STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Living Community Mother of Mercy	230 Church Avenue, Box 676 Albany, MN 56307

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to assess the independent use of an electric lift chair for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm when R1 attempted to self-transfer from the lift chair, fell, hit her head, and sustained a hematoma (a collection of blood in the tissues after an injury) and laceration of the forehead, sent to the emergency department (ED) for further evaluation, wound care, pain control, and received four stitches to the right forehead. R1 sustained an additional fall from a wheel chair, hit her head, sustained a hematoma to right lateral proximal (point of attachment) hip, sent to ED for further evaluation and pain control. The facility implemented corrective action, so the deficient practice was issued at past non-compliance.Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], identified she was admitted on [DATE], from the hospital. R1 had difficulty heading in some environments (when a person spoke softly or setting was noisy), impaired vision (able to see large print, but not regular print in newspapers/books), severely impaired cognition with thinking and/or memory, and no behaviors. R1 was dependent upon staff for toileting, lower body dressing, substantial /maximal assistance needed with shower/bathes, personal hygiene, repositioning in bed, sit to stand, all transfers, and used manual wheelchair for mobility. She was always continent of bowel and bladder. Medical history included renal insufficiency, arthritis, osteoporosis (causes bones to become weak and brittle), macular degeneration (blurred or reduced central vision), and encephalopathy (is a change in how your brain function and/or dysfunction and can appear as confusion, disorientation, memory loss, personality changes, agitation or irritability, and can be temporary or permanent), and kyphosis (excessive rounding of the upper back and can cause back pain and stiffness).R1's provider orders from 4/15/26, through 4/21/26, identified: -Order date 4/15/26, Physical therapy (PT) and Occupational therapy (OT) to evaluate and treat. -Order date: 4/21/26, OT to perform cognitive testing. -Order date 4/21/26, Acetaminophen oral tablet 500 milligrams (mg). Give 1000 mg by mouth three times a day related to wedge compression fracture (a spinal fracture where the front of the vertebra collapses while the back stays intact, giving the bones a wedge or triangular shape with weakened bones from osteoporosis). -Order date 4/21/26, Acetaminophen oral tablet 500 mg. Give 500 mg by mouth every 24 hours as needed for pain.R1's Fall risk evaluation completed on 4/15/26 at 12:33 p.m., identified short term memory loss. Poor safety awareness (i.e. self-transfers, forget to lock wheelchair brakes), moderately impaired vision, unable to ambulate to chair, required assist of two to transfer, and had three or more health conditions and medications that would increase her risk factors. R1 was identified as a risk for falls. Nursing interventions/approaches: discussed with family/R1 importance and reminders to use call light prior to any transfers and help with activities of daily living (ADLs) to prevent falls.R1's care plan dated 4/28/26, identified:-R1 was deemed vulnerable due to risk for falls, history of falls, cognitive deficits, and poor impulsive control, and required assist with ADLs. Staff were expected to encourage resident/responsible part to address questions/concerns to staff and interdisciplinary team to discuss resident's status, well-being, and observe and document changes in mood, behavior, and routine. Date initiated 4/14/26. -R1 had (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	potential for injury related osteoarthritis and wedge compression fracture to spine. He was ok to have power lift chair in room but without power function intact. Therapy deemed inappropriate to have full power function. Daughter gave verbal consent 4/20/26. Date initiated: 4/20/26.-R1 had self-care deficit related to encephalopathy (a broad term for any disease, damage, or malfunction of the brain that alters its function or structure and occurs when the brain is deprived of oxygen, exposed to toxins, or affected by an underlying illness and causes a change in mental state and/or behavior). Staff were instructed to transfer with physical assist of two staff and EZ aide and stay with her while on toilet. Date initiated 4/15/26. -R1 had potential for injury related to impaired mobility, incontinence of bowel and bladder, impaired cognition, antipsychotic/antianxiety/narcotic/diuretic medications, impaired vision/hearing, history of falls, fluctuating blood sugars, and limited range of motion (ROM). She was impulsive as evidenced by (AEB) did not consistently ask for help or use call light, poor safety awareness, self-transferred, self-toileted, and refused to wear shoes with transfers. Staff were directed to keep call light within reach and encourage to use it, lift recliner use not recommended, deemed inappropriate to have power lift chair function, remained in neutral position, and continue to monitor appropriateness. Date initiated: 4/15/26. Date revised 4/20/26. - R1 had impaired cognitive function related to difficulty making decisions, disorientation, forgetfulness, impaired decision making, periods of confusion, and unable to make safe decisions. Staff were directed to explain cares/procedures prior to beginning it in simple and few words, provide cues, reorientation, and reminders as needed. Date initiated 4/14/26. -R1 had a communication problem related to a hearing deficit and impaired (very poor) vision related to macular degeneration. Staff were directed to anticipate needs, allow adequate time to respond, and use simple, brief, consistent words/cues, and keep call light within reach. Date initiated 4/15/26.R1's care sheet dated 5/6/26, identified Ambulation: not at this time, pivot only, assist of one with two wheeled walker and gait belt for transfers. Had glasses, very poor vision, hard of hearing, and stay with resident while on toilet. Lift recliner not recommended. Do not prop feet in recliner, on chair/stool, place in be to elevate feet.R1's progress notes from 4/15/26 through 5/5/26, identified:-4/15/26 at 10:49 a.m., BIMS completed and showed cognitive impairment. Patient Health Questionnaire (PHQ9) (assessment for mental health/depression) completed with score of 3/30 (0-4 minimal depression/mood concerns). She stated had difficulty concentrating at times. -4/15/26 at 11:06 a.m., R1 was admitted to facility from a local hospital for weakness and encephalopathy, not ambulating at this time, transferred with assist of two, pivots with walker and gait belt. R1 was able to demonstrate success in using the bed remote, television remote, and call light to make needs known. She was oriented to person only and noted weakness to bilateral upper extremities upon admission. -4/15/26, and 4/16/26, Orientated to person only, impaired short-term memory, decision making, and confused. -4/17/26, at 11:51 a.m., Alert and orientated to situation only, impaired short-term memory/decision making, and confused. Pleasant but anxious mood. -4/17/26 at 11:56 a.m., Reported by daughter she became more confused and restless in the evenings. She refused medications last evening. Was reported she was up multiple times during the night, in and out of her recliner, bed, and unable to get comfortable. -4/18/26 at 9:03 a.m., Orientated to situation only, impaired decision-making ability/short term memory, and confused. She required assist of staff and EZ stand with transfers. Changes in mood, behaviors noted, and some anxiety. -4/18/26 at 3:41p.m., R1 was found on floor laying on right side beside recliner with legs and arms curled. Injuries: open skin tear to superior area of right temporal region with moderate to severe bleeding. Severe pain noted to right temporal area, she was unable to place numerical value of pain, increased with touch. Open area cleansed with normal saline (NS), active bleeding contained after application of 4 x 4 gauze sponge dressing applied. Stretch gauze wrapped around injury and secured with surgical tape. Provider and daughter notified. Non emergent emergency medical services (EMS) notified for transfer. -4/19/26 at 9:26 a.m., Fall follow-up (FU): laceration with stitches noted above right eyebrow, clean, dry and intact with no signs of bleeding or infection. Denied pain. She was lethargic but arousable. Monitored closely for safety at least every 30 minutes while in her room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-4/19/26 at 7:38 p.m., R1 remained pleasantly confused throughout shift. -4/20/26 at 9:26 a.m., Orientated to situation only, impaired short-term memory and decision-making ability, and confused. Unsteady gait, impaired balance and weakness, required supervision. Self-transfer resulted in a fall on 4/18/26. -4/20/26 at 1:31p.m., Writer called and updated daughter. Power cord taken out of R1's room due to PT and OT noted increased confusion. Daughter stated ok to have recliner remain in her room without power cord intact. -4/21/26 at 8:51 p.m., IDT reviewed fall on 4/20/26. Noted she had used a power lift chair at home prior to admission. She had a power lift chair in place and the surface she sat on prior to attempting to self-transfer. She used non-skid footwear, and her left knee gave out, sent to hospital, had laceration sutured, and no fractures were identified. R1 was noted to have increased confusion and decreased cognitive impairment during PT session today. Therapy and nursing decided R1 was not to have full function of the power to lift chair at this time. Writer removed power cord and updated daughter. No, as needed (PRN) medication use within 24 hours of fall and no acute changes in resident's condition prior to the fall. -4/21/26 at 9:15 p.m., New order from Nurse Practitioner (NP): Occupational therapy (OT) perform St. Louis University Mental Status (SLUMS) (a cognitive assessment tool designed to screen for signs of cognitive impairment in older adults, including various types of dementia, like Alzheimer's disease) for cognitive testing. -4/26/26 at 1:15 a.m., R1 anxious throughout shift, reported difficulty falling asleep and frequently activating her call light. -4/26/26 at 2:30 a.m., Writer followed up with continued anxiety and repeated call light use. Was determined R1 wanted her clothing to be placed back on. -4/27/26 at 10:11 a.m., Provider noted increased insomnia and anxiety concerns in the evenings/night. -4/27/26 at 7:59 p.m., New order Trazadone 25 milligrams (mg) by mouth at bedtime related to insomnia -4/28/26 at 9:56 a.m., Changes to mood and behavior noted. Lethargic due to little to no sleep. -5/1/26 at 1:35 a.m., R1 observed to be anxious during routine rounding. Refused to return to bed. Placed R1 in wheelchair and positioned her at nursing station at 1:00 a.m. and appeared calmer. Sent message to provider requested evaluation for possible anxiety medication. -5/1/26 at 12: 13 p.m., New orders: Hydroxyzine (antihistamine primarily used to treat short-term anxiety) 25 mg every 6 hours PRN times 14 days for anxiety and increased Trazadone to 50 mg every HS. -5/2/26 at 12:52 p.m., Changes in mood/behavior noted, lethargic due to poor sleep. -5/3/26 at 5:30 a.m., R1 went to sleep at about 10:15 p.m. and appeared to sleep through most of the night. -5/5/26 at 11:14 a.m., R1 complained of upper left thigh pain 10/10, holding/guarding it while tearful. Left extremity if more swollen with 2+ edema and when tried to extend it she quickly reacted in pain. Updated provider. -5/5/26 at 10:21 p.m., R1 returned from local hospital ED via ambulance. No evidence of bone injury or intracranial hemorrhage. Instructions: ice thigh, acetaminophen, and rest. -5/6/26 at 9:39 a.m., IDT reviewed fall and interviewed floor nurse that was present at time of fall. R1 was noted to have feet elevated in room due to her cognitive decline she may have attempted to use bedside tray table to assist with standing. New intervention: lay resident in bed to elevate feet versus using a stationary item and leaving in wheelchair. Physical therapy (PT) visits dated 4/15/27, through 5/8/26, identified:-4/15/26 at 5:30 p.m., PT Evaluation and Plan of Treatment identified: referral for PT was made due to recent hospital stay for acute encephalopathy and increased confusion. R1's prior living environment: she lived at home with others and reported she slept on the couch, lifting her legs into bed was difficult. R1's fall risk assessment identified that she felt unsteady when standing, walking, and afraid of falling. She had a fall 4/2025, with a fracture of the left pelvis and a fall 5/19/25, sustained first lumbar (the first bone at the top of the back) compression (vertebra in the spine collapses due to trauma, weakened bone density, or osteoporosis) fracture. R1 required skilled therapy to address lower extremity core strength, transfers, and ambulation, improve balance, and decrease risk for falls. Without skilled therapy R1 was at greater risk for falls, resulting in injury or hospitalization.-4/17/26, R1 was pleasant and cooperative. She reported pain and weakness in left lower extremity (LLE). -4/20/26, Nursing reported R1 fell out of her lift chair this morning and bumped her head. Good participation and motivation for transfers, exercises, balance and gait training. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-4/21/26, R1 required a prolonged knee extension stretch due to tight hamstrings. She required frequent cueing and rest breaks throughout the session due to fatigue. -4/22/26, Good participation and motivation with transfers, exercise, balance, and gait training. She required rest breaks due to fatigue. -4/23/26, Required step by step extensive direction for mobility. -4/24/26, R1 started to have heavy eyelids and required cues for keeping eyes open and awake. Attempted gait training ambulation with FWW put unable to awaken. -4/30/26, R1 had limited strength and weakness in her bilaterally lower extremities (BLE) and limited knee extension left greater than right. -5/1/26, R1 was able to ambulate with two wheeled walker 8 feet and 15 feet contact guide assistance (CGA) (the caregiver must keep continuous, hands-on physical contact with the patient, usually on their gait belt or back, to provide physical support, maintain balance, and assist with coordination if they stumble). Complained of some left thigh pain followed by wheelchair at a slow pace with shuffling steps. -5/6/24, Attended care conference. R1 had a recent fall, likely due to self-transferring, went to ER, no fractures. -5/7/26, R1 was drowsy and did not sleep well last night. She had increased pain in her lower right extremity (RLE) due to recent fall. Staff nurse confirmed she had a large hematoma on right lateral thigh. R1 complained of increased pain, took small steps, and was very cautious due to fall. Tylenol given and bio freeze applied to right thigh for pain prior to therapy session with relief. -5/8/26, R1 reported right thigh pain where hematoma was, restricted movement, and unable to provide a pain scale number. OT visits from 4/16/26, through 5/7/26, identified:-4/16/26, OT Evaluation and Plan of Treatment, identified R1 was alert however oriented to person only and increased confusion noted from her baseline. She was able to follow directions with simple cueing. Stand pivot transfer (SPT) wheelchair to toilet with front wheeled walker (FWW) she required moderate assist of one to stand and cues for sequencing. Dependent on clothing management and peri cares. Barriers likely to impact discharge to next level: exacerbation of cognitive impairment. Patient characteristics that may impact treatment: lacked capacity for chronic disease management. R1 had a fall history in the past year with an injury: sacral fracture and lumbar compression fractures. She felt unsteady when standing and worried about falling. Lacked insight into condition and risk factors. Multiple medical conditions/history, and multiple medications. Followed one step directions usually with cues/prompts. Decision making ability for routine activities was severely impaired. Problem solving new situations, dependent. Memory: dependent. Safety awareness: lacked awareness/impaired. Upper extremity strength impaired bilaterally. Self-care function score 2 (score 0 to 12; 12 being the highest function). She required substantial/maximal assistance with toilet transfers. -4/16/26, R1 was alert and oriented to person only, increased confusion noted from her baseline and followed directions with simple cueing. Barrier impacting treatment: mental status. Required treatment modifications to overcome barriers: required maximum cues for sequencing tasks and orientation.-4/17/26, R1 required verbal and tactile cues/input throughout session to stay awake, alert, and for correct sequencing. -4/20/26 at 11:29 a.m., R1 was generally restless lying in bed upon arrival. Assisted to bathroom with moderate assist with maximum cues, and gait belt. She was somewhat limited by low vision and confusion. Changes identified: R1 required maximum cues for sequencing tasks, in combination with orientation times person only, and prompted concerns with use of power lift chair. Recommendations at this time was removal of power lift option and utilized adjustable angle bed for periods of rest versus power lift chair. Due to her short stature, her feet need to be elevated or else they will dangle risking sliding forward from chair. Collaborated with director of nursing (DON) and provided written communication of recommendations. -4/21/26, R1 participated with verbal and tactile cues for directions and placement possibly due to eyesight. -4/22/26, improved ADL engagement, able to ambulate 10 steps to toilet with maximum cues and rests/breaks due to fatigue. -4/23/26, R1 was pleasantly confused and willing to participate. R1 was administered SLUMS, identified a score of 4/30, and indicated dementia. [NAME] Cognitive Scale (ACL) (a standard measure of cognitive functioning) with a score of 3.6 (scores between 3.0 and 3.8 meant a person required someone to look after them and help with ADLs). It was recommended 24-hour (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	supervision was provided and remove access to dangerous objects. -4/24/26, Worked to progress from EZ aid with two person assist to pivot transfers with FWW. Required step by step cues for technique with transfers. Recommendation: one assist with EZ aid transfers. -4/27/26, R1 required several rest periods due to maximum fatigue and frequent cueing.-5/2/26, R1 required cues to turn feet and process of completing stand pivot transfer (SPT). -5/4/26, R1 assisted to gym in wheelchair, falling asleep, attempted to arouse several minutes without success. Unable to complete OT due to sleepiness and decreased alertness when woken up. -5/5/26, R1 alert today and required extra time to process directives. -5/5/26, R1 had fall self-transferring yesterday, sent to emergency room (ER) for imaging, no fracture. Applied elevating footrests due to complaints of right/shortened hamstring/calve was tight due to increased sitting with knees at 90 degrees. -5/7/26, R1 trialed a lightweight manual wheelchair with low seat to the floor and was able to reach floor with feet to propel herself while in wheelchair. Facility 5-day report submitted on 4/24/26 at 3:04 p.m., identified R1 was placed in power lift recliner chair after lunch in full reclined position. She attempted to stand up and her leg gave out. She fell, hit her head, and cried out for help. Nursing assistance entered R1's room found a large pool of blood and recliner in a fully reclined position. The call light was found on the same side as the recliner R1 had fallen from, within reach. Licensed practical nurse (LPN) attempted to slow the bleeding, applied pressure, ice, while she called EMS. R1 required evaluation in ER and received four sutures. Clinical manager, registered nurse (RN) felt that R1 was appropriate to have the full power function at the time of admission, but the assessment was omitted during the admission process. Maintenance director (MD) was interviewed and noted the power lift chairs are standard items provided in resident rooms at time of admission. The morning after the fall RN completed the adaptive equipment assessment and deemed R1 as appropriate and updated care plan. That afternoon therapy was working with resident deemed her inappropriate due to level of cognition at the time of the assessment being completed. This report (allegation) was not verified as R1 had a power lift chair at home and the care plan was being followed at the time of the fall.R1's ED provider notes dated 4/18/26 at 3:54 p.m., identified: Chief complaint fall injury. She presented the ED via EMS from nursing home memory care unit for further evaluation of a head injury after a fall. Just shortly prior to arrival she attempted to get up out of her chair without assistance when she stated her left leg gave out causing her to fall to the ground. She did not lose consciousness. She had a right sided headache near the area of injury and bleeding was controlled. No changes in vision or hearing. Physical exam identified a frail elderly female with a laceration. Through secondary assessment a hematoma (a collection of blood trapped underneath the skin due to a blow to the head) to the right forehead was identified. Ofirmev (acetaminophen) 1 gram (g) administered via intravenously (IV) for pain and NS 0.9% 500 milligrams (ml) IV for dry mucus membranes. Family felt like her confusion might have been a little bit worse today than usual. The following tests were ordered: chest and pelvic x-rays (unchanged no acute findings), computed tomography (CT) (imagining that used x-ray techniques to create detailed images of the body) of the head/cervical/lumbar spine/thoracic (no acute abnormalities found), and urinalysis (negative results), and urine culture. Forehead laceration was repaired with four sutures (see separate procedure note). History suggests mechanical cause of the fall. discharged in stable condition back to nursing home via EMS.R1's right forehead laceration repair document dated 4/18/26 at 6:47 p.m., identified laceration length 2.5 centimeters (cm), anesthesia lidocaine topical application and local infiltration (Lidocaine 1% with epinephrine) 1 ml subcutaneously (SQ) were administered. Laceration was irrigated with normal saline and four nylon sutures and three steri strip were used to repair the site. Antibiotic ointment and non- adherent dressing were applied. Estimated blood loss 1 ml.R1's Physical Device Evaluation dated 4/20/26 at 10:16 a.m., identified device being assessed, power lift recliner. Current applicable medical conditions: cognitive deficit and arthritis. R1's specific medical symptoms that required use of device: [R1] used lift power recliner for limited mobility and elevate legs when sitting. This device was a therapeutic intervention to achieve proper body position, balance or alignment: yes. The resident's level of (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	did not sit in the recliner anymore was afraid of falling again, scared her when she hit her head quite hard, was bleeding and was taken to the hospital.During an interview on 5/7/26 at 2:27 p.m., NA-E stated R1 was forgetful and confused, would not have been safe to use a lift chair remote, unable to remember how to use it, tended to self-transfer, placed her at a high risk for falls.During an interview on 5/7/26 at 2:43 p.m., LPN-B stated R1 had impaired cognition and had not changed since admission. The admitting nurse and therapy would have been expected to assess R1 upon admission for safe use of the lift recliner prior to use. We do not know if the resident understands what the buttons are used for and could have placed them at risk for injuries/falls. R1 would have not been safe to use the remote to operate the lift chair safely due to impaired cognition. The remote should have been removed until assessment was completed. R1 self-transferred and not safe alone in room with the lift recliner electric remote or manual and placed her at risk for another fall/injury. The other day R1's daughter came to visit in the morning and asked if R1's feet could be elevated. The daughter placed R1's feet on a chair on top of a pillow while she sat in her wheelchair in her room and everything was fine. At 1:45 p.m. R1 was toileted, and feet placed back up on a chair in her room. At about 2:10 p.m. we heard someone hollering out and found R1 laying on the floor. LPN-B entered R1's room and noted the chair her feet were placed on was pushed across the floor and she was scared. R1 stated after fall she may have moved that chair, possibly grabbed the bedside table and fell onto the floor. R1 substantiated a large hematoma on the right outer thigh. Prior to this fall she complained about left leg could have been due to previous left hip replacement surgery. LPN-B stated she sent R1 to ER via ambulance, diagnosed her with a hematoma to right thigh and no fractures.During an interview on 5/8/26 at 8:40 a.m., family member (FM) stated R1's cognition/memory was poor when admitted to the facility from the hospital. Her memory varied from one day to the next and some days it was better than others. There was an electric lift chair in her room when admitted . R1 had an electric lift chair at home she used but someone was there with her most of the time with her. R1 was kind of out of it and needed cues to push the buttons. FM had bought a call light button off Amazon, and R1 used it most of the time, but there were times she forgot. R1 used the control for the lift chair, to use the call light, pushed the lift chair all the way up and FM thought she was going to fall out of it and another time she forgot to use call light again, was almost standing up by herself without assistance, really concerned her. FM stated she did not share that information with staff and was unaware if an assessment was completed on R1 upon admission regarding safe use of lift chair. FM stated she assumed therapy would determine if R1 would be safe in the lift recliner with a remote. Follow- up interview on 5/12/26 at 8:53 a.m., FM stated she did not remember being asked if she felt comfortable and safe with R1 using the remote to her lift recliner at the facility upon admission or after that. Risks and benefits were not explained for use of the lift chair independently. FM stated on 5/5/26, R1 was scared to be placed into the recliner after her fall. FM stated around 9:00 a.m. she placed R1's feet on a chair while she sat in her wheelchair about two feet away from her bed, the bedside table was placed between her and the bed, and call placed light on table or pinned to her. FM informed nurse working prior to leaving the facility that morning how she had left her mother in her room and nurse verbally acknowledged what she had said. After lunch that same day she received a phone call and informed R1 had fallen from her wheelchair and was currently on the floor. FM immediately went to facility, only lived a short distance away, arrived before paramedics got there. R1laid on the floor with head behind the door to her room and legs in front of the recliner. R1 was in pain crying and screaming. Staff had informed her the bedside table had been tipped over and laid over R1's legs when they found her. FM pointed out a bruise on R1's face more noticeable on the left outer forehead, purple in color approximately two inches by 1/2 inch, and stated she hit her head during this fall. R1 was sent into ER via ambulance. During an interview on 5/8/26 at 10:45 a.m., with maintenance director (MD) stated the lift chair recliners located in resident rooms have a power system to r