STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225732	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Stoneham	25 Woodland Road Stoneham, MA 02180

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. 37330 Based on records reviewed and interviews for one of three sampled residents (Resident #1) who during the overnight shift (11:00 P.M. to 7:00 A.M.) on 1/30/25 into 1/31/25, had an unwitnessed fall and was found on the floor by staff, the facility failed to ensure he/she was free from neglect, when although Resident #1 told staff he/she was hurt and was screaming I'm in pain, without assessing him/her for the potential for injuries, Nurse #1 picked Resident #1 up off the floor put him/her in a wheelchair, picked him/her up again, transferred him/her back into bed and left the room. Despite Certified Nurse Aide (CNA) #1 reporting to Nurse #1 that Resident #1 was still complaining of and was in obvious pain, Nurse #1 did not go check on Resident #1 and still did not assess him/her for injuries. Nurse #1 finished his shift, left the facility and never reported the incident to anyone. Day shift nursing staff, who were totally unaware that Resident #1 had an unwitnessed fall on the previous shift, were unable to provide care, as Resident #1 screamed whenever staff tried to touch him/her. Resident #1 was emergently transferred to the Hospital Emergency Department, where he/she was diagnosed with a left hip fracture. Findings include: The Facility's Policy titled, Abuse, dated as reviewed 06/17/24, indicated neglect is defined as the failure of the Facility its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The Policy indicated the Facility is to prevent and prohibit all types of abuse and neglect. The Policy indicated the Facility assures that residents are free from neglect by having the structures and process to provide needed care and services to all residents, which includes but is not limited to the provision of a facility assessment to determine what resources are necessary to care for its residents competently. The Facility's Policy titled, Resident Rights, dated as reviewed 09/10/24, indicated the following: a resident has the right to be treated with respect and dignity; a resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. (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	Review of the Facility's Incident Report, dated 02/06/25, indicated on 01/31/25 sometime around 8:30 A.M. Resident #1 was observed by Certified Nurse Aide (CNA) #2 screaming as if in pain and would not allow CNA #2 to provide care to him/her. The Report indicated Resident #1 reported 10/10 pain (a pain scale where 0 is no pain and 10 is the worst pain imaginable, severe or unbearable pain) his/her leg. The Report indicated Resident #1 informed Nurse #2 and the Staff Development Coordinator (SDC) that he/she had fallen out of bed in the early morning and two men assisted him/her back to bed. The Report indicated Resident #1's left leg was rotated outward and noted to be larger than the right leg. The Report indicated Emergency Medical Services (911) had been called and in the Emergency Department Resident #1 was found to have a Displaced Proximal Left Femoral Subtrochanteric Fracture (break in thigh bone just below the bony prominence in the lower part of the hip). Resident #1 was admitted to the Facility in December 2024, diagnoses included Rhabdomyolysis (breakdown of muscle tissue), Hypertension (high blood pressure), Orthostatic Hypotension (low blood pressure that happens when standing up from sitting or lying down), Bradycardia (slower than expected heart rate, generally beating fewer than 60 minute), Wedge Compression fracture of T11-T12 vertebra subsequent encounter for fracture with routine healing (occurs when the front (anterior) portion of the vertebra collapses, resulting in a wedge-shaped deformity), difficulty with walking, muscle weakness and history of falling. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 12/19/24, indicated Resident #1's Brief Interview for Mental Status (BIMS), score was 14/15 (score of 13-15 indicates intact cognition, 12-8 indicates moderate cognitive impairment, 0-7 indicates severe cognitive impairment). Review of the Certified Nurse Aide (CNA) #1's Written Witness Statement, dated 02/03/25, indicated on 01/31/25 at 2:30 A.M., she was helping Resident #3, heard a fall [loud bang] and left Resident #3's room to see what was going on. The Statement indicated Resident #1 was on the floor screaming, help me. The Statement indicated CNA #1 told Nurse #1, to call the ambulance because Resident #1 was screaming, but Nurse #1 said they should put Resident #1 back into bed. The Statement indicated Nurse #1 picked Resident #1 up off the floor put him/her into his/her wheelchair, then picked Resident #1 up from his/her wheelchair and put him/her into the bed. The Statement indicated CNA #1 did not move or touch Resident #1, but did hold the wheelchair. The Statement indicated she (CNA #1) was uncomfortable, that Resident #1 was screaming, I'm in pain, and that Nurse #1 told her not to say anything about this. During an interview on 03/18/25 at 2:00 P.M., (and during a follow-up interview on 03/19/25 at 1:07 P.M.) CNA #1 said on 01/31/25, sometime around 2:30 A.M., she heard a loud bang while providing care to Resident #3 and went to find out what the noise was. CNA #1 said the noise came from the room diagonally across from the room she was providing care in. CNA #1 said she found Resident #1 in his/her room lying face up on the floor and called Nurse #1 for help. (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	CNA #1 said when Nurse #1 came to the room, Resident #1 was screaming, I'm in pain, I'm in pain. CNA #1 said that Nurse #1 said to get Resident #1 up off the floor. CNA #1 said she told Nurse #1 No, that in school she learned that when a patient falls and screams, they may have something broken and that they should call an ambulance. CNA #1 said Nurse #1 said No, we do not need to call the ambulance, and told her to bring Resident #1's wheelchair over to him. CNA #1 said she brought the wheelchair over to Nurse #1 and Nurse #1 picked up Resident #1 up off the floor, by himself, that Resident #1 was screaming, I'm in pain, I'm in pain. and placed him/her in the wheelchair. CNA #1 said then Nurse #1 transferred Resident #1 out of the wheelchair by himself to the bed. CNA #1 said Resident #1 was still screaming, I'm in pain. CNA #1 said Nurse #1 did not perform an assessment on Resident #1 prior to moving Resident #1 up off the floor and did not even check his/her vital signs. CNA #1 said shortly thereafter, she and Nurse #1 left the room at the same time and Resident #1 was still saying he/she was in pain. CNA #1 said she asked Nurse #1 if he was going to call 911 and complete the paperwork and Nurse #1 said, to her Forget about it, Forget about it. CNA #1 said around 4:00 A.M., she assisted Resident #1's roommate with care and Resident #1 was moaning like he/she was in pain. CNA #1 said she told Nurse #1 again about Resident #1's pain and asked him to take Resident #1's vital signs and to see if he/she was ok. CNA #1 said Nurse #1 waved his hand in a backward motion at her, as if he was dismissing her concerns and telling her to go away. CNA #1 said she never saw Nurse #1 go check on or assess Resident #1, after she asked him to. During an interview on 03/18/25 at 1:15 P.M., Nurse #2 said on 01/31/25 she started her shift around at 8:00 A.M. and had not receive an oncoming Nurse Change Shift Report from Nurse #1, because he had left the Facility prior to her arrival. Nurse #2 said the other nurse who was working with her on the day shift did not report to her that there was any change of condition or a fall regarding Resident #1. Review of the Nurse #1 Written Witness Statement, dated 01/31/25, indicated he was called into Resident #1's room by CNA #1, because Resident #1 was seated halfway in his/her wheelchair and CNA #1 could not sit him/her up by herself. The Statement indicated he assisted Resident #1 in the wheelchair and back to bed with CNA #1's help and left for the day. The Statement indicated Nurse #1 did not witness any fall. During an interview on 04/01/25 at 9:40 A.M., Nurse #1 said on the night shift (1/30/25 into 1/31/25), he did not hear Resident #1 fall, and when he transferred Resident #1 into bed, he/she was not in pain. Nurse #1 denied he received any reports from CNA #1 that Resident #1 was in pain and that he had no idea how Resident #1 fractured his/her hip. During an interview on 03/19/25 at 9:40 A.M., the Director of Nurses (DON) said she received a phone call on 01/31/25, at around 9:00 A.M. from the Staff Development Coordinator (SDC) that Resident #1 reported he/she had fallen during the overnight shift, and two men picked him/her up and put him/her back into bed. The DON said the SDC reported that Resident #1's left hip was larger than his/her right and Resident #1 was sent to the Hospital. The DON said she had not received any phone calls from the night shift Nurse (Nurse #1) regarding Resident #1's fall on 01/31/25. The DON said she had asked the SDC to start an investigation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The DON said it was not until she and the Administrator spoke with CNA #1 on 02/03/25 and obtained her statement that they were informed Resident #1 had fallen on 01/31/25, and had been found on the floor. The DON said CNA #1 told them she called Nurse #1 for help, told him that they should call 911 and that Nurse #1 told her (CNA #1), No, we were going to put him/her back to bed. The DON said CNA #1 said Resident #1 told them (CNA #1 and Nurse #1) he/she was in pain and that his/her leg hurt. The DON said she reviewed Resident #1's Medical Record and there was no documentation related to Resident #1's fall on 01/31/25, that there were no Nursing assessment including no pain assessment, no documentation to support the Physician was notified of Resident #1's acute pain to obtain orders, and that Resident #1 was not given any medication to treat or manage his/her pain. The DON said her expectations were that the Nursing staff follow the Facility's Policy and Procedures which included that Resident #1 should not have been moved off the floor after the fall occurred until Nursing completed a Nursing Assessment which includes a physical and pain assessment and taking care of the resident's needs immediately. The DON said Nursing staff should have called Emergency Medical Services if Resident #1 was in pain and/or an injury was suspected. The DON said her expectations were that Nursing notify the Physician, Health Care Proxy, Facility Management, complete the Fall Packet/Risk Management Progress Note, and inform the oncoming shift. Review of Resident #1's Hospital Discharge Summary, dated 02/07/25, indicated Resident #1 had an unwitnessed fall at the Facility, was diagnosed with a Closed Displaced Subtrochanteric Fracture of the Left Femur, with the broken pieces out of alignment, treated surgically using a metal rod (intramedullary nail) inserted into the bone's hollow channel) on 02/01/25. On 03/18/25, 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) 01/31/25, Resident #1 was transferred to the Hospital and was found to have a Displaced Proximal Left Femoral Subtrochanteric Fracture (break in thigh bone just below the bony prominence in the lower part of the hips). B) 02/03/25, Nurse #1 was suspended pending an Investigation, and on 02/06/25, Nurse #1 was terminated from the Facility. C) 02/07/25, Resident #1 returned to the Facility status post Left Femur Open Reduction and Internal Fixation (ORIF) with intramedullary nail on 02/01/25, and his/her Care Plans were reviewed and updated as needed. D) 02/07/25, the Director of Nursing and Cooperate Nurse reviewed and performed an audit of the Facility's previous three months of resident falls, including conducting an audit related to Nurse #1's involvement with any Facility incidents. There were no concerns identified during the audits and it was determined Nurse #1 was not involved in any of the fall incidents. E) 02/10/25 through 02/26/25, the Staff Development Coordinator provided in-person education to all Licensed staff on the following topics: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- Fall Management - Review Policy & Procedure - Assessments - Fall Reporting Tools - Falls - Immediate action - Reporting - Resident Rights, Abuse and Neglect F) 02/20/25 an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the Facility leadership team. The Director of Nursing and the Cooperate Nurse developed a plan of correction related to the deficient practice, the plan and corrective measures were reviewed. G) 02/26/25 and ongoing, the Unit Manager and Director of Nursing review each fall (Incident/Accident Reports) to ensure Licensed Staff are following Facility's Policy and Procedure, they will collect the data and present findings to QAPI Committee. H) Effectiveness of corrective action plan will be reviewed during Monthly QAPI meetings until further notice. I) Director of Nursing and Executive Director are responsible for overall compliance.

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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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37330 Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who during the overnight shift (11:00 P.M. to 7:00 A.M.) on 1/30/25 into 1/31/25, had an unwitnessed fall, was found on the floor by staff complaining of pain, the facility failed to ensure he/she was provided care and services that met professional standards of nursing practice, when although Resident #1 was crying out in pain, without completing any type of assessment, Nurse #1 picked Resident #1 up off the floor, initially put him/her in a wheelchair, then transferred him/her again by picking him/her up out of the wheelchair, put him/her in bed, and left the room. Nurse #1 did not complete any type of assessments, did not document the fall in a progress note that night, did not complete an incident report, and did not inform oncoming nursing staff during change of shift report that Resident #1 had been found on the floor after an unwitnessed fall and had been complaining of pain since the fall. Resident #1 was transferred to the Hospital Emergency Department, at the start of the day shift, where he/she was diagnosed with a left hip fracture. Findings include: Standard Reference: Standard of Practice Reference: 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 bear full responsibility for systematically assessing health status and recording the related health status and recording the related health data. They also stipulate that both the registered and practical nurse incorporated 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. The Facility's Policy titled Incident and Reportable Event Management, dated as reviewed 09/25/24, indicated an accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. The Policy indicated an unwitnessed or witnessed fall is an event management, a fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force; An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall; a fall without injury is a fall, unless there is evidence suggesting otherwise and when a Resident is found on the floor, a fall is considered to have occurred. The Policy indicated if an event Incident/Injury occurs the Licensed Nurse should do the following: - Evaluate the residents and render first aid if needed. The Nurse evaluation be completed prior to moving a resident who has fallen, to determine presence of injury. - Create an event note and include the following details: Assessment details of the resident-including location details of the resident; Presence or absence of injury, and any treatments rendered; If resident can report what occurred, this should be included in the notes; Notification of Family or responsible party; and Notification of Physician and any orders received. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	- Create a risk report in the electronic system and identify the most appropriate type of event from the available options in the system. - Notify the following in accordance with state and federal requirements including the Supervisor on duty and/or Director of Nursing. Review of the Facility's Incident Report, dated 02/06/25, indicated on 01/31/25 sometime around 8:30 A.M. Resident #1 was observed by Certified Nurse Aide (CNA) #2 screaming as if in pain and would not allow CNA #2 to provide care to him/her. The Report indicated Resident #1 reported 10/10 pain (a pain scale where 0 is no pain and 10 is the worst pain imaginable, severe or unbearable pain) in his/her leg. The Report indicated Resident #1 informed Nurse #2 and the Staff Development Coordinator (SDC) that he/she had fallen out his/her bed in the early morning and two men assisted him/her back to bed. The Report indicated Resident #1's left leg was rotated outward and noted to be larger than the right leg. The Report indicated Emergency Medical Services (911) had been called and in the Emergency Department Resident #1 was found to have a Displaced Proximal Left Femoral Subtrochanteric Fracture (break in thigh bone just below the bony prominence in the lower part of the hip). Review of Resident #1's Hospital Discharge Summary, dated 02/07/25, indicated Resident #1 had an unwitnessed fall at the Facility, was diagnosed with a Closed Displaced Subtrochanteric Fracture of the Left Femur, with the broken pieces out of alignment, treated surgically using a metal rod (intramedullary nail) inserted into the bone's hollow channel) on 02/01/25. Resident #1 was admitted to the Facility in December 2024, diagnoses included Rhabdomyolysis (breakdown of muscle tissue), Hypertension (high blood pressure), Orthostatic Hypotension (low blood pressure that happens when standing up from sitting or lying down), Bradycardia (slower than expected heart rate, generally beating fewer than 60 minute), Wedge Compression fracture of T11-T12 vertebra subsequent encounter for fracture with routine healing (occurs when the front (anterior) portion of the vertebra collapses, resulting in a wedge-shaped deformity), difficulty with walking, muscle weakness and history of falling. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 12/19/24, indicated Resident #1's Brief Interview for Mental Status (BIMS), score was 14/15 (score of 13-15 indicates intact cognitive, 12-8 indicates moderate cognitive impairment, 0-7 indicates severe cognition impairment). Review of Resident #1's Care Plan, titled Pain, dated 01/07/25, indicated Resident #1's Pain interventions included to anticipate the resident's need for pain relief and respond immediately to any complaints of pain, pain meds as ordered, observe and report to Nurse any signs or symptoms of non-verbal pain and observe and report to Nurse resident complaints of pain or requests for pain treatment. During an interview on 03/18/25 at 2:00 P.M., (and during a follow-up interview on 03/19/25 at 1:07 P.M.) Certified Nurse Aide (CNA) #1 said on 01/31/25, sometime around 2:30 A.M., she heard a loud bang while providing care to Resident #3 and went to find out what the noise was. CNA #1 said the noise came from the room diagonally across from the room she was providing care in. CNA #1 said she found Resident #1 in his/her room lying face up on the floor and she called Nurse #1 for help. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	CNA #1 said when she called for help, Nurse #1 was at the Nurses Station sitting in a chair, his feet were up on another chair, he had a blanket covering him and his eyes were closed. CNA #1 said she called Nurse #1's name, he did not answer, then she called his name again and he jumped. CNA #1 said when Nurse #1 came to Resident #1's room, he/she was screaming, I'm in pain, I'm in pain. CNA #1 said Nurse #1 said to get Resident #1 up off the floor. CNA #1 said she told Nurse #1 No, they should not move him/her. CNA #1 said she told Nurse #1 that in school she learned that when a patient falls and screams, they may have something broken and they needed to call for an ambulance. CNA #1 said Nurse #1 said to her, No, we do not need to call the ambulance, and told her to bring Resident #1's wheelchair over to him. CNA #1 said she brought the wheelchair over to Nurse #1 and Nurse #1 picked up Resident #1 up off of the floor, by himself, and put him/her in the wheelchair, and that Resident #1 was screaming, I'm in pain, I'm in pain. CNA #1 said Nurse #1 then transferred Resident #1 out of the wheelchair by himself to the bed. CNA #1 said Resident #1 was still screaming, I'm in pain. CNA #1 said Nurse #1 did not perform an assessment on Resident #1 prior to him moving Resident #1 up off the floor and did not even check his/her vital signs. CNA #1 said shortly thereafter, she and Nurse #1 left the room at the same time and Resident #1 was still crying out in pain. CNA #1 said she had asked Nurse #1 if he was going to call 911 and complete the paperwork and Nurse #1 said to her, Forget about it, Forget about it. CNA #1 said around 4:00 A.M., she assisted Resident #1's roommate with care and Resident #1 was moaning like he/she was in pain. CNA #1 said she had informed Nurse #1 again about Resident #1's pain and asked him to take Resident #1's vital signs and to check to see if he/she was ok. CNA #1 said Nurse #1 waved his hand in a backward motion at her, as if he was dismissing her concerns and telling for her to go away. CNA #1 said she did not see Nurse #1 go check on or assess Resident #1 when she asked him to. Review of the Facility's Witness Statement, dated 01/31/25, written by Nurse #1, indicated he was called into Resident #1's room by CNA #1, because Resident #1 was halfway seated in his/her wheelchair and CNA #1 could not sit him/her up by herself. The Statement indicated he assisted Resident #1 in the wheelchair and back to bed with CNA #1's help and left for the day. The Statement indicated Nurse #1 did not witness any fall. During an interview on 04/01/25 at 9:40 A.M., Nurse #1 said on 01/30/25 he started his shift around at 3:00 P. M. and ended his shift on 01/31/25 around 7:00 A.M. Nurse #1 said Resident #1 was alert to self but confused. Nurse #1 said Resident #1 was able to express if he/she was in pain or in discomfort. Nurse #1 said at the start of the 11:00 P.M. to 7:00 A.M. shift, Resident #1 was in bed sleeping and he did not see Resident #1 again until around 4:30 A.M. or 5:00 A.M. Nurse #1 said he was at the Nursing station, preparing to start his morning medication pass when CNA #1 called him to help her, because Resident #1 was position half way out (sliding) of his/her wheelchair and CNA #1 was unable to sit up Resident #1 in his/her wheelchair. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Nurse #1 said he had asked Resident #1 what he could do to help him/her and if he/she needed to go to the bathroom. Nurse #1 said Resident #1 said, No. Nurse #1 said he pulled on Resident #1's pants to get him/her back in a sitting position in his/her wheelchair and then transferred him/her back into bed. Nurse #1 said that although Resident #1 was in bed at the start of the shift, that he did not know how Resident #1 had gotten into the wheelchair that night. Nurse #1 said he did not see Resident #1 fall and said he does not know how Resident #1 fractured his/her hip. Nurse #1 said he did not need to assess Resident #1 since he had no concerns and Resident #1 did not say anything to him about being in pain. Nurse #1 said he did not hear any banging noises during the 11:00 P.M. to 7:00 A.M. shift. Nurse #1 said he did not observe Resident #1 to be in pain and was not informed by anyone that Resident #1 was in pain. Nurse #1 said around 5:30 A.M. or 6:00 A.M., was the last time he saw Resident #1, because he had gone to the room to help his/her roommate. Nurse #1 said Resident #1 was not in pain then. Nurse #1 said he did not speak to any oncoming shift staff regarding Resident #1. Nurse #1 said he had no clue what happened to Resident #1. Review of Resident #1's Medical Record indicated there was no documentation of Resident #1's fall, no incident report, no type of assessment including Pain and Neurological as having been completed on 01/31/25, by Nurse #1. During an interview on 03/18/25 at 1:15 P.M., Nurse #2 said on 01/31/25 she started her shift around at 8:00 A.M. and did not receive an oncoming Nurse Change of Shift Report from Nurse #1 because he had left the Facility prior to her arrival. Nurse #2 said there was no progress note or incident report in Resident #1's Medical Record about him/her being found on the floor during the overnight shift or that he/she had complained of being in pain all night. During an interview on 03/18/25 at 4:31 P.M., the Unit Manager said her expectations was that Nurses would immediately assess a resident after a fall for the potential for injury and pain prior to moving them and notify the oncoming shift Nursing Staff of any incidents, accidents or changes in a resident. The Unit Manager said she reviewed Resident #1's Medical Record and there was no documentation of Resident #1's fall, no notification to Physician or Facility Administrative Staff, no incident report, and no assessments, having been completed on 01/31/25, by Nurse #1. During an interview on 03/19/25 at 9:40 A.M., the Director of Nurses (DON) said she and the Administrator interviewed Nurse #1 and he said around 4:30 A.M., CNA #1 called him to help her since Resident #1 was hanging out off his/her wheelchair and he assisted Resident #1 back to bed. The DON said she had asked Nurse #1 if he completed an assessment since Resident #1 was positioned that way in his/her wheelchair and that Nurse #1 said, No. that there was no need to assess Resident #1 and there was nothing wrong with him/her. The DON said she asked Nurse #1 if Resident #1 fell and he said, No. The DON said Nurse #1 did not respond when she asked how he thought Resident #1 obtained a hip fracture. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	The DON said she reviewed Resident #1's Medical Record and there was no documentation related to Resident #1's fall on 01/31/25, that there were no nursing assessments including a pain assessment, and no documentation to support the Physician was notified of Resident #1's new onset of acute pain. The DON said her expectations were that the Nursing staff to follow the Facility's Policy and Procedures which include residents should not have been moved off the floor after a fall occurred until first completing a thorough Nursing Assessment. The DON said Nursing staff should call Emergency Medical Services if Resident #1 was in pain and or an injury was suspected. On 03/18/25, 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) 01/31/25, Resident #1 was transferred to the Hospital and was found to have a Displaced Proximal Left Femoral Subtrochanteric Fracture (break in thigh bone just below the bony prominence in the lower part of the hips). B) 02/03/25, Nurse #1 was suspended pending an Investigation, and on 02/06/25, Nurse #1 was terminated from the Facility. C) 02/07/25, Resident #1 returned to the Facility status post Left Femur Open Reduction and Internal Fixation (ORIF) with intramedullary nail on 02/01/25, and his/her Care Plans were reviewed and updated as needed. D) 02/07/25, the Director of Nursing and Cooperate Nurse reviewed and performed an audit of the Facility's previous three months of resident falls, including conducting an audit related to Nurse #1's involvement with any Facility incidents. There were no concerns identified during the audits and it was determined Nurse #1 was not involved in any of the fall incidents. E) 02/10/25 through 02/26/25, the Staff Development Coordinator provided in-person education to all Licensed staff on the following topics: - Fall Management - Review Policy & Procedure - Assessments - Fall Reporting Tools - Falls - Immediate action - Reporting - Resident Rights, Abuse and Neglect F) 02/20/25 an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the Facility leadership team. The Director of Nursing and the Cooperate Nurse developed a plan of correction related to the deficient practice, the plan and corrective measures were reviewed. G) 02/26/25 and ongoing, the Unit Manager and Director of Nursing review each fall (Incident/Accident Reports) to ensure Licensed Staff are following Facility's Policy and Procedure, they will collect the data and present findings to QAPI Committee. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	H) Effectiveness of corrective action plan will be reviewed during Monthly QAPI meetings until further notice. I) Director of Nursing and Executive Director are responsible for overall compliance.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 37330 Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who during the overnight shift (11:00 P.M. to 7:00 A.M.) on 1/30/25 into 1/31/25, had an unwitnessed fall, was found on the floor by staff and was crying out in pain, the facility failed to ensure he/she was provided with care and treatment consistent with professional standards of practice related to pain management. Certified Nurse Aide (CNA) #1 said she found Resident #1 on the floor in his/her room, he/she was crying out in pain and immediately called Nurse #1 for help. CNA #1 said she asked Nurse #1 more than once to check on Resident #1 that night, because he/she kept crying out in pain. Nurse #1 did not complete a pain assessment on Resident #1, there was no documentation to support Nurse #1 medicated or did anything to treat or manage Resident #1's pain including not notifying the Physician. Day Shift nursing staff were unable to provide care, as Resident #1 screamed whenever staff tried to touch him/her, he/she was transferred to the Hospital Emergency Department, and was diagnosed with a left hip fracture. Findings include: The Facility's Policy titled Pain Assessment and Management, dated reviewed 09/05/24, indicated that the Facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The Policy indicated based on the comprehensive assessment of a resident, the Facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. The Policy indicated all residents will be assessed for pain indicators upon admission/readmission, quarterly and with any change in condition. The Facility's Policy titled Changes in Resident's Condition or Status, dated reviewed 09/05/24, indicated the Facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status. Review of the Facility's Incident Report, dated 02/06/25 at 1:48 P.M., indicated on 01/31/25 sometime around 8:30 A.M. Resident #1 was observed by Certified Nurse Aide (CNA) #2 screaming as if in pain and would not allow CNA #2 provide care to him/her. The Report indicated Resident #1 reported 10/10 pain (a pain scale where 0 is no pain and 10 is the worst pain imaginable, severe or unbearable pain) in his/her leg. The Report indicated Resident #1 informed Nurse #2 and the Staff Development Coordinator (SDC) that he/she had fallen out his/her bed in the early morning and two men assisted him/her back to bed. The Report indicated Resident #1's left leg was rotated outward and noted to be larger than the right leg. The Report indicated Emergency Medical Services (911) had been called and in the Emergency Department Resident #1 was found to have a Displaced Proximal Left Femoral Subtrochanteric Fracture (break in thigh bone just below the bony prominence in the lower part of the hip). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Hospital Discharge Summary, dated 02/07/25, indicated Resident #1 had an unwitnessed fall at the Facility, was diagnosed with a Closed Displaced Subtrochanteric Fracture of the Left Femur with the broken pieces out of alignment, treated surgically using a metal rod (intramedullary nail) inserted into the bone's hollow channel) on 02/01/25. Resident #1 was admitted to the Facility in December 2024, diagnoses included Rhabdomyolysis (breakdown of muscle tissue), Hypertension (high blood pressure), Orthostatic Hypotension (low blood pressure that happens when standing up from sitting or lying down), Bradycardia (slower than expected heart rate, generally beating fewer than 60 minute), Wedge Compression fracture of T11-T12 vertebra subsequent encounter for fracture with routine healing (occurs when the front (anterior) portion of the vertebra collapses, resulting in a wedge-shaped deformity), difficulty with walking, muscle weakness and history of falling. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 12/19/24, indicated Resident #1's Brief Interview for Mental Status (BIMS), score was 14/15 (score of 13-15 indicates intact cognition, 12-8 indicates moderate cognitive impairment, 0-7 indicates severe cognitive impairment). Review of Resident #1's Care Plan, titled Pain, dated 01/07/25, indicated Resident #1's Pain interventions included to anticipate the resident's need for pain relief and respond immediately to any complaints of pain, pain meds as ordered, observe and report to Nurse any signs or symptoms of non-verbal pain and observe and report to Nurse resident complaints of pain or requests for pain treatment. Review of Resident #1's Medication Administration Record, for January 2025, indicated Resident #1 had the Physician's Orders for medications for pain management as follows: - Lidocaine External Patch 4% apply at 9:00 A.M. to Left & Right lower back for Pain and Remove patch at 9::00 P.M. - Tylenol (Acetaminophen) Oral Tablet 325 mg (milligram), give two tablets every 6 hours as needed for pain. Further Review of the MAR indicated up until 01/31/25 Resident #1 had only requested Tylenol once. Documentation on the MAR for 01/31/25, indicated that, despite CNA #1 reporting to and making Nurse #1 aware, more than once that Resident #1 was moaning and saying he/she was in pain, he/she was not administered anything to treat or manage his/her pain. There was no documentation to support the Physician was notified or that new orders were obtained to treat his/her acute pain. During an interview on 03/18/25 at 2:00 P.M., (and during a follow-up interview on 03/19/25 at 1:07 P.M.) CNA #1 said on 01/31/25, sometime around 2:30 A.M., she heard a loud bang while providing care to Resident #3 and went to find out what the noise was. CNA #1 said she found Resident #1 in his/her room lying face up on the floor and she called Nurse #1 for help. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	CNA #1 said Nurse #1 came to Resident #1's room, that Resident #1 was screaming, I'm in pain, I'm in pain, but that Nurse #1 told her to get Resident #1 up off the floor. CNA #1 said she told Nurse #1 No, they should not move him/her. CNA #1 said she told Nurse #1 that in school she learned that when a patient falls and screams, they may have something broken and they needed to call for an ambulance. CNA #1 said Nurse #1 said No, we do not need to call for an ambulance, and said to bring Resident #1's wheelchair over to him. CNA #1 said Nurse #1 picked up Resident #1 off the floor, by himself and that Resident #1 was screaming, I'm in pain, I'm in pain and placed him/her in the wheelchair. CNA #1 said then Nurse #1 transferred Resident #1 out of the wheelchair by himself to the bed, and that Resident #1 was still crying out, I'm in pain. CNA #1 said when she and Nurse #1 left the room, she asked Nurse #1 if he was going to call 911 and complete the paperwork and that Nurse #1 said, Forget about it, Forget about it! CNA #1 said around 4:00 A.M., she assisted Resident #1's roommate with care and Resident #1 was still moaning like he/she was in pain. CNA #1 said Resident #1 had to urinate, but she was unable to assist him/her to use a urinal/bedpan, because when she touched Resident #1 to move him/her, he/she was in pain. CNA #1 said she was unable to pull down Resident #1's pants and that just touching Resident #1, he/she was groaning in pain. CNA #1 said she informed Nurse #1 again about Resident #1's pain, asked him to take Resident #1's vital signs and to check to see if he/she was ok. CNA #1 said Nurse #1 had motioned his hand in a backward motion at her as if he was dismissing her concerns and telling her to go away. During an interview on 03/19/25 at 2:29 P.M., CNA #2 said she worked with Resident #1 in the past, had worked with Resident #1 the day prior and he/she had not been in or complained of pain. CNA #2 said she was usually able to get Resident #1 out of bed without any difficulty or concerns. CNA #2 said on 01/31/25, she worked the 7:00 A.M. to 3:00 P.M. shift, and around at 7:45 A.M., she observed Resident #1 in bed, that he/she was screaming and when she tried to assist him/her with care to get him/her out of bed, Resident #1 said to her, I'm in a lot of pain, do not touch me, I'm in a lot of pain. CNA #2 said she could tell by Resident #1's facial expression that he/she was very uncomfortable. CNA #2 said she informed Nurse #2 right away, and she (Nurse #2) immediately assessed Resident #1. During an interview on 03/18/25 at 1:15 P.M., Nurse #2 said on 01/31/25 she started her shift around at 8:00 A.M. and shortly thereafter CNA #2 came to her reporting that Resident #1 was complaining of left leg pain. Nurse #2 said she went to assess Resident #1 and asked Resident #1 to move his/her left leg, and he/she said, No, it hurts. Nurse #2 said when she touched Resident #1's left hip area, he/she said Ouch, Ouch. Nurse #2 said she asked Resident #1 what happened, and Resident #1 said he/she had fallen this morning, and a man got him/her up. Nurse #2 said she asked the Staff Development Coordinator (SDC) and the Unit Manager to come help with assessing Resident #1 with her. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/18/25 at 3:10 P.M., the Staff Development Coordinator (SDC) said on 01/31/25 he helped Nurse #2 assess Resident #1. The SDC said he observed Resident #1's left upper thigh area was larger than his/her right and with any slight movement, Resident #1 said it was very painful for him/her. The SDC said when he assessed Resident #1's pedal pulses (rhythmic throbbing or pulsations that can be felt when palpating the arteries in the feet) his slight touch, per Resident #1, hurt. The SDC said Resident #1 said he/she had fallen out of bed and a male placed him/her back into bed. The SDC said Resident #1 had sweat pants on and they had to cut them off him/her to provide Resident #1 some comfort and relief from the pain. The SDC said Resident #1's left leg was rotated in an outward position and Resident #1's left thigh was twice as large than his/her right. The SDC said Resident #1 was groaning, had facial grimacing and he/she clearly was in pain. The SDC said staff called Emergency Medical Services to transfer Resident #1 to the Hospital. During an interview on 03/18/25 at 4:31 P.M., the Unit Manager said on 01/31/25 she helped assess Resident #1. The Unit Manger said Resident #1 was verbalizing he/she was in pain, she observed that his/her left leg was swollen and was in an externally (outward) rotated position. The Unit Manager said Resident #1 said he/she fell out of bed and a man picked him up and placed him/her back to bed. The Unit Manager said Resident #1's was wearing sweat pants that were tight, staff were unable to take them off him/her because Resident #1 was in so much pain, so they had to cut them off him/her. The Unit Manager said her expectations was that Nurses would immediately assess a resident after a fall for the potential for injury and pain prior to moving them. The Unit Manager said she reviewed Resident #1's Medical Record and there was no documentation of Resident #1's fall, no notification to Physician or Facility Administrative Staff, no incident report and no Pain Assessment completed on 01/31/25, by Nurse #1. During an interview on 04/01/25 at 9:40 A.M., Nurse #1 said on 01/30/25 he started his shift around at 3:00 P. M. and ended his shift on 01/31/25 around 7:00 A.M. Nurse #1 said Resident #1 was alert to self but confused. Nurse #1 said Resident #1 was able to express if he/she was in pain or in discomfort. Nurse #1 said at the start of the 11:00 P.M. to 7:00 A.M. shift, Resident #1 was in bed sleeping and he did not see Resident #1 again until around 4:30 A.M. or 5:00 A.M. Nurse #1 said he was at the Nursing station, preparing to start his morning medication pass when CNA #1 called him to help her, because Resident #1 was position half way out (sliding) of his/her wheelchair. Nurse #1 said he pulled on Resident #1's pants to get him/her back in a sitting position in his/her wheelchair and then transferred him/her back into bed. Nurse #1 said that although Resident #1 was in bed at the start of the shift, that he did not know how Resident #1 had gotten into the wheelchair that night. Nurse #1 said he did not need to assess Resident #1 since he had no concerns and Resident #1 did not say anything to him about being in pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Nurse #1 said he did not observe Resident #1 to be in pain and was not informed by anyone that Resident #1 was in pain. Nurse #1 said around 5:30 A.M. or 6:00 A.M., was the last time he saw Resident #1, because he gone to the room to help his/her roommate. Nurse #1 said Resident #1 was not in pain then. During an interview on 03/19/25 at 9:40 A.M., the Director of Nurses (DON) said she reviewed Resident #1's Medical Record and there was no documentation related to Resident #1's fall on 01/31/25, that there were no Nursing assessments including a pain assessment, no documentation to support the Physician was notified of Resident #1's acute pain to obtain new orders, and that Resident #1 was not given any medications to treat or manage his/her pain. On 03/18/25, 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) 01/31/25, Resident #1 was transferred to the Hospital and was found to have a Displaced Proximal Left Femoral Subtrochanteric Fracture (break in thigh bone just below the bony prominence in the lower part of the hips). B) 02/03/25, Nurse #1 was suspended pending an Investigation, and on 02/06/25, Nurse #1 was terminated from the Facility. C) 02/07/25, Resident #1 returned to the Facility status post Left Femur Open Reduction and Internal Fixation (ORIF) with intramedullary nail on 02/01/25, and his/her Care Plans were reviewed and updated as needed. D) 02/07/25, the Director of Nursing and Cooperate Nurse reviewed and performed an audit of the Facility's previous three months of resident falls, including conducting an audit related to Nurse #1's involvement with any Facility incidents. There were no concerns identified during the audits and it was determined Nurse #1 was not involved in any of the fall incidents. E) 02/10/25 through 02/26/25, the Staff Development Coordinator provided in-person education to all Licensed staff on the following topics: - Fall Management - Review Policy & Procedure - Assessments - Fall Reporting Tools - Falls - Immediate action - Reporting - Resident Rights, Abuse and Neglect F) 02/20/25 an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the Facility leadership team. The Director of Nursing and the Cooperate Nurse developed a plan of correction related to the deficient practice, the plan and corrective measures were reviewed. G) 02/26/25 and ongoing, the Unit Manager and Director of Nursing review each fall (Incident/Accident Reports) to ensure Licensed Staff are following Facility's Policy and Procedure, they will collect the data and present findings to QAPI Committee. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	H) Effectiveness of corrective action plan will be reviewed during Monthly QAPI meetings until further notice. I) Director of Nursing and Executive Director are responsible for overall compliance.