STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at St Louis Park LLC	3201 Virginia Avenue South Saint Louis Park, MN 55426

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement the baseline care plan developed for 1 of 3 residents (R2, R3 and R4) reviewed. The care plans indicated the residents had cognitive concerns and were to have one-to-one staff care and 15-minute checks. R2 had a fall within hours of admitting to the facility. Upon observation R3 and R4 were not receiving one-to-one cares or 15 minutes checks. Findings include: R2's baseline care plan dated 5/20/25 indicated safety monitoring would be implemented as needed to ensure residents safety, (i.e.) 15-minute safety checks and 1:1 staff to resident ratio. R2's nursing progress note dated 5/20/25 at 2:39 p.m. indicated R2 was arrived at the facility at 2:00 p.m. on a stretcher with one emergency medical systems (EMS) person. R2 was [AGE] years old with a primary diagnosis of glioblastoma (aggressive brain cancer) with recent craniotomy revision (a section of the skull bone is removed to expose the brain for surgery), sepsis (infection of the blood) and diabetic wound with a history of bacteria (bacteria found in the blood stream). He was a fully code (CPR was to be performed). R2 had a PICC (peripherally inserted central catheter) line on his right arm. R2 was at the facility for rehab, physical therapy (PT) and occupational therapy (OT). R2's note did not indicate any safety checks to be performed on R2. R2's admission Minimum Data Set (MDS) dated [DATE] was not completed as R2 was admitted to the facility on [DATE] and discharged on 5/21/25. Upon interview on 5/30/25 at 3:25 p.m. registered nurse (RN)-B stated he worked the night shift on 5/20/25. He stated R2 was not a 1:1 or receiving 15-minute safety checks because the facility could not manage that on the night shift as they only staff one nurse and one nursing assistant (NA). Upon interview on 6/2/25 at 10:11 a.m. RN-A reviewed R2's care plan and stated the care plan should not have stated 1:1 care for R2. His care plan was meant to be 15-minute checks. The 15 minutes safety are informal checks completed by all the staff, for example looking in the room, answering call lights, assisting with toileting, or giving medications. R3's baseline care plan dated 5/31/25 indicated safety monitoring would be implemented as needed to ensure residents safety, (i.e.) 15-minute safety checks and 1:1 staff to resident ratio. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's nursing progress notes dated 5/31/25 at 9:00 p.m. indicated R3 admitted from the hospital at 7:43 p.m. on a stretcher by two EMS staff. R3 had a history of left femoral neck fracture, total hip arthroplasty with WBAT (weight bearing as tolerated, Type II diabetes, depression, generalized anxiety. R3 was alert and oriented and continent of bowel and bladder. The note did not indicate any 1:1 care or 15-minute safety checks. R3's MDS dated [DATE] was not completed since R3 had admitted on [DATE]. Upon interview on 6/2/25 at 10:51 a.m. R3 stated she was weak when she stood and has a brain injury therefor since she had not been assessed by therapy, she should have had 15-minute safety checks. Since her admission staff only entered her room when they brought her meds or meals and when she pressed the call light. She stated she did not recall her care were supposed to be. R4's baseline care plan dated 5/24/25 indicated safety monitoring would be implemented as needed to ensure residents safety, (i.e.) 15-minute safety checks and 1:1 staff to resident ratio. R4's nursing progress notes dated 5/24/25 at 2:53 p.m. indicated R4 was admitted to the facility at 2:30 p.m. with two EMS personnels from the hospital. R4 was admitted to the facility due to multiple falls and was at the facility for PT. Per R4's hospital notes R4 was impulsive and did not use his call light. R4 was alert and oriented to himself. The notes did not indicate 1:1 care or 15-minute safety checks. Upon interview on 6/2/25 at 11:08 a.m. R4 stated he was not certain what was supposed to be doing for him. He stated staff came into his room [ROOM NUMBER]-3 times a day to bring him food and medications. Upon continuous observation on 6/2/25 from 11:08 a.m. to 12:33 p.m. R3 and R4 both had their doors closed. At 11:39 a.m. the director of nursing (DON) and the social worker (SW) entered R3's room. The DON exited her room at 11:42 and the SW exited at 11:50 a.m. At 12:25 p.m. R3 walked out of her room with her walker as the food cart was coming down the hall. She turned around and went back into her room. R3's meal was delivered to her room at 12:33 p.m. No staff entered R4's room during the observation period. His meal was delivered at 12:40 p.m. R3 and R4 were not receiving 1:1 care or 15-minute safety checks. Upon interview on 6/2/25 at 12:16 p.m. nursing assistant (NA)-A stated the transitional care unit which housed R2, R3, and R4 did not have any residents with 1:1 care 15-minute checks. He stated the only time had a worked with 15-minute safety checks was when residents were combative with each other, otherwise safety checks were every two hours. The checks were the when the NA's rounded the unit, provided visualization of the residents, repositioned the residents or check and changed incontinent briefs. He stated he had not had a 1:1 resident in years at the facility. Upon interview on 6/2/25 at 1:18 p.m. the Social Worker stated she was not certain how 1:1 care or 15-minute checks got on the care plans. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 6/2/25 at 1:30 p.m. RN-C stated the unit did not have any 1:1 care or 15-minute safety checks. Upon care plan review, she stated she was not aware the care plans indicated 1:1- or 15-minute checks. If the care plan indicated specific checks, then the facility is required to do what the plan indicated. In addition, it should indicate 1:1 or 15-minute checks, not both. The initial care plan needed to be patient centered and accurate so staff can do their job properly. Upon interview on 6/2/25 at 1:59 p.m. the Administrator stated when the facility staff create a 48-hour care the 1:1 and 15-minute safety checks are an example to use. She stated the care plan was meant to offer safety checks as needed for new residents. She stated after the 48-hours it should be reviewed and removed if that is not what the facility doing. She did not expect the staff to follow the example on the baseline care plan however the care plan should indicate clear parameters for the safety checks needed. A facility policy titled Baseline Care Plan with a revision date of 8/2017 indicated the interdisciplinary team reviewed the healthcare practitioner's orders and implement a baseline care plan within 48 hours of admission to meet the resident's immediate base care needs, including things as; initial goals, physical orders, nursing orders, dietary orders, therapy services and social services as needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide fundamental quality of care of professional standards of practice for 1 of 3 residents reviewed for quality of care. R2 had a fall, and the facility was unable to ensure neurological checks (a critical assessment to identify any potential damage to the brain and nervous system) had been completed. Findings include: R2's baseline care plan dated 5/20/25 indicated safety monitoring would be implemented as needed to ensure residents safety, (i.e.) 15-minute safety checks and 1:1 staff to resident ratio. R2's nursing progress note dated 5/20/25 at 2:39 p.m. indicated R2 arrived at the facility at 2:00 p.m. on a stretcher with one emergency medical systems (EMS) person. R2 was [AGE] years old with a primary diagnosis of glioblastoma (aggressive brain cancer) with recent craniotomy revision (a section of the skull bone is removed to expose the brain for surgery), sepsis (infection of the blood) and diabetic wound with a history of bacteria (bacteria found in the blood stream). He was a full code (CPR was to be performed). R2 had a PICC (peripherally inserted central catheter) line on his right arm. R2 was at the facility for rehab, physical therapy (PT) and occupational therapy (OT). R2's note did not indicate any safety checks to be performed on R2. R2's incident note dated 5/20/25 at 10:43 indicated R2 was found seated on the floor less than five minutes after two nursing assistants and the nurse offered to help him use the bathroom. R2 stated he was trying to stand up to use the bathroom. He denied pain, hitting his head and had no injury. R2's vital signs were; blood pressure 145/98 (normal 120/80), pulse 85 (normal 60-100), respirations 18 (normal 12-20), oxygen saturation was 96% on room air (normal 92% - 100%), pain 0/10 (0 being no pain and 10 being great pain). Under the heading hit head title on the document (initiate neuro-checks for head bump) indicated R2 did not hit his head. A voice mail was left for the on-call provider. The immediate action that took place was to lower the bed and re-educated R2 on using the call light and placed his telephone within reach. The note did not indicate what R2 was doing prior to the fall, where he fell from or what his immediate or follow-up neuro-checks indicated. R2's nursing note dated 5/21/25 at 10:10 a.m. indicated R2 was found seated on the floor of his room, when asked he stated, I was trying to go to the bathroom and fell. R2 denied hitting his head, no injury was noted at that time. Neuro check sheet was started. R2 was reeducated on using the call-light. The note was documented the morning following the fall and after he went to the hospital. R2's nursing note dated 5/21/25 indicated R2 was sent to the emergency department (ED) around 9:00 a.m. related to a fall. The Family called emergency medical services (EMS). R2's admission Minimum Data Set (MDS) dated [DATE] was not completed as R2 was admitted to the facility on [DATE] and discharged on 5/21/25. R2's electronic Medical Administration Record (EMAR) dated 5/21/25 at 6:00 a.m. indicated to complete neuro sheet as applicable for three days. This was initiated 7 hours after R2's fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's (EMAR) dated 5/21/25 at 6:00 a.m. indicated for staff to make a progress note post fall x72 hours, make sure to include any signs of symptoms of injury and effectiveness of new fall interventions every shift for 3 days. This was initiated 7 hours after R2's fall. R2's (EMAR) dated 5/21/25 at 6:00 a.m. indicated post fall vital sign checks every shift for 24 hours. This was initiated 7 hours after R2's fall. R2's (EMAR) dated 5/21/25 at 0700 indicated to monitor R2 for signs and symptoms of injury post fall x 72 hours. This was initiated 8 hours after R2's fall. R2's (EMAR) dated 5/21/25 did not indicate any neuro-checks to be completed after R2's fall. A written statement to the facility on 5/22/25 by RN-B indicated: Taking care of R2 was very exhausting R2 was demanding and time consuming. He was verbally aggressive, arrogant, loud, and condescending, talking down to staff during cares. You guys don't know what you are doing. FM-B was present all night and witnessed R2's ranting and even shouting at her. All R2 wanted to do all night was Eat! Eat! Eat! He was constantly demanding more food, one after another enabled by FM-B. FM-B came to the nurses desk for multiple things one after the other, asking for help including more food for R2. She asked for help with him to the bathroom, RN-B helped him to the bathroom when the NA was on a break and for some reason R2 was pretending he was not able to walk/stand. That night NA was in his room multiple times either doing cares, delivering food, or fixing R2's incontinent brief. Between RN-B and NA-A R2's needs and wants were addressed to the best of their ability. Trying to do vital signs on R2 and administer his IV antibiotics was time consuming because he wanted to do something else instead. RN-B's statement did not include the assessments he provided for R2's behavior and post fall. RN-B did not document R2's behaviors in the progress notes. Upon interview on 5/30/25 at 12:15 p.m. R2's family member (FM)-A stated she had not heard from R2 for a few hours on 5/20/25. At approximately 10:45 p.m. she called his room and did not receive an answer. She then called the reception area to ask for staff to check on R2. She was on the phone and registered nurse (RN)-A stated R2 was on the floor, and he was looking for staff to assist him to get him up with the mechanical lift. She stated she was worried because the staff were unable to provide information on how he fell to her over the phone. R2 was a fall risk due to his brain cancer and recent surgery, therefor he was to be closely monitored. FM-A called FM-B and asked her to go to the facility to see R2 and stay with him until the morning until the family could speak with the facility. FM-B got to the facility at approximately 12:30 a.m. FM-B was concerned about R2 as she noticed he appeared short of breath, confused, and combative. FM-B was told the facility conducts 15-minute neuro-checks for the first hour following a fall, 30 minutes for the next hour and then hourly for 24 hours. FM-B stated the staff were not completing half hour or hourly checks when she was there. FM-B had to go out and get staff at the desk when R2 needed assistance because the staff did not answer the call light. Another family member, FM-C, arrived at the facility on 5/21/25 at approximately 8:00 a.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 5/30/25 at 1:31 p.m. RN-C the nurse manager stated she spoke with FM-C the morning after R2's fall. FM-C stated R2 was to be a 1:1 with his cares as he was in the hospital. RN-C stated she re-read the hospital discharges notes and did not find an order to indicate R2 was to be a 1:1 for cares. FM-C requested documentation of what cares were performed following R2's fall including his neuro-checks. FM-C was told the nurse on duty puts batch orders (the facility fall protocol) into the residents electronic chart, so the staff are sure to complete all the post fall assessments. RN-C stated the neuro-checks can be documented on a hard copy instead in the electronic chart. RN-C could not locate the neuro-checks at the time of the survey. The morning of 5/21/25 RN-C attempted to complete a risk assessment for R2 around 8:30 a.m. however the family would not allow her to and was wanting R2 to be sent to the hospital. The family called EMS. Upon interview on 5/30/25 at 3:10 p.m. RN-A stated he worked and completed R2's admission on [DATE]. He stated two nursing assistants had asked R2 if he wanted assistance to the bathroom moments before he found R2 on the floor. He was walking past R2's room and found him seated on the floor. He stated R2's wife was on the phone with him. RN-A told FM-A R2 was on the floor, and he was getting assistance and a mechanical lift. About 40 minutes after the fall, FM-C arrived at the facility and stayed the night with R2. RN-A stated he started a hard copy of a neuro-flow sheet and completed the first three neuro-checks. RN-A reported the fall and left the neuro-check sheet for RN-B, the incoming night nurse. Upon interview on 5/30/25 at 3:25 p.m. RN-B stated he worked the night shift on 5/20/25 and referred to it as a crazy night stating FM-C was in his face all night with questions about R2. He stated he came to work the following day and heard the family had complained that no staff were in R2's room all night. His response was he took R2 to the bathroom when the NA-A was busy. In addition, he hung R2's IV medication and completed his admission vital signs, which were every 4 four hours for the first 24 hours. When prompted about R2's fall RN-B stated the fall happened on the evening shift, so all the fall evaluations were completed at that time. He stated he could not recall if the neuro-checks were still ongoing into the night, if they were he completed them on a hard copy sheet. NA-A was not available for an interview during the survey. Upon interview on 6/2/25 at 8:49 a.m. FM-C arrived at the facility on 5/21/25 due to concerns RM-B called and informed her of. FM-C observed R2's mental status to be altered, increased confusion and anxiety along with grabbing his head. FM-C requested post fall documentation, especially concerned with R2's neuro-checks. The staff could not provide the neuro checks. FM-C was given copies of R2's vital signs taken 5/20/25 at 2:34 p.m., 5/20/25 at 8:01 p.m. (these were before the fall), 5/20/25 at 11:03 p.m. (this was right after the fall), 5/21/25 at 12:47 a.m. and 5/21/25 at 4:03 a.m. and R2's incident fall note from 5/20/25 at 10:43 p.m. FM-C was concerned about R2's neurological status. She called EMS around 9:00 a.m. Upon interview on 6/2/25 at 1:59 p.m. the Administrator expected staff to follow the facility protocol for falls. She was not certain what documentation was completed post-fall for R2. An email request dated 6/2/25 at 3:16 p.m. sent to the Administrator requesting R2's neuro-checks. None were provided. A policy regarding neuro-checks was requested however none was provided. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled falls with a revision date of 2/20/25 indicated: Fall occurs: a. When a resident has fallen, or is found on the floor, nursing staff will provide comfort, but not move the resident until evaluated for injury. b. The nursing staff will record vital signs (including orthostatic BP), when appropriate. c. If a bump to the head is suspected or confirmed complete neuro checks and update the provider timely. Nursing should utilize the neuro flow sheet per policy. d. If resident is noted to be on a blood thinning medication and sustains a fall there is significant risk of bleeding. This should be reported to the provider in a timely manner. e. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. If a fracture is suspected, do not move resident, but stay with resident and wait for instructions from medical provider or for emergency medical staff to arrive. e. Once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details. f. Nursing staff will notify the resident's medical provider and family in an appropriate time frame. When a fall results in a significant injury or condition change, nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, nursing staff will notify the practitioner routinely (e.g., by fax, phone, or in-house communication book, the next office/visit day). g. Nursing staff will observe for delayed complications of a fall for (72) hours after an observed or suspected fall and will document findings in the medical record. h. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings. i. Nursing staff will complete an incident review and analysis. 2. Defining Details of Falls: a. After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred, where it occurred and what the individual was trying to do at the time the fall occurred. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Identifying Causes of a Fall or Fall Risk: a. Nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence including medical history, known functional impairments, etc. b. Staff will evaluate chains of events or circumstances preceding a recent fall, including: 1) Time of day of the fall; 2) What the resident was doing or attempting to do; 3) Whether the resident was standing, walking, reaching, or transferring from one position to another; 4) Whether the resident was among other persons or alone; 5) When was the last time the resident was repositioned or toileted; 6) Time of the last meal; 7) Whether any environmental risk factors were involved (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or 8) Whether there is a pattern of falls for this resident. c. The interdisciplinary team will review falls daily at morning meeting. d. The staff will continue to collect and evaluate information until they either identify the cause of falling or determine that the cause cannot be found. e. As indicated, the attending physician may examine the resident or may initiate testing to try to identify causes. f., when possible, the attending physician or nursing staff will document the basis for identifying specific factors as the cause. g. If the cause of a fall is unclear, the fall has a significant medical cause such as a transient ischemic attack or an adverse drug reaction (ADR), or if the resident continues to fall despite attempted interventions, the nursing staff will discuss the situation with the attending physician or Medical Director. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. If causes of a fall cannot be readily identified and if the fall is accompanied by other signs and symptoms (e.g., confusion, lethargy, restlessness), the staff and physician will consider a possible underlying acute medical cause. Based on interview and record review the facility failed to provide fundamental quality of care of professional standards of practice for 1 of 3 residents reviewed for quality of care. R2 had a fall, and the facility was unable to provide documentation that neurological checks (a critical assessment to identify any potential damage to the brain and nervous system) had been completed. Findings include: R2's baseline care plan dated 5/20/25 indicated safety monitoring would be implemented as needed to ensure residents safety, (i.e.) 15-minute safety checks and 1:1 staff to resident ratio etc. R2's nursing progress note dated 5/20/25 at 2:39 p.m. indicated R2 arrived at the facility at 2:00 p.m. on a stretcher with one emergency medical systems (EMS) person. R2 was [AGE] years old with a primary diagnosis of glioblastoma (aggressive brain cancer) with recent craniotomy revision (a section of the skull bone is removed to expose the brain for surgery), sepsis (infection of the blood) and diabetic wound with a history of bacteria (bacteria found in the blood stream). He was a full code (CPR was to be performed). R2 had a PICC (peripherally inserted central catheter) line on his right arm. R2 was at the facility for rehab, physical therapy (PT) and occupational therapy (OT). R2's note did not indicate any safety checks to be performed on R2. R2's incident note dated 5/20/25 at 10:43 indicated R2 was found seated on the floor less than five minutes after two nursing assistants and the nurse offered to help him use the bathroom. R2 stated he was trying to stand up to use the bathroom. He denied pain, hitting his head and had no injury. R2's vital signs were; blood pressure 145/98 (normal 120/80), pulse 85 (normal 60-100), respirations 18 (normal 12-20), oxygen saturation was 96% on room air (normal 92% - 100%), pain 0/10 (0 being no pain and 10 being great pain). Under the heading hit head title on the document (initiate neuro-checks for head bump) indicated R2 did not hit his head. A voice mail was left for the on-call provider. The immediate action that took place was to lower the bed and re-educated R2 on using the call light and placed his telephone within reach. The note did not indicate what R2 was doing prior to the fall, where he fell from or what his immediate or follow-up neuro-checks indicated. R2's nursing note dated 5/21/25 at 10:10 a.m. indicated R2 was found seated on the floor of his room, when asked he stated, I was trying to go to the bathroom and fell. R2 denied hitting his head, no injury was noted at that time. Neuro check sheet was started. R2 was reeducated on using the call-light. The note was documented the morning following the fall and after he went to the hospital. R2's nursing note dated 5/21/25 indicated R2 was sent to the emergency department (ED) around 9:00 a.m. related to a fall. The Family called emergency medical services (EMS). R2's admission Minimum Data Set (MDS) dated [DATE] was not completed as R2 was admitted to the facility on [DATE] and discharged on 5/21/25. R2's electronic Medical Administration Record (EMAR) dated 5/21/25 at 0600 indicated to complete neuro sheet as applicable for three days. This was initiated 7 hours after R2's fall. (continued on next page)

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The Estates at St Louis Park LLC	3201 Virginia Avenue South Saint Louis Park, MN 55426

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's (EMAR) dated 5/21/25 at 0600 indicated for staff to make a progress note post fall x72 hours, make sure to include any signs of symptoms of injury and effectiveness of new fall interventions every shift for 3 days. This was initiated 7 hours after R2's fall. R2's (EMAR) dated 5/21/25 at 0600 indicated post fall vital sign checks every shift for 24 hours. This was initiated 7 hours after R2's fall. R2's (EMAR) dated 5/21/25 at 0700 indicated to monitor R2 for signs and symptoms of injury post fall x 72 hours. This was initiated 8 hours after R2's fall. R2's (EMAR) dated 5/21/25 did not indicate any neuro-checks to be completed after R2's fall. A written statement to the facility on 5/22/25 by RN-B indicated: Taking care of R2 was very exhausting R2 was demanding and time consuming. He was verbally aggressive, arrogant, loud and condescending, talking down to staff during cares. You guys don't know what you are doing. FM-B was present all night and witnessed R2's ranting and even shouting at her. All R2 wanted to do all night was Eat! Eat! Eat! He was constantly demanding more food, one after another enabled by FM-B. FM-B came to the nurses desk multiple things one after the other, asking for helpe including more food for R2. She asked for help with him to the bathroom, RN-B helped him to the bathroom when the NA was on a break and for some reason R2 was pretending he was not able to walk/stand. That night NA was in his room multiple times either doing cares, delivering food or fixing R2's incontinent brief. Between RN-B and NA-A R2's needs and wants were addressed to the best of their ability. Trying to do vital signs on R2 and administer his IV antibiotics was time consuming because he wanted to dosomething else instead. RN-B's statement did not include the assessments he provided for R2's behavior and post fall. RN-B did not document R2's behaviors in the progress notes. Upon interview on 5/30/25 at 12:15 p.m. R2's family member (FM)-A stated she had not heard from R2 for a few hours on 5/250/25. At approximately 10:45 p.m. she called his room and did not receive an answer. She then called the reception area to ask for staff to check on R2. She was on the phone and registered nurse (RN)-A stated R2 was on the floor, and he was looking for staff to assist him to get him up with the mechanical lift. She stated she was worried because the staff were unable to provide information on how he fell to her over the phone. R2 was a fall risk due to his brain cancer and recent surgery, therefor he was to be closely monitored. FM-A called FM-B and asked her to go to the facility to see R2 and stay with him until the morning until the family could speak with the facility. FM-B got to the facility at approximately 12:30 p.m. FM-B was concerned about R2 as she noticed he appeared short of breath, confused, and combative. FM-B was told the facility conducts 15-minute neuro-checks for the first hour following a fall, 30 minutes for the next hour and then hourly for 24 hours. FM-B stated the staff were not completing half hour or hourly checks when she was there. FM-B had to go out and get staff at the desk when R2 needed assistance because the staff did not answer the call light. FM-C arrived at the facility on 5/21/25 at approximately 8:00 a.m. (see her interview below). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 5/30/25 at 1:31 p.m. RN-C the nurse manager stated she spoke with FM-C the morning after R2's fall. FM-C stated R2 was to be a 1:1 with his cares as he was in the hospital. RN-C stated she re-read the hospital discharges notes and did not find an order to indicate R2 was to be a 1:1 for cares. FM-C requested documentation of what cares were performed following R2's fall including his neuro-checks. FM-C was told the nurse on duty puts batch orders (the facility fall protocol) into the residents electronic chart, so the staff are sure to complete all the post fall assessments. RN-C stated the neuro-checks can be documented on a hard copy instead in the electronic chart. RN-C could not locate the neuro-checks at the time of the survey. The morning of 5/21/25 RN-C attempted to complete a risk assessment for R2 around 8:30 a.m. however the family would not allow her to and was wanting R2 to be sent to the hospital. The family called EMS. Upon interview on 5/30/25 at 3:10 p.m. RN-A stated he worked and completed R2's admission on [DATE]. He stated two nursing assistants had asked R2 if he wanted assistance to the bathroom moments before he found R2 on the floor. He was walking past R2's room and found him seated on the floor. He stated R2's wife was on the phone with him. RN-A told FM-A R2 was on the floor, and he was getting assistance and a mechanical lift. About 40 minutes after the fall, FM-B arrived at the facility and stayed the night with R2. RN-A stated he started a hard copy of a neuro-flow sheet and completed the first three neuro-checks. RN-A reported the fall and left the neuro-check sheet for RN-B, the incoming night nurse. Upon interview on 5/30/25 at 3:25 p.m. RN-B stated he worked the night shift on 5/20 and referred to it as a crazy night stating FM-B was in his face all night with questions about R2. He stated he came to work the following day and heard the family had complained that no staff were in R2's room all night. His response was he took R2 to the bathroom when the NA-A was busy. In addition, he hung R2's IV medication and completed his admission vital signs, which were every 4 four hours for the first 24 hours. When prompted about R2's fall RN-B stated the fall happened on the evening shift, so all the fall evaluations were completed at that time. He stated he could not recall if the neuro-checks were still ongoing into the night, if they were he completed them on a hard copy sheet. NA-A was not available for an interview during the survey. Upon interview on 6/2/25 at 8:49 a.m. FM-C arrived at the facility on 5/21/25 due to concernss RM-B called and informed her of. FM-C observed R2's mental status to be altered, increased confusion and anxiety along with grabbing his head. FM-C requested post fall documentation, especially concerned with R2's neuro-checks. The staff could not provide the neuro checks. FM-C was given copies of R2's vital signs taken 5/20/25 at 2:34 p.m., 5/20/25 at 8:01 p.m. (these were before the fall), 5/20/25 at 11:03 p.m. (this was right after the fall), 5/21/25 at 12:47 a.m. and 5/21/25 at 4:03 a.m. and R2's incident fall note from 5/20/25 at 10:43 p.m. FM-C was concerned about R2's neurological status. She called EMS around 9:00 a.m. Upon interview on 6/2/25 at 1:59 p.m. the Administrator expected staff to follow the facility protocol for falls. She was not certain what documentation was completed post-fall for R2. An email request dated 6/2/25 at 3:16 p.m. sent to the Administrator requesting R2's neuro-checks. None were provided. A policy regarding neuro-checks was requested however none was provided. (continued on next page)

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