STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265667	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meyer Care Center	1201 West 19th Street Higginsville, MO 64037

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 interview and record review, the facility failed to complete and document an incident report, make notifications according to the facility protocol and investigate the fall/ injury when one sampled resident (Resident #2) had a fall from his/her bed that resulted in increased pain and possible injury out of three sampled residents. The facility census was 39 residents. Based on interview and record review, the facility failed to complete and document an incident report, make notifications according to the facility protocol and investigate the fall/ injury when one sampled resident (Resident #2) had a fall from his/her bed that resulted in increased pain and possible injury out of three sampled residents. The facility census was 39 residents. Review of the facility's Fall Policy and Procedure revised 2025, showed It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents. The policy showed:-The risk assessment will be completed by the nurse or designee upon admission, quarterly, or when a significant change is identified.-The risk assessment will contain the following components: a. Identify environmental hazards and individual risks, including the need for supervision, b. Evaluate and analyze hazards and risks.-An At Risk for Falls care plan will be completed for each resident to address each item identified on the risk assessment and will be updated accordingly.-The At Risk for Falls care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk of an accident.-Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice.-The policy did not show who should be notified when a fall occurs or how the nursing staff was expected to document the fall. 1.Review of Resident #2's Face Sheet showed the resident was admitted to the facility on [DATE] with diagnoses including high cholesterol, kidney disease, depression, anxiety disorder, heartburn, atrial fibrillation (irregular heartbeat), high blood pressure, and supraventricular tachycardia (fast heartrate). Review of the resident's Fall Risk assessment dated [DATE], showed the resident:-Was disoriented to person, place and time.-Had a history of falls within the last three months.-Was chair bound.-Had a fall risk score of 13 (a score of 10 or above was at high risk for falls). Review of the resident's Baseline Care Plan dated 2/9/26 showed the resident:Baseline Care Plan dated 2/9/26 showed the resident:-Needed one to two persons to assist with mobility and ambulation.-Needed one to two persons to assist with bathing, dressing, toileting, grooming.-Received psychotropic medications and pain medications-Had a history of falls and had falls prior to admission.-Was alert with cognitive impairment. Review of the resident's Pain assessment dated [DATE] showed:-The resident had pain and was able to communicate pain.-The resident's pain assessment site was his/her right knee.-His/her worse pain was a 5 (on a pain scale of zero to 10, 10 was severe pain).-Pain increased with activity and was relieved with repositioning, medication (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	management, relaxation and warm compress placement.-Pain medication was needed at least daily.-The resident had no current pain.-The resident was satisfied with his/her current pain management. Review of the resident's Physician's Order Sheet (POS) dated 2/26 showed physician's orders for:-Tylenol 500 milligrams (mg) one tablet every 6 hours as needed for mild pain/fever (ordered 2/9/26).-Morphine Sulfate give 0.5 milliliters (ml) every hour as needed for mild pain/shortness of air (ordered 2/9/26).-Morphine Sulfate give 0.25 ml every hour as needed for mild pain/shortness of air (ordered 2/9/26).-Morphine Sulfate give 0.75 ml every hour as needed for moderate pain/ shortness of air (ordered 2/9/26).-Morphine Sulfate give 1ml every hour as needed for severe pain/shortness of air (ordered 2/9/26).-Oxycodone 5 mg four times daily for pain (ordered 2/9/26).-Hydroxyzine 25 mg every 8 hours as needed for anxiety (ordered 2/9/26)-Lorazepam give 0.5 ml every hour as needed for mild/moderate anxiety (ordered 2/9/26).-Lorazepam give 0.25 ml every hour as needed for mild anxiety (ordered 2/9/26).-Lorazepam give 0.75 ml every hour as needed for moderate anxiety (ordered 2/9/26).-Lorazepam give 1 ml every hour as needed for severe anxiety (ordered 2/9/26). Review of the resident's Nursing Notes showed:-2/9/26 the resident was admitted to the facility. Resident appears clean and well groomed. Resident is alert to self only. Speech is soft but clear. Has upper and lower dentures present upon admit. Regular diet with thin liquids. Mouth/lips appears clean, pink, moist. No glasses or hearing aids. Vision and hearing adequate. Lung sounds are clear. No cough or congestion noted. Oxygen was at 97 percent on room air. Resident is incontinent of bowel and bladder. Resident's buttocks and genital area clean and free from redness or breakdown. Skin is warm and dry. No open areas or sores. Right knee has a healed surgical incision. There was no redness, warmth, drainage, or sutures (stitches). Resident was unable to bear weight on lower extremities due to weakness. Full body mechanical lift was required for transfers. Hospice (end of life care) is also providing services and equipment such as low air loss mattress, padded specialized wheelchair, shower chair, and mechanical lift. Medications were reviewed with Hospice and his/her responsible party. Per hospice hydroxyzine (a medication used to treat anxiety) and Ativan (a medication used to treat anxiety and sleeping disorders) for end-of-life comfort and care. The resident's primary care physician was notified of the resident's admission. The resident's vital signs (blood pressure, pulse respirations, temperature and oxygen level) were stable. The resident's call light was within reach. All nurse admission paperwork was reviewed with the resident's family member. The responsible party signed code status and all consents. Review of the resident's Behavior Note dated 2/10/26 showed:-After placing the resident in bed, the resident was trying to get out of bed. The resident would not use his/her call light at all. When nursing staff asked if he/she wanted to get back up in his/her recliner the resident would refuse. At one point nursing staff got the resident back up in his/her recliner to see if he/she would be more comfortable for the resident to relax and get some rest tonight. The resident continued to try and climb out of his/her recliner. Nursing staff placed the resident back in his/her bed and the nursing staff working on the unit sat in the resident's room and would only leave if a call light went off and the nurse was still in another resident room as well. When the nursing aide had to leave the resident's room, he/she returned to see the resident's lower extremities hanging off of the side of his/her bed and wiggling his/her hips trying to get out of bed. Finally, this nurse and aid got the resident up for the day and placed him/her in his/her specialized wheelchair. The resident was sitting up at the nursing station desk, has finally settled down and resting. Review of the resident's Functional Ability and Goals assessment dated [DATE] showed the resident:-Was dependent on staff for bathing, dressing, eating, transfers, mobility and toileting-Had limited range of motion in his/her lower extremities and used a wheelchair for mobility and did not walk. Review of the resident's (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nursing Notes showed:-2/10/26 at 9:17 P.M., showed the resident's respirations were even and unlabored at rest, no oxygen needed. The resident had no cough or congestion. His/her skin was intact with no wounds or injuries noted. The resident was lying in bed with eyes closed and no signs/symptoms of pain or discomfort was noted. The resident spit medication back out after administering medication, was able to administer Ativan 0.5 ml to the resident for restlessness.-2/11/26 at 10:14 A.M., showed the resident remained on acute charting for admission. The resident was in his/her specialized wheelchair at the nurse's station. After breakfast the resident was agitated when staff put him/her in bed. Once he/she was placed in his/her wheelchair the resident relaxed and closed his/her eyes. He/she showed no signs of pain or discomfort. Hospice was present at this time.-2/13/26 at 12:24 P.M. showed when going in to take the resident's vital signs and give his/her medication, the resident appeared lethargic. The resident would open his/her eyes partially before rolling his/her eyes back and shutting them again. When trying to administer medications, the resident took the spoon in his/her mouth and just barely swallowed. The resident remained lethargic when the nurse tried to give a drink of water. The nurse took the resident's vital signs and noted his/her oxygen respirations were between 55 and 77 % on room air (normal is 96-100%). The nurse called the Hospice Licensed Practical Nurse (LPN) A, who was in the building. The nurse also noticed the resident's right wrist and hand were bent at the wall. The nurse noticed the resident was grimacing and this may have been why. The nurse documented he/she gently moved the resident's hand, and he/she let out a loud scream. The nurse informed Hospice LPN A of his/her observations. Roughly 5 minutes later, they went to make him/her more comfortable and noted that his/her right hand and right elbow was swollen, and his/her right wrist appeared bruised. It also was noted the arm to be in an awkward position. The nurse contacted the Director of Nursing (DON) and the DON directed him/her to order a 2 view x-ray of the resident's right elbow and right wrist. The nurse notified the resident's physician and the x-ray vendor. The resident's daughter was notified and was now at the resident's bedside. The x-ray vendor arrived and upon their arrival, the resident's responsible party declined to allow them to complete the x-ray because the resident's health status was consistently declining at this time. They notified the x-ray vendor, and they left the facility. The resident's responsible party and Hospice remained at the resident's bedside and Hospice LPN A ordered the hospice comfort cart (a hospice comfort cart is a mobile, curated cart, often managed by volunteers, designed to provide emotional and physical support to patients and families during end-of-life care. Stocked with items like snacks, toiletries, reading materials, and comfort items, it offers comfort and distraction to families, aiding them in staying bedside). Record review of the resident's medical record showed there was no nursing note documented on 2/12/26. There were no nursing notes showing the resident had an incident on 2/12/26 or on 2/13/26 that would have indicated any injury occurred during care or that a fall had occurred that could have caused an injury to the resident. Review of a facility email dated 2/13/26 showed:-The Assistant Director of Nursing (ADON) spoke with Agency LPN A who was the nurse who was on duty on night shift on 2/12/26 and worked directly with the resident.-Agency LPN A said during the night shift (on 2/12/26), the resident rolled out of bed onto his/her left side between midnight and 1:00 AM. -The resident was found lying on the mat next to his/her bed. -Agency LPN A completed a head-to-toe assessment and found no injuries and his/her range of motion was at baseline.-Agency LPN A said he/she and a Certified Nurse's Aide (CNA) used the full body mechanical lift to place the resident back into his/her bed.-Agency LPN A said he/she would never move the resident if there was indication that there was an injury to the resident (if something looked or felt broken).-Agency LPN A said he/she understood that he/she should have completed an incident report per policy and notified everyone, but (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	he/she was being pulled several different directions to provide requested pain medications and to assist with answering call lights.-Agency LPN A said normally he/she would complete an incident report right away but must have spaced it out with everything else that was going on, but he/she would complete an incident report and make a note when he/she returned for his/her shift tonight. Review of the resident's Hospice Note dated 2/13/26 showed:-The Hospice Nurse arrived for a visit and LPN B came to report that the resident was having increased restlessness and pain.-The resident was laying on his/her right side appeared restless and was moaning.-The resident's right arm was bent at a 90-degree angle and his/her wrist was hanging off of the side of his/her bed and angled downward.-The resident had limited range of motion and pain. His/her right elbow to fingertips were cool to the touch and pedal pulse (rhythmic expansion of the artery) was present but weak. The resident had swelling throughout his/her right arm. There were no other injuries noted.-Facility staff reported that the night shift agency nurse said the resident had rolled out of bed early this morning and was found on the floor mat next to his/her bed.-Hospice was not notified.-The facility nurse reported the resident had scheduled Ativan and Oxycodone prior to Hospice arrival.-Pain assessment showed an estimated pain rating of 9 (on a pain scale of zero to 10, 10 was severe pain) based on a non-verbal pain assessment tool. Periods of labored breathing have been observed and may indicate distress caused by acute pain. Despite not being able to verbalize the presence of pain, the resident was making it clear throughout moans and groans that he/she was in significant discomfort and tightness in his/her jaw and grimace on his/her face indicated his/her pain was increased. The resident indicated pain at his/her right wrist. Despite the writer's attempts to offer vocal and tactile comfort, the resident's pain was too severe to be soothed, and a medication change was indicated for pain management. -A new order for Ativan 1 ml every 30 minutes for anxiety/restlessness and Morphine 1 ml every 30 minutes for pain/air hunger, until pain was under control. The writer documented he/she gave the resident Morphine three times while at the resident's bedside for pain control.-The facility Administrator and DON were aware of the situation.-Additional notes documented at 1:45 P.M., showed the Hospice nurse assessment showed the resident was not responsive to stimuli, had labored breathing that was irregular with shallow respirations. The nurse completed a non-verbal pain assessment and the resident's estimated pain level was at 2. The resident showed no audible signs of pain/discomfort, his/her facial expressions were calm, and his/her body language conveyed a sense of comfort and ease. The resident's pain seemed controlled. Review of the resident's Medical Record showed there was no documentation showing an incident report was completed regarding the resident's fall on 2/12/26 to include what occurred, the circumstances of the fall, when the resident was last seen prior to the fall, interventions that were in place prior to the fall, what immediate interventions were put in place after the fall, the nursing assessment of the resident (to include documentation of the resident's vital signs and neurological checks), notifications (physician, Hospice and responsible party). There was no documentation showing the facility investigated the injury after discovering that Agency LPN A acknowledged that the resident had a fall from bed on 2/12/26 and what the facility determined to be the root cause of the resident's injury after discovering the resident had an injury to his/her right wrist/elbow that was discovered on 2/13/26. Review of the resident's Coroner Report dated 2/16/26 (via facility email) showed:-He/She received a notification of the Hospice associated death of the resident on 2/13/26 at 7:35 P.M from Hospice.-Family Member A was concerned regarding the resident's death and potential of abuse/neglect while in the facility so additional information was gathered.- According to information provided by Family Member A, facility nursing staff and Hospice, the resident had a history of health issues, most recently a knee surgery, and was transferred to another skilled (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	nursing facility where the resident exhibited severe pain, restlessness/agitation falls and continuing to deteriorate.-The resident was transferred to the current facility and Hospice was initiated for a diagnosis of heart disease, but the resident also had a current history of sepsis with ongoing dementia, prostate cancer, arthritis in the hip, knees and shoulders and aortic stenosis (heart valve failure).-According to information provided by the resident's family, facility nursing staff and Hospice the resident continued to deteriorate and on 2/13/26 when hospice evaluated the resident, the resident also appeared to have misalignment of his/her right wrist with severe pain with any manipulation. The facility and Hospice ordered an x-ray and the resident's daughter declined with concerns of potentially causing more pain. -Subsequent questioning by the facility found that the night nurse on 2/12/26 reported the resident was found to have fallen out of bed and was placed back in bed without any finding of injury and against protocol, the nurse made no notification to the facility administration, physician or family either at the time of the incident or afterwards.-At the resident's time of death, the Hospice nurse who was present did not observe redness, swelling or bruising on the resident's body and there was no evidence of head injury. There was no suggestion by any of the family or involved caretakers that there was a head injury observed on the resident.-The fall from a low mattress onto a mat in a resident who was not anticoagulated (did not take any medications used to thin the blood) with no evidence of a head injury was unlikely to cause a severe enough head injury to account for brain bleeding. The fall causing death was extremely improbable in the resident who was near death from multiple causes. Although lack of reporting the fall would seem to be inappropriate, it was an unfortunate incident at the end of life, which was otherwise appropriately managed with appropriate care given. An autopsy of the resident was not indicated. During a telephone interview on 2/17/26 at 2:25 P.M., Family Member A said:-The resident was admitted on [DATE] and was on Hospice and declining and needed total care. -On 2/12/26, Hospice LPN A called between 10:30 A.M. and 11:00 A.M., and said that the resident was declining rapidly, and he/she needed to come to the facility as soon as possible.-When he/she arrived at the facility at 11:30 A.M. Hospice LPN A said that the resident was in the dying process, but he/she also told him/her that the resident's arm looked broken, they had found his/her arm in a strange position, and it was disfigured. -He/She saw the resident's right arm/hand and it looked swollen and disfigured. -He/She called his/her friend who had visited the resident at around 6:00 A.M. on 2/13/26, and asked if he/she noticed anything and his/her friend said that when he/she asked Agency LPN A about how the resident was doing, Agency LPN A said that the resident may have fallen out of bed that night, but his/her friend did not see anything that indicated the resident was injured or in pain because he/she was asleep and it was dark in his/her room.-When he/she began asking the facility staff about what happened to the resident, the DON said that there was agency staff working on the night shift on 2/12/26 and the agency nurse did not document anything in the resident's medical record, but he/she had told the ADON that the resident had fallen out of bed.-The facility never notified him/her that the resident fell out of bed or that the resident's arm was swollen, disfigured or possibly broken. Hospice LPN A informed him/her of this.-While he/she was in the facility, the DON ordered an x-ray, but he/she contacted the Hospice physician, and he/she suggested not to put the resident through any more pain, and he/she agreed so he/she declined the x-ray for the resident. The Hospice physician ordered more pain medication to manage the resident's pain. -At 12:30 P.M. an executive at the facility (unknown name) said that they were going to complete a full investigation regarding the incident because Agency LPN A had not followed the facility protocol after the resident fell. -The resident passed away later that day, but he/she would like to get an x-ray of his/her arm to determine if it was actually broken.-He/She requested (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a bent position and hanging off of the side of the bed.-He/She stated to LPN B that the resident was in an awkward position and asked if his/her arm had been like that and LPN B said it had been that way, but the resident had not been moved yet so she asked LPN B to notify the DON who came in and said that they needed to get an x-ray of the resident's arm.-He/She completed an assessment of the resident and noted that when he/she touched the resident on his/her right arm the resident would moan in pain.-He/She did not see any additional injuries on the resident and there was no indication of a head injury.-He/She never moved the resident, but he/she called the resident's responsible party and reported that the resident was declining rapidly (in the dying process), and his/her responsible party was already on the way to the facility and was there within 30 minutes.-The DON contacted the Agency LPN A to investigate what could have happened to the resident and that was when he/she was notified that Agency LPN A stated the resident fell out of bed on the night of 2/12/26. The DON notified him/her of what the agency said happened.-The DON received the order for the x-ray of the resident's hand/arm, but the resident's responsible party declined to have the x-ray completed.-He/She was not able to say if the resident's arm/wrist was broken because they did not have the x-ray results to show whether it was or not, but the resident did have increased pain, and they needed to increase his pain medication.-Hospice should have been notified as soon as the resident fell, and they were not notified by the facility until 2/13/26.-He/She began sitting with the resident at bedside on 2/13/26 from 10:30 A.M. until 1:30 P.M. and obtained an order to increase his/her pain medication (Morphine) to manage his/her increased pain. The resident continued to decline and at 1:30 P.M. he/she was relieved by another Hospice nurse who sat with the resident until he passed on 2/13/26.-He/She did not believe that the facility staff had been neglectful or were providing any poor care to the resident nor did he/she believe that the facility had abused the resident. During a telephone interview on 2/19/26 at 3:18 P.M., Agency LPN A said:-The resident had been declining and was having more restlessness and agitation leading up to 2/12/26. -He/She has worked at the facility several times and was the charge nurse on the night shift on 2/12/25 from 6:15 P.M. to about 7:30 A.M. on 2/13/26.-Around 12:50 A.M., Agency CNA A came in to tell him/her that the resident was on the floor.-When he/she saw the resident, he/she was laying partially on his/her back/side on the floor mat beside his/her bed. The resident was on a low bed in the lowest position.-The resident had a history of moving around in bed and he/she had been in the resident's room three times to check on the resident and twice he/she had to reposition him/her in bed.-When he/she saw the resident on the floor mat, he/she physically assessed the resident from head to toe and at that time the resident did not have any injuries and showed no signs of injury and did not vocalize or show signs of any pain.-He/She instructed Agency CNA A to get the sling for the full body lift and the lift. When Agency CNA A returned, they placed the sling under the resident, but they were unable to get the lift low enough to attach the sling to the lift so they could lift the resident. -He/She and Agency CNA A physically lifted the resident (with him/her at the foot of the sling and Agency CNA A at the head of the sling) and placed him/her back in bed.-At that time, the resident still showed no sign or symptom of injury or pain, and he/she did not yell out in pain or show any facial grimacing/crying that would indicate pain.-After the resident was in bed, he/she went to get narcotic pain medication for other residents and began assisting Agency CNA A with answering call lights. -He/She did not document a nursing note, write an incident report or make any notifications to the resident's physician, Hospice or responsible party regarding the resident's fall because he/she did not have time, and it was very busy that night.-He/She did not document the resident's vital signs after he/she fell.-The resident had no further incidents after he/she was back in bed, he/she did not have any observations afterward that indicated the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265667	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meyer Care Center	1201 West 19th Street Higginsville, MO 64037

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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 0689 Level of Harm - Actual harm Residents Affected - Few	resident was in increased pain or had any injuries. The resident remained in bed the rest of the night.-He/She told the charge nurse at shift change that the resident rolled out of his/her bed and that he/she did not have any injury before he/she left the facility at 7:30 A.M., but he/she still did not make a nursing note, incident report nor did he/she make any notifications to the resident's physician, Hospice or responsible party. He/she said he/she did not notify the Administrator, DON or ADON of the resident's fall before he/she left for the day.-Later on, that day, on 2/13/26 at around 11:00 A.M. the ADON called him/her and asked if the resident had shown any signs of increased pain. He/she told the ADON that the resident had rolled onto the floor mat out of bed during his/her shift and he/she had completed a head-to-toe assessment, and the resident did not have any injury or show signs/symptoms of pain or injury at that time. -He/She told the ADON that he/she had not notified the physician, responsible party or Hospice of the resident's fall. -He/She told the ADON that he/she would write the incident report and did so after his/her phone conversation with the ADON.-He/She was aware that he/she was supposed to document the incident report and write a nursing note documenting what happened, his/her assessment of the resident (to include vital signs) and notifications at the time of the incident or at sometime during his/her shift. During a telephone interview on 2/20/26 at 9:47 A.M. The DON said:-He/she was not notified of the resident's fall on 2/12/26 until around 12:00 P.M. on 2/13/26.-On 2/13/26, LPN B asked if he/she would come to assess the resident. -When he/she saw the resident he/she was in bed asleep and his/her right arm was laying on the bed, but it did not look to be swollen, bruised, disjointed and he/she did not notice anything that would have indicated that there was an injury.-Hospice LPN A was in the resident's room at this time and LPN B said when he/she moved the resident's arm, he/she grimaced in pain, so they were then trying to find out why he/she had pain there.-He/She spoke with the Hospice LPN A, and they decided to get an x-ray for the resident to check for a possible injury.-When they notified Family Member A, he/she did not want the x-ray completed and declined the x-ray twice.-They were trying to find out what could have created the pain to his/her arm/wrist, and he/she spoke with the day shift staff, and no one had any knowledge of anything that had happened to cause pain to his arm/wrist.-The ADON contacted Agency LPN A who had worked the night shift (on 2/12/26) and this was when they found out that the resident had rolled out of his/her bed onto the fall mat. -He/She was notified that Agency LPN A assessed the resident at the time and did not note any injury to the resident, the resident was put back into bed using the full body li