

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER West Hickory Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 3310 W Commerce Rd Milford, MI 48380	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568</p> <p>This citation pertains to Intake Number: MI00146312</p> <p>Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse by a resident for two (R805 and R808) of five residents reviewed for abuse, resulting in R806 punching R808 in the head and six days later R806 punching R805 in the face, neck and chest causing psychosocial harm using the reasonable person concept. Findings include:</p> <p>A review of a Facility Reported Incident (FRI) submitted to the State Agency revealed R806 came into contact with (R805's) foot with her walker and (R806) then made contact with closed fists to (R805's) face, neck, and chest area. This was witnessed by two staff members.</p> <p>A review of R805's clinical record revealed R805 was admitted into the facility on [DATE] with diagnoses that included: vascular dementia. A review of a MDS assessment dated [DATE] revealed R805 had severely impaired cognition, delusions, and verbal behaviors.</p> <p>A review of R805's progress notes revealed a note dated [DATE] that read, Writer notified of resident's foot being rolled over and hit 3 (times) by another resident .</p> <p>On [DATE] at 10:25 AM, an interview and observation were attempted with R805. However, staff reported R805 was transferred to the hospital that morning and was not currently present in the facility.</p> <p>A review of R806's clinical record revealed R806 was admitted into the facility on [DATE], readmitted on [DATE], and expired on [DATE] with diagnoses that included: dementia with anxiety, adjustment disorder with anxiety, and Alzheimer's disease. A review of R806's MDS assessment revealed R806 had severely impaired cognition and no behaviors.</p> <p>A review of a nursing progress note written on [DATE] at 1:57 PM, revealed documentation that noted R806 rolled over another resident's foot and hit her three times.</p> <p>A review of an investigation conducted by the facility in regards to the incident of R806 running over R805's foot and hitting her three times revealed the following:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A handwritten statement from Housekeeper (HK 'C' noted, I (HK 'C') seen (R806) run over (R805's) foot with her walker. (R805) yelled at her (R806) to stop then (R806) proceeded to punch (R805) 3 (times) on the right side of her chest.</p> <p>A handwritten statement from CNA 'D' noted, I saw (R806) punching (R805) today. They both live across the rooms from each other. (R806) punched (R805) at least 2 to 4 times. She punching her front of ice room on her face and neck.</p> <p>A signed statement written by CNA 'E' dated [DATE] noted, .At times (R806) has showed constant signs of aggression towards staff and other residents. Due to her confusion and the confusion of others aggressive interactions have taken place. Majority of the time (R806) is the one to start the altercation. As between these two residents (R805 and R806) she is known to wander into others rooms the most. I am very familiar with (R805) and can say that she hardly ever leaves her room to go into anyone elses and start any type of problems.</p> <p>A review of a typed investigation summary revealed R805 and R806 were cognitively impaired and unable to participate in an interview. The summary documented the following, Investigation Summary .During interviews with staff and residents it was determined that (R805) had stepped into the hallway near her room as she does periodically during the day to approach staff instead of using her call light. While in the hallway (R806) came up to her with her 4-wheeled walker, unaccompanied by staff and made contact with (R805's) foot using her walker, seemingly unintentionally (It should be noted that the intentional act of rolling over R805's foot was not addressed in either statement by the witnesses). (R805) reacted, telling (R806) to stop. (R806) then struck (R805) with closed hands to her face, neck, and chest area .(R806) was placed on 1:1 observation assigned to a staff member to lessen the likelihood of additional incidents .Conclusion .the facility is able to verify that the alleged incident in fact did occur as witnessed by two staff members .</p> <p>Further review of R806's progress notes revealed the following:</p> <p>A note written on [DATE] that read, .Writer got called to room by room mate because resident is walking around room bottom naked with roommate clothes on after leaving bm (bowel movement) on her bed and roommate's bed .</p> <p>A note written on [DATE] that read, Resident's roommate was interviewed and she stated that the resident threw BM at her in the middle of the night .</p> <p>A note written on [DATE] at 8:45 PM that read, .refused a shower .went for a walk. Around 10 min (minutes later) the main entry alarm went off and stopped soon after .resident was up front trying to get out and saying she wanted to kill herself .yelling at staff .grabbed the guide rail at the side of the wall and became combative, yelling, swatting, grabbed at CNA (Certified Nursing Assistant)'s shirt and tried to rip it .Resident took off her own shirt and tried to rip it .grabbed CNAs hoodies and started hitting her with her slipper, swore at her and attempted to bite her .grabbed the nursing cart and was yelling and started throwing medicine cups onto groups and trying to rip off side of cart .grabbed a cup out of another resident's hand .</p> <p>A note written on [DATE] that read, Resident continues to go in and out of rooms .easily agitated and difficult to redirect. Staff member is with resident at all times .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A note written on [DATE] that read, Resident was in another room .flipped writer the middle finger and said <expletives> .</p> <p>A note written on [DATE] that read, Resident found in an empty room bathroom putting on pull ups .</p> <p>A note written on [DATE] that read, Early in shift resident was found in neighbor's closet. Yelled at writer to get out .At lunch time resident went into bathroom and had BM on floor and in toilet .</p> <p>Further review of the facility's investigation into the incident between R806 and R805 revealed no mention of R806's behaviors that she exhibited prior to the incident on [DATE].</p> <p>On [DATE] at 4:14 PM, an interview was conducted with CNA 'D', one of the witnesses to the incident between R806 and R805 on [DATE]. CNA 'D' reported she witnessed R806 punch R805 in the face, neck, and shoulder. When queried about whether R806 had a history of aggressive behavior, CNA 'D' stated, She is very aggressive. Always fighting other residents. CNA 'D' further reported that on the unit where R806 resided, There's so much fighting over there. They are all so hyper all the time.</p> <p>On [DATE] at 4:18 PM, a telephone interview was attempted with HK 'C'. HK 'C' was not available for an interview prior to the end of the survey.</p> <p>On [DATE] at 4:44 PM, R808 was interviewed. When queried about any incidents or altercations with other residents, R808 reported a few months ago, R806 resided in the room next door and they shared a bathroom. R806 came through the bathroom into R808's room. R808 told R806 that she was in the wrong room. R806 became very agitated and punched R808 in the face, then laid on R808's bed.</p> <p>A review of R808's clinical record revealed R808 was admitted into the facility on [DATE]. A review of R808's MDS assessment revealed R808 had intact cognition.</p> <p>A review of an investigation conducted by the facility revealed an Investigation Summary that read, On [DATE] at approximately 10:15 am (six days prior to the incident between R806 and R805), R808 was sitting in her room in her wheelchair just inside her door, the door to her room was open toward the bathroom door that sits between her room and another resident's room. The bathroom was shared. The bathroom door was closed. The resident, (R806) has a room on the other side of the bathroom. (R808) was watching television when the bathroom door opened behind her wheelchair pushing the room door into the back of her wheelchair. (R808) rolled her wheelchair forward to allow the doors to open about a foot. (R806) pushed herself through the door as (R808) said Go the other way and something to the effect of this isnt your room. (R806) then made contact with (R808's) left side of her face, temple and head area with a closed fist .(R806) was provided a CNA assigned only to her for 24 hours to reduce the risk of other occurrences .The facility is able to verify that the alleged incident in face occurred even though there were no witnesses as (R808) is cognitively intact and staff heard the commotion and witnessed (R806) in (R808's) room at the time of the alleged incident .</p> <p>A review of a signed statement written by CNA 'D' revealed on [DATE] (the day before the incident between R806 and R808), (R806) went into (another resident's) room all naked .and when I tried to take her back to room, she tried to hit me and on [DATE], (R806) walked into (R808's) room started beating her and when (CNA 'E') and I tried to take her to her room, she tried to hit me as well.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:54 PM, an interview was conducted with the facility Administrator who did not work in the facility at the time of the above mentioned incidents. The Administrator could not provide any additional information other than what was documented, but reported it would be expected that effective interventions were implemented to prevent repeated resident to resident abuse.		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568</p> <p>This citation pertains to Intake Number(s): MI00146702.</p> <p>Based on observation, interview, and record review, the facility failed to thoroughly assess a resident with a change in condition and notify the physician for one (R801) of two residents reviewed for changes in condition. Findings include:</p> <p>A review of a complaint submitted to the State Agency revealed an allegation that the staff refused to call the physician at R801's request when she was not feeling well. R801 was diagnosed with COVID-19 and was hospitalized for five days.</p> <p>On 9/25/24 at 12:30 PM, R801 was observed lying in bed. R801 was alert and able to participate in an interview. When queried about any recent hospitalization s, R801 reported in August 2024 she started feeling sick with a severe headache. R801 reported she was concerned because she had multiple sclerosis (MS) and a compromised immune system and there was a COVID outbreak in the facility at that time. R801 explained she notified the nurse of the headache and the nurse gave her pain medication which did not relieve the headache. Then the nurse gave her a different pain medication which did not relieve the headache. R801 reported she asked to be tested for COVID-19, swabbed her own nose, and the test was positive. R801 reported the next shift nurse came in and she still did not feel well. R801 explained that she was afraid of how she felt and really wanted the nurse to contact the physician. R801 reported nobody ever took her vital signs or performed an assessment and the nurse (R801 did not know her name) refused to contact the physician. R801 reported the nurse told her she could not give her additional pain medications and she would not call the doctor because she didn't want to get in trouble. R801 told the nurse she was going to call 911 if she did not call the doctor and the nurse said Do what you have to do. R801 called 911 who stayed on the line with her. R801 reported she was so upset when she called and told them she was sick, alone, afraid, and upset because they were not addressing her medical needs. Eventually there was a knock at the door and it was EMS (emergency medical services) and R801 heard the nurse tell them they could leave because R801 was confused and overstepped her bounds. R801 yelled out I am not confused and EMS came in and took her to the hospital of her choice. R801 reported she was hospitalized for about five days and required intravenous fluids and medications, oxygen because her oxygen level was 90 percent when she arrived at the hospital, and needed potassium supplementation.</p> <p>A review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and readmitted on [DATE] (R801 was hospitalized from 8/18/24 until 8/21/24) with diagnoses that included: COVID-19 (8/18/24) and MS. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had intact cognition.</p> <p>A review of R801's progress notes revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note written on 8/18/24 by Licensed Practical Nurse (LPN) 'F' documented, During this shift, resident c/o (complained of) headache. Writer gave PRN (as needed) Tramadol (a pain medication) and rechecked resident 1 hour post administration. Resident stated the Tramadol did nothing to take away the headache. Writer then gave PRN Tylenol per orders. Resident stated that she felt tired and ache <sic>, but that the Tylenol seemed to be helping with the pain. Writer completed a COVID test and the COVID test was (positive). Notified (physician) and will continue to monitor symptoms .</p> <p>A progress note written on 8/19/24 by Charge Nurse, LPN 'G' documented, Writer called resident to see why she went to the hospital. Resident stated she had a horrible headache that wouldn't go away and she received her prn pain meds but didn't work. Resident stated she asked the nurse to see if she can call the doctor to get something stronger. The nurse stated I can only give what you have in your orders, resident stated she told the nurse she was going to call 911 and the nurse stated Go ahead and do what you need to do. Resident call 911 and was sent to (hospital) on August 18 in the evening.</p> <p>It was documented in a progress note dated 8/21/24 that R801 was readmitted to the facility.</p> <p>There was no progress note that indicated when and why R801 went to the hospital prior to LPN 'G's progress note after she called R801 at the hospital.</p> <p>A review of hospital records for R801 revealed a History of Physical dated 8/19/24 that documented, . COVID-19 infection .acute respiratory failure requiring oxygen .PRN breathing treatment and cough suppressants .</p> <p>On 9/25/24 at 2:56 PM, an interview was conducted with LPN 'F'. When queried about R801 on 8/18/24, LPN 'F' reported R801 complained of a headache, she gave medication to treat it, tested her for COVID-19, notified the physician of the positive COVID-19 test, and passed the information on to the next shift. When queried about whether R801's vital signs were done or any further assessment, LPN 'F' reported vital signs were done daily and documented in the vitals tab. LPN 'F' could not provide any additional information about whether she checked R801's vital signs due to her not feeling well and positive COVID-19 test.</p> <p>On 9/25/24 at 3:00 PM, an interview was conducted with LPN 'G'. When queried about why she contacted R801 at the hospital on 8/19/24, LPN 'G' reported she was not sure what happened and why R801 went to the hospital. LPN 'G' confirmed there was no documentation of why and when R801 went to the hospital but was hearing about what was happening over the weekend and called the resident because she was cognitively intact. LPN 'G' reported there was an agency nurse who worked when R801 went to the hospital and she should have assessed R801, documented the assessment, and contacted the physician if R801 was not feeling well and requested the physician to be contacted. LPN 'G' reported it was to be documented in the progress notes. LPN 'G' further reported that nurse was not allowed to work in the facility after that night.</p> <p>On 9/25/24 at 3:15 PM, an interview was conducted with the Director of Nursing (DON) who did not work at the facility at the time of R801's hospital transfer. The DON reported the expectation of the nurse when a resident had a change in condition was to assess the resident, including vital signs, and contact the medical provider. The assessment and physician's response should be documented in a progress note.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275</p> <p>This citation pertains to Intake #MI00146039</p> <p>Based on observation, interview and record review the facility failed to ensure a resident received proper care to prevent a fall for one (R807) of two reviewed for falls. Findings include:</p> <p>A complaint was filed with the State Agency (SA) that alleged on June 21, 2024; a staff person attempted to conduct routine personal hygiene on R807 on their own. The staff person allowed the resident to fall between the bed and the wall. The fall caused bruising to the resident and a transfer to the hospital.</p> <p>On 9/25/24 at approximately 10:40 AM, R807 was observed sitting in their wheelchair on top of a Hoyer lift sling. The resident was alert but not able to answer any questions asked.</p> <p>A review of R807's clinical record noted the resident was admitted to the facility on [DATE] with diagnoses that included: neurocognitive disorder with Lewy bodies, need for assistance with personal care, and abnormalities of gait and mobility. A review of the resident's Minimum Data Set (MDS) revealed the residents Brief Interview for Mental Status (BIMS) noted them as severely cognitively impaired.</p> <p>Continued review of R807's clinical record revealed the following:</p> <p>6/21/24-Alert Note: Writer was called into R807's room. She was lying on the floor on her right side between the bed and the wall .Skin assessment performed, red on right side back area. Right pupil non-reactive and some swelling in the back of her head at the right side .On call Provider notified with new orders to transfer to hospital for evaluation. Writer called 911 . (Authored by Nurse 'A).</p> <p>6/22/24 - Fall Management: .Balance: Not able to attempt test without physical support .Mobility: Confined to a chair .Contenance .Incontinent .History- During past 90 days there has been 0 falls .Summary: Nursing assessment performed .red on right side of back area .some swelling in the back of her head at the right side .new orders to transfer resident to hospital .R807 requires 2 persons for brief changes and activity in bed. She is unable to assist or control any movement with assistance on either side of the bed. On person on each side of the bed during care would prevent falling out of bed. (Authored by Nurse A).</p> <p>An Investigation/Accident (IA) report was provided by the facility and documented, in part, the following: Witnessed Fall .Date: 6/21/24 (8:50 PM) .Incident Description: CNA (certified nursing assistant) called writer to R807's room. She was lying on her right side between the bed and the wall .Statement: CNA B was changing R807's brief, she was rolled over on her bed remote and fell out of the bed onto the floor .Notes: Immediate Action: Staff educated on resident safety while providing care in bed .Resident interview: Resident unable to speak .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/25/24 at approximately 2:17 PM, a phone interview was conducted with Nurse A regarding R807's fall on 6/21/24. Nurse A noted that they no longer work at the facility and could not recall what happened on 6/21/24 nor could they identify the CNA involved. *It should be noted that a review of Nurse A's personnel record indicated the nurse was terminated from employment in July 2024.</p> <p>On 9/25/24 at approximately 2:21 PM, a phone call was made to CNA B. No contact was made, and a voice message could not be left. Review of CNA Bs personnel record noted CNA B no longer worked at the facility. Documents noted in their personnel record noted attempts were made to provide in-service training regarding resident care and safety on or about 6/24/25. The in-service notes indicated that CNA B refused to participate in re-education.</p> <p>On 9/25/24 at approximately 3:21 PM, an interview was conducted with the interim Director of Nursing (DON). The DON had reported that they were employed by an outside company and started working at the facility in the beginning of September 2024 as a number of staff including the prior DON were no longer employed by the facility. When asked about R807 and the fall that occurred on 6/21/24, the DON noted that they were not employed when the accident occurred, however based on their review of the IA it appeared as if CNA B rolled the resident incorrectly away from her while doing a brief change and/or linen change. The DON noted that if the CNA had rolled the resident correctly, they most likely would not have ended up on the floor between the bed and their window.</p>		