1 said during the evening of 05/04/25, she received a telephone call from a Facility Nurse to notify her that Resident #3 had fallen. Family Member #1 said she immediately went to the Facility, saw Resident #3 lying on the floor in the area between his/her bed and window, and saw CNA #1 holding a towel to the back of Resident #3's head because he/she was bleeding. Family Member #1 said Resident #3 cried out in pain (which was unlike him/her) whenever staff tried to move his/her right leg. During a telephone interview on 06/10/25 at 11:55 A.M., (which included a review of her written witness statement, dated 05/04/25 and an additional witness statement, dated 05/09/25, both of which were obtained by the facility), CNA #1 said she works for a staffing agency, has been working at the Facility for several months, and was very familiar with Resident #3. CNA #1 said she routinely checks the CNA Assignment Sheet, obtains report at shift change from another CNA, and checks the resident Care Kardex (a centralized quick-reference document used by CNAs and other staff to track patient information and care plans) in the computer if she has any questions about care. CNA #1 said that on the evening of 05/04/25 around 7:30 P.M., she, along with another CNA transferred Resident #3 into bed via a mechanical lift. CNA #1 said they positioned Resident #3 on his/her back in the center of the bed and then the other CNA left the room. CNA #1 said after the other CNA left the room, she proceeded to get Resident #3 ready for bed. CNA #1 said another CNA (later identified as CNA #3) was in the room, but she was across the room assisting Resident #3's roommate. CNA #1 said she proceeded to get Resident #3 undressed, washed up, and covered his/her upper body with a hospital gown. CNA #1 said she then positioned Resident #3 onto his/her left side with his/her right leg crossed over his/her left leg so she provide incontinent care. CNA #1 said the bed had been raised to a higher position during care. CNA #1 said after she performed incontinent care for Resident #3, she placed a brief underneath him/her while he/she was lying on his/her side, and realized she did not have barrier cream (a cream used to protect a person's skin from moisture associated with incontinence) nearby. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	CNA #1 said she turned away from Resident #3 to look for the barrier cream, saw that it was on his/her dresser against the wall across from the foot of his/her bed, and that it was out of her reach. CNA #1 said she never completely walked away from Resident #3's bedside, but had maybe taken a step away from Resident #3 to obtain the cream. CNA #1 said the next thing she heard was somebody screaming Resident #3's name (later identified as CNA #2), observed CNA #2 run into the room and heard a loud noise. CNA #1 said it was then that she realized Resident #3 had fallen to the floor. CNA #1 said she was aware that Resident #3's Kardex said that he/she required two staff members to assist with bed mobility, for transfers in and out of bed, but said she thought Resident #3's Kardex said he/she was a one assist for all other ADL care. CNA #1 said she thought that bed mobility only meant when staff had to boost a resident up in bed or assist them to make small movements. CNA #1 said she did not think that when she provided personal care to a resident while they were in bed, that positioning them for care was bed mobility. CNA #1 said she had cared for Resident #3 many times without having assistance of another staff member. During an interview on 06/04/25 at 10:25 A.M., (which included a review of her written witness statement, dated 05/04/25, and an additional witness statement, dated 05/09/25, both of which were obtained by the facility), CNA #2 said on 05/04/25 around 7:45 P.M., as she was walking down the hall, she looked into Resident #3's room, saw him/her lying on his/her left side, he/she was actively rolling towards his/her right side and fell off of the bed. CNA #2 said when she saw Resident #3 falling, she screamed out his/her name and ran into his/her room, but she could not get to him/her in time to prevent the fall. CNA #2 said she had an unobstructed view of Resident #3 from the hallway and did not see a CNA or any other staff member in the room. CNA #2 said when she ran into the room, CNA #1 appeared from somewhere near the middle of the room and ran around the foot of Resident #3's bed to try to get to him/her before he/she fell, but she (CNA #1) was also unable to get to him/her in time. CNA #2 said information related to residents' care needs, and the amount of staff assistance required is located on their resident Kardex in the computer. CNA #2 said there is also some care information on the CNA Assignment Sheets, but CNAs should always check the Kardex before providing care to a resident. CNA #2 said Resident #3 is totally dependent on staff to provide all care, including ADLs. During a telephone interview on 06/04/25 at 1:45 P.M. (which included a review of her written witness statement, dated 05/09/25, and an additional witness statement on 05/09/25, both of which were obtained by the facility), CNA #3 said that during the evening of 05/04/25 around 7:45 P.M., she was providing care to Resident #3's roommate (Bed A, near the door), CNA #1 was providing care to Resident #3 in the bed by the window, and there were no other CNAs in the room. CNA #3 said her back was turned away from Resident #3, but that she saw CNA #2 run into the room yelling that Resident #3 was falling and heard a loud sound. CNA #3 said she did not know where, in the room, CNA #1 was prior to Resident #3's fall. During an interview on 06/04/25 at 10:03 A.M., CNA #4 said Resident #3 is dependent on staff members for all care, including meals, dressing, transfers, bed mobility, and personal hygiene. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	CNA #4 said each resident has a Kardex in the computer that includes the type of care and assistance each resident requires, and CNAs know that they should consult the Kardex prior to providing care to a resident. During an interview on 06/04/25 at 10:45 A.M., Nurse #1 said Resident #3 is total care, meaning he/she requires physical assistance from staff for feeding, dressing, bathing, bed mobility, positioning, transfers, and incontinence care. Nurse #1 said any information related to the level of staff assistance, including the number of staff member a resident requires during care is located in their Care Plan and the Kardex. Nurse #1 reviewed Resident #3's Care Plan and said, based on the information in his/her Care Plan, there should always be two caregivers present when providing care. Nurse #1 said if two caregivers were assisting Resident #3 on the evening of 05/04/25, one caregiver could have remained with him/her to maintain his/her safety, while the other caregiver could have obtained the barrier cream. During an interview on 06/04/24 at 11:07 A.M., Unit Manager #1 said Resident #3 is totally dependent on staff to provide care, and staff (CNAs) access the level of care a resident requires by looking at the Care Plan, the Kardex, and to some extent the CNA Assignment Sheets. Unit Manager #1 said the Kardex should have the most up to date information and is the preferred source to obtain resident care information. After reviewing Resident #3's Care Plan, Unit Manager #1 said that based on the Care Plan, there should always be two staff members present while providing care to him/her, and when CNA #1 provided care by herself, she was not following Resident #3's plan of care. During an interview on 06/04/25 at 4:10 P.M., the Director of Nursing (DON) said CNA #1 works for a staffing agency but has worked at the facility for several months and often took care of Resident #3. The DON said Resident #3's Care Plan clearly indicated Resident #3 required two staff members be present to assist with dressing, transfers, toileting, bed mobility and positioning. The DON said they were unable to provide a copy of Resident #3's care Kardex that was in effect at the time of the incident, because their Electronic Medical Record (EMR) does not have the capability to retrieve previous versions after an update. The DON did say however, that Resident #3's Kardex would have indicated the same level of care and staff assistance he/she required, per his/her plan of care at that time. The DON said CNA #1 did not follow Resident #3's plan of care and should have had another staff member assist with care. On 06/06/25 the Facility was found to be in Past Non-Compliance and provided the surveyor with a plan of correction which addressed the area of concern as evidenced by: A) On 05/07/25, CNA #1 was re-educated, topics included but were not limited to the following: - facility policy related to provision of care to residents, - the need to review and follow each residents plan of care/ resident care Kardex, - ensuring the required level of staff assistance is present and used during the provision of care, (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	- facility protocol related to residents who are care planned for two person assist, - having all necessary supplies ready and available before providing care to a resident. B) On 05/09/25, Resident #3's Care Plan and CNA Care Kardex were immediately reviewed to ensure accuracy with the need for the specific number of staff member assistance clearly indicated for each ADL. C) From 05/09/25 through 05/13/25 (and ongoing) - Facility Unit Managers and/or Designees conducted facility wide audits to ensure the following: - All residents are receiving the necessary level of staff assistance needed for bed mobility (including when turning and repositioning a resident in bed to provide care), - Level of care and staff assistance is recorded accurately on both the Care Plan and Care Kardex, - Observations and record reviews for all residents with scoop mattresses to ensure they are receiving appropriate and necessary level of staff assistance required for bed mobility, including turning/repositioning while in bed to provide care while taking into consideration the width of the mattress and ability of each resident to participate in care. D) From 05/09/25 through 05/13/25 (and ongoing) - Interdisciplinary Team audited all residents to determine the need for additional fall interventions for safety and appropriateness of interventions that were in place. E) From 05/12/25 through 05/16/25 (and ongoing), the Staff Development Coordinator and/or their Designee completed nursing/CNA education, which included but was not limited to the following topics: - CNA's must check the Care Kardex prior to providing care as changes may occur daily, - Review of all current residents requiring two person assist for bed mobility, positioning and what two person assist for positioning and bed mobility means, - Clarifications of ADL tasks - bed mobility, turning and repositioning -as to what constitutes a two-person assist, - Careful positioning of residents when close to the edge of the bed, especially when they utilize scoop mattresses, - CNA's (nursing staff) to ensure second staff person is in place, and that necessary supplies needed are obtained and within reach prior to starting personal care to the resident. F) Ongoing, random audits conducted by the Staff Development Coordinator and/or their Designee to ensure accuracy of Care Plans, resident's Kardex, and staff are providing the appropriate level of assistance to residents. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	G) Deficient practice was presented at an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting, and the will continue to be discussed at monthly QAPI meetings as needed to ensure substantial compliance is achieved and maintained. H) The Director of Nursing and/or their Designee are responsible for overall compliance.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had multiple wounds and required an appointment with an outside wound specialist, the Facility failed to ensure nursing staff clarified and/or followed up on his/her wound consult recommendations related to the need for an X-ray, in a timely manner, which resulted in a delay in treatment. Findings include: Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered Nurse and Practical Nurse respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Resident #1 was admitted to the Facility in March 2025, diagnoses included Type 2 Diabetes Mellitus, Multiple Myeloma (a type of cancer that affects a type of white blood cell in the body that produces antibodies to fight infection), Chronic Thrombocytopenia (a decreased amount of blood clotting cells in the body), Anemia (lower than normal red blood cells in the body), chronic foot wounds with recent right toe amputation. Review of a Wound Clinic Consultation Note, dated 03/12/25, indicated it included the following recommendation: - X-ray to right great toe placed and included an order requisition to obtain an X-ray of 3rd toe, right foot to rule out Osteomyelitis (an infection of the bone often caused by bacteria, that can lead to inflammation and potentially permanent bone damage if left untreated). Review of a Wound Clinic Consultation Note, dated 03/19/25, indicated in included the following recommendation: - Right foot X-ray to rule out Osteomyelitis in right third toe, ordered in CIS (the wound clinic computer system), and can be completed at [Name of Hospital]. Further review of Resident #1's medical record indicated there was no documentation to support that after his/her Wound Clinic appointment on 3/12/25 or 3/19/25, since the wound clinic had not provided results of an X-ray to the facility, that nursing followed up with the Clinic to clarify the X-ray order, and who was responsible for completing it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 06/05/25 at 1:25 P.M., the Wound Clinic Nurse Practitioner (NP) said their clinic does not have X-ray capabilities and that she put an order in for him/her to have an X-ray done at their outpatient Radiology office, and said if it was a problem for the Facility to get Resident #1 there, the Facility should have obtained an order from their Provider to have a portable X-ray done at the Facility. Review of a Wound Clinic Consultation Note, dated 04/15/25, indicated it included the following recommendation: - Patient needs an X-ray of right foot. Review of Resident #1's Medical Record indicated there was an X-ray report, dated 04/16/25 (obtained a month after the Facility was notified of the recommendation for the X-ray), with results that indicated he/she had Osteomyelitis in his/her right third toe. During an interview on 06/05/25 at 2:00 P.M., Unit Manager #2 said when a resident goes outside the Facility for a specialist visit, the Facility sends a Report of Consultation form with the resident or responsible person to give to the specialist so they can provide a summary of the visit as well as any recommendations they may have for the resident's ongoing care. Unit Manager #2 said the resident will come back from the appointment with the Report of Consultation form and the specialist will then fax a more detailed visit note to the facility shortly after the visit. Unit Manager #2 said it was the responsibility of the unit nurse who receives the Consultation form or the detailed visit note, to review the notes and discuss them with the Facility Provider, and obtain orders as needed. Unit Manager #2 said she reviewed the Wound Clinic Consultation Notes and corresponding visit notes on 03/12/25, 03/19/25 and 04/15/25 after each appointment and saw an X-ray to Resident #1's right foot was warranted to rule out Osteomyelitis. Unit Manager #2 said the way the Report of Consultation Notes were written were ambiguous and confusing, and seemed as though the Wound Clinic was planning to obtain the X-ray because the notes referred to ordering the imaging and entering the order into their own (Wound Clinic) computer system. Unit Manager #2 said it wasn't until she reviewed the Wound Consultation Note, dated 04/15/25, that she called the Wound Clinic to clarify and ask who was responsible to obtain Resident #1's X-ray. Unit Manager #2 said she was told by the Wound Clinic that they expected the Facility obtain Resident #1's right foot X-ray, (which was completed on 04/16/25 at the Facility). Unit Manager #2 said the results indicated Resident #3 had developed Osteomyelitis in his/her right third toe. During an interview on 06/05/25 at 2:30 P.M., the Director of Nursing said she reviewed the Wound Clinic Notes and Reports of Consultation and said the recommendations made by the clinic were unclear and understood why Unit Manager #2 thought the Wound Clinic was obtaining the X-ray for Resident #1. The DON said a call could have been made to the Wound Clinic by facility nursing staff to clarify the recommendation after his/her visit on 03/19/25.

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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 records reviewed and interviews, for one of three sampled residents (Resident #3), who required the assistance of two staff members for dressing, toileting care needs, bed mobility, and positioning, the Facility failed to ensure he/she was provided with the necessary level of staff assistance to maintain his/her safety to prevent an incident/accident resulting in a serious injury. On 05/04/25, Certified Nurse Aide (CNA) #1 provided care to Resident #3 without having another staff member present for assistance, CNA #1 repositioned Resident #3 onto his/her side in bed, then turned away from Resident #3 to grab something, leaving him/her unattended and he/she rolled off the bed onto the floor. Resident #3 was transferred to the Hospital Emergency Department (ED) and diagnosed with a closed displaced fracture (broken pieces of bone that moved away from each other) of the right femoral neck (part of the thigh bone just below the hip joint). Findings include: Review of the Facility's Policy titled, Fall Risk Reduction, dated as revised 11/2/23, indicated but was not limited to the following: - All residents will be assessed for falls risk factors. - Those determined to have risk factors will receive individualized interventions based on the risk factors in order to reduce risk for falls and minimize occurrence of falls. - Include fall interventions on Kardex and Care Plan. - Review and revise Care Plan and Kardex regularly to ensure individualized interventions are effective. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/09/25, indicated that on 05/04/25, around 7:45 P.M., CNA #1 was providing care to Resident #3 when he/she rolled out of the bed, was assessed to have a one centimeter (cm) laceration to the back of his/her head, pain in his/her leg, was transferred to the hospital and subsequently admitted with a right hip fracture. Review of Resident #3's Hospital History and Physical, dated 05/05/25 indicated he/she sustained a closed displaced fracture of the right femoral neck. Resident #3 was admitted to the Facility in April 2017, diagnoses included Dementia and Parkinson's Disease (a movement disorder of the nervous system that worsens over time). Review of Resident #3's Quarterly Minimum Data Set (MDS) Assessment, dated 02/05/25, indicated he/she was severely cognitively impaired as evidenced by a score of 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) Assessment (score of 0-7 suggest severe cognitive impairment, 8-12 suggest moderate cognitive impairment, and 13-15 suggest that cognition is intact). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Further review of the MDS indicated Resident #3 had impaired range of motion to both sides of his/her upper and lower extremities, was dependent on staff for transfers, required substantial to maximum assistance rolling left to right, and with all ADLs. Review of Resident #3's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with his/her Quarterly MDS Assessment, dated 02/05/25, indicated he/she was dependent on two staff members for dressing, toileting, bed mobility and positioning. Review of Resident #3's Fall Prevention Care Plan, reviewed and renewed with his/her Quarterly MDS Assessment, dated 02/05/25, indicated he/she was at increased risk for falls and interventions for his/her safety included two staff members to assist with dressing, toileting, transfers bed mobility and positioning. Review of a Nursing Progress Note, dated 05/04/25 at 9:54 P.M., indicated the following: - This Nurse was called into Resident #3's room by a CNA around 7:45 P.M. - The CNA reported Resident #3 rolled out of bed during care. - Small laceration was observed on back of his/her head, of approximately 1 centimeter (cm). - Applied pressure to the head injury to stop the bleeding. - Called Resident #3's daughter, who came in and wanted him/her to be sent out to the ED for evaluation. - Telephone call placed to on-call provider and Assistant Director of Nursing. - Resident #3 transferred to the hospital around 8:35 P.M., accompanied by two emergency medical technicians. During a telephone interview on 06/03/25 at 2:45 P.M., Family Member #1 said during the evening of 05/04/25, she received a telephone call from a Facility Nurse notifying her that Resident #3 had fallen. Family Member #1 said she immediately went to the Facility and saw Resident #3 lying on the floor in the area between his/her bed and the window, and that CNA #1 holding a towel to the back of Resident #3's head because he/she was bleeding. Family Member #1 said Resident #3 was crying out in pain (which was unlike him/her) whenever staff tried to move his/her right leg. Family Member #1 said prior to Resident #3's fall on 5/04/25, he/she would be out of bed in a specialized chair every day and was often in the Facility's common area where he/she could be around other people. Family Member #1 said since the fall, Resident #3 is no longer able to get out of bed and remains in his/her room because the mechanical lift required to transfer him/her out of bed into his/her specialized chair causes him/her too much pain. During a telephone interview on 06/10/25 at 11:55 A.M., (which included a review of her written witness statement, dated 05/04/25 and an additional witness statement, dated 05/09/25, both of which were obtained by the facility), CNA #1 said she works for a staffing agency, has been working at the Facility for several months, and was very familiar with Resident #3. (continued on next page)

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	225363	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #1 said she routinely checks the CNA Assignment Sheet, obtains report at shift change from another CNA, and checks the care Kardex (a centralized quick-reference document used by CNAs and other staff to track patient information and care plans) in the computer if she has any questions about care. CNA #1 said that on the evening of 05/04/25 around 7:30 P.M., she, along with another CNA transferred Resident #3 into bed via a mechanical lift. CNA #1 said they positioned Resident #3 on his/her back in the center of the bed and the other CNA left the room. CNA #1 said after the other CNA left the room, she proceeded to get Resident #3 ready for bed, which included changing his/her clothes. CNA #1 said another CNA (later identified as CNA #3) was in the room, but she was across the room assisting Resident #3's roommate. CNA #1 said while the bed was in a high position, she proceeded to get Resident #3 undressed, washed up, and covered his/her upper body with a hospital gown. CNA #1 said she then positioned Resident #3 on his/her left side with his/her right leg crossed over his/her left leg so to provide incontinent care. CNA #1 said after she performed incontinent care for Resident #3, she placed a brief underneath him/her while he/she was still lying on his/her side, and realized she did not have his/her barrier cream (a cream used to protect a person's skin from moisture associated with incontinence) nearby. CNA #1 said she turned away from Resident #3 to look for the barrier cream, and saw that it was on his/her dresser which was against the wall across from the foot of his/her bed, which was out of her reach. CNA #1 said she may have taken a step away from Resident #3 to obtain the cream, then turned towards CNA #3 who was behind her after hearing her say something. CNA #1 said the next thing she heard was somebody screaming Resident #3's name (later identified as CNA #2), observed CNA #2 run into the room and heard a loud noise. CNA #1 said it was then that she realized Resident#3 had fallen on the floor. CNA #1 said she was aware that Resident #3's Kardex said that he/she required two staff members to assist with bed mobility, for transfers in and out of bed, but said she thought Resident #3's Kardex said he/she was a one person assist for all other ADL care. CNA #1 said she thought that bed mobility only meant when staff had to boost a resident up in bed or assist them to make small movements. CNA #1 said she did not think that when she provided personal care to a resident while they were in bed, that positioning them for care was bed mobility. During an interview on 06/04/25 at 10:25 A.M., (which included a review of her written witness statement, dated 05/04/25, and an additional witness statement, dated 05/09/25, both of which were obtained by the facility), CNA #2 said on 05/04/25 around 7:45 P.M., as she was walking down the hall, she looked into Resident #3's room, saw him/her lying on his/her left side actively rolling towards his/her right side off of the bed, and then he/she fell. CNA #2 said when she saw Resident #3 falling, she screamed his/her name and ran into his/her room, but she could not get to him/her in time to prevent the fall. CNA #2 said she had an unobstructed view of Resident #3 from the hallway and did not see any other CNA or staff member in the room. CNA #2 said when she ran into the room, CNA #1 appeared from somewhere near the middle of the room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 06/04/25 at 1:45 P.M. (which included a review of her written witness statement, dated 05/09/25, and an additional witness statement on 05/09/25, both of which were obtained by the facility), CNA #3 said that during the evening of 05/04/25 around 7:45 P.M., she was providing care to Resident #3's roommate (Bed A, near the door), CNA #1 was providing care to Resident #3 in the bed by the window, and there were no other CNAs in the room. CNA #3 said her back was turned away from Resident #3, but she saw CNA #2 run into the room yelling that Resident #3 was falling and heard a loud sound. CNA #3 said she did not know where CNA #1 was in the room prior to Resident #3's fall. CNA #3 said Resident #3 cannot do anything for him/herself and said he/she requires two people for transfers because he/she requires a mechanical lift. During an interview on 06/04/25 at 10:45 A.M., Nurse #1 said Resident #3 is total care, meaning he/she requires staff assistance with feeding, dressing, bathing, and incontinence care. During the interview, Nurse #1 reviewed Resident #3's Care Plan and said, based on the information in his/her Care Plan, there should have been two caregivers present when CNA #1 was providing care to Resident #3. Nurse #1 said if two caregivers were assisting Resident #3 on the evening of 05/04/25, one caregiver would have remained with him/her while the other caregiver could have obtained the barrier cream. Nurse #1 said if CNA #1 stepped away from Resident #3, she should not have left his/her bed in a high position and should not have left him/her positioned on his/her side. Nurse #1 further said prior to his/her fall, Resident #3 used to spend much of the day in the common area outside of his/her room so he/she could be around other people, but since the fall, he/she is no longer able to get out of bed and relies on both Morphine and Fentanyl (opioid pain medications) to remain comfortable. During an interview on 06/04/24 at 11:07 A.M., Unit Manager #1 said Resident #3 is totally dependent on staff to provide care and there should always be two staff members present while providing care to him/her. Unit Manager #1 said on 05/04/25, when Resident #3 fell out of bed, CNA #1 should not have been alone, and when CNA #1 stepped away from his/her bed, Resident #3 should not have been left lying on his/her side with the bed in a high position because that was unsafe. Unit Manger #1 further said if CNA #1 could not get to the barrier cream, after she saw that it was out of her reach, she could have asked CNA #3, who was in the room caring for Resident #3's roommate to get it for her. During an interview on 06/04/25 at 4:10 P.M., with the Director of Nursing (DON) and the Quality Improvement (QI) Manager, the DON said Resident #3 was care planned to have two staff members present to assist with dressing, transfers, toileting, bed mobility and positioning, and CNA #1 did not adhere to Resident #1's plan of care. In addition, the DON said if CNA #1 either looked away or stepped away from Resident #3 to find a needed supply, she should not have left him/her lying on his/her side as that was unsafe, and said when providing care, all necessary supplies should be within reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The QI Manager said during her investigation after the incident, she noted Resident #3 utilized a scoop mattress that had bolsters (raised edges) on both sides with the exception of a 24 inch opening at the center of both sides of the mattress. The QI Manager said she noted that scoop mattress measured 29 inches wide, which is 7 inches narrower than a standard facility mattress. The QI Manager said when she interviewed CNA #1, she said she was confident Resident #3 was placed in the center of the bed on his/her left side but was positioned so that his/her right leg was crossed over his/her left leg. The QI Manager said that position likely caused a gravitational pull that propelled Resident #3's her body weight over the side of the bed causing him/her to roll quickly, and fall out of bed. The QI Manager said according to Resident #3's Care Plan, he/she should have had two caregivers present during care. On 06/06/25 the Facility was found to be in Past Non-Compliance and provided the surveyor with a plan of correction which addressed the area of concern as evidenced by: A) On 05/07/25, CNA #1 was re-educated, topics included but were not limited to the following: - facility policy related to provision of care to residents, - the need to review and follow each residents plan of care/ resident care Kardex, - ensuring the required level of staff assistance is present and used during the provision of care, - facility protocol related to residents who are care planned for two person assist, - having all necessary supplies ready and available before providing care to a resident. B) On 05/09/25, Resident #3's Care Plan and CNA Care Kardex were immediately reviewed to ensure accuracy with the need for the specific number of staff member assistance clearly indicated for each ADL. C) From 05/09/25 through 05/13/25 (and ongoing) - Facility Unit Managers and/or Designees conducted facility wide audits to ensure the following: - All residents are receiving the necessary level of staff assistance needed for bed mobility (including when turning and repositioning a resident in bed to provide care), - Level of care and staff assistance is recorded accurately on both the Care Plan and Care Kardex, - Observations and record reviews for all residents with scoop mattresses to ensure they are receiving appropriate and necessary level of staff assistance required for bed mobility, including turning/repositioning while in bed to provide care while taking into consideration the width of the mattress and ability of each resident to participate in care. D) From 05/09/25 through 05/13/25 (and ongoing) - Interdisciplinary Team audited all residents to determine the need for additional fall interventions for safety and appropriateness of interventions that were in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	E) From 05/12/25 through 05/16/25 (and ongoing), the Staff Development Coordinator and/or their Designee completed nursing/CNA education, which included but was not limited to the following topics: - CNA's must check the Care Kardex prior to providing care as changes may occur daily, - Review of all current residents requiring two person assist for bed mobility, positioning and what two person assist for positioning and bed mobility means, - Clarifications of ADL tasks - bed mobility, turning and repositioning -as to what constitutes a two-person assist, - Careful positioning of residents when close to the edge of the bed, especially when they utilize scoop mattresses, - CNA's (nursing staff) to ensure second staff person is in place, and that necessary supplies needed are obtained and within reach prior to starting personal care to the resident. F) Ongoing, random audits conducted by the Staff Development Coordinator and/or their Designee to ensure accuracy of Care Plans, resident's Kardex, and staff are providing the appropriate level of assistance to residents. G) Deficient practice was presented at an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting, and the will continue to be discussed at monthly QAPI meetings as needed to ensure substantial compliance is achieved and maintained. H) The Director of Nursing and/or their Designee are responsible for overall compliance.