STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285204	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Haven	424 Harrison St Beemer, NE 68716

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(E)Based on record review and interview; the facility failed to have informed consent and/or comprehensive informed consent for the use of psychotropic medications (any medications that affect behavior, mood, thoughts, or perception) in advance of administration that included the current dose and/or alternate treatment plan options for Residents 4, 5, 9, 18, and 27. The sample size was 6 and the facility census was 32. Findings are: A. Review of the facility policy Use of Psychotropic Medication(s) dated 1/14/26 revealed it was the policy of the facility to ensure residents only received psychotropic medications when other nonpharmacological interventions were clinically contraindicated. These medications were to be used only to treat the residents' medical symptoms and not used for discipline or staff convenience. The following compliance guidelines were identified: -psychotropic drugs include antipsychotics, antidepressants, hypnotics and antianxiety medications. -psychotropic medications are to be used only when a practitioner determined the medication(s) was appropriate to treat specific, diagnosed and documented conditions and the medication was beneficial to the resident as evidenced by monitoring and documentation of the resident's response to the medication(s). -the indications for initiating, maintaining, or discontinuation of medication(s), as well as the use of non-pharmacological approaches, was to be determined by evaluating the residents' physical, behavioral, mental and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks and the preferences and goals for treatment. -prior to initiation or increasing a psychotropic medication. The resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. -the facility was to document that the resident or the resident representative was informed in advance of the risks and benefits of the proposed care, and the treatment alternatives. -the facility was to document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deemed to use (written consent, narrative not etc.) (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Review of Resident 9's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 6/17/26 revealed the resident was admitted [DATE] with diagnoses of Non-Alzheimer's dementia, other fractures, malnutrition, depression, and anxiety. The following was assessed regarding the resident: -severe cognitive impairment. -no behaviors exhibited. -received antipsychotic, antidepressant, and opioid medications. Review of a facsimile (fax) dated 3/31/26 at 7:23 PM revealed a new order for Alprazolam (medication used to treat anxiety or panic attacks) 0.25 milligram (mg) 1 tablet every 8 hours as needed for anxiety for 14 days. Review of a fax dated 5/20/26 at 12:15 PM revealed a new order for Alprazolam 0.25 mg daily for 7 days. Review of a fax dated 5/23/26 at 12:42 PM revealed a new order to give Resident 9 an additional 0.25 mg of Alprazolam at 4:00 PM for a total of 0.5 mg for the next 3 days. Further review of Resident 9's medical record revealed no documentation the resident and/or the resident's representative were informed of the risks, benefits, or alternative treatments for the use of the antianxiety medication Alprazolam on 3/31/26, 5/20/26 and on 5/23/26. Review of Resident 9's Psychotropic Medication Therapy Informed Consent Form dated 2/17/26 at 2:18 PM revealed the resident's representative gave a verbal consent to increase the dosage of the medication Zoloft (medication used to treat depression) from 50 mg to 75 mg to treat the resident's anxiety. However, there were no identified symptoms, evidence of potential effects or adverse effects, and/or alternate non-pharmacological treatment options identified. Review of Resident 9's Psychotropic Medication Therapy Informed Consent Form dated 2/17/26 at 2:25 PM revealed the resident's representative gave a verbal consent for use of Alprazolam 0.25 mg as needed for anxiety. Further review of the resident's medical record revealed the facility failed to identify the resident's symptoms for use of the medication, evidence of potential effects or adverse effects, and/or alternate non-pharmacological treatment options. Review of Resident 9's Psychotropic Medication Therapy Informed Consent Form dated 4/1/26 at 3:30 PM revealed the resident's representative gave verbal consent for use of Alprazolam .25 mg twice a day for 30 days to treat the resident's anxiety. Further review of the resident's medical record revealed there were no indicated symptoms, evidence of potential effects or adverse effects, and/or alternate non-pharmacological treatment options. Review of Resident 9's Psychotropic Medication Therapy Informed Consent Form dated 4/22/26 at 2:11 PM revealed the resident's representative gave verbal consent for the facility to increase Zoloft from 75 mg to 100 mg daily to address the resident's anxiety. However, there was no evidence the facility had educated the representative regarding potential effects or adverse effects, and/or nonpharmacological interventions. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 9's Psychotropic Medication Therapy Informed Consent Form dated 5/20/26 at 1:24 PM revealed the resident's representative gave verbal consent for the administration of Trazadone (medication used to treat depression) for a diagnosis of dementia with behaviors. However, there was no documentation to indicate the dosage of medication the resident was to receive or how often the resident was to receive. In addition, there was no evidence the facility had educated the representative regarding potential effects or adverse effects, and/or nonpharmacological interventions. Review of Resident 9's Psychotropic Medication Therapy Informed Consent Form dated 5/27/26 at 3:56 PM revealed an order for Seroquel (antipsychotic medication) 25 mg 1/2 tablet for dementia with behavioral disturbances. Further review revealed no evidence to indicate how often the resident was to receive the medication, or that the facility had provided the representative with education as to the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of Resident 9's Psychotropic Medication Therapy Informed Consent Form dated 6/22/26 at 8:50 PM revealed a new order for Alprazolam .25 mg to be given as a one-time dose for agitation/anxiety. However, there was no evidence the facility had educated the representative regarding potential effects or adverse effects, and/or nonpharmacological interventions. During an interview with the Director of Nursing (DON) on 6/24/26 at 8:45 AM the DON confirmed there were no consents completed by the resident and/or the resident's responsible party prior to administration of the following medications: -3/31/26 order for Alprazolam .25 mg BID prn x14 days for increased anxiety/agitation.-5/20/26 order for Alprazolam .25 mg x7 days for increased anxiety. -5/23/26 order for Alprazolam .25 mg added to .25 mg x 3 days (total of .5 mg) for increased behaviors. In addition, the consents did not include documentation of non-pharmacological interventions attempted prior to initiation of medications and/or treatment alternatives, a list of symptoms the resident was displaying, and the potential effects or adverse effects of the medications. C. Review of Resident 4's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of Parkinson's disease, Non-Alzheimer's dementia and depression. The assessment indicated the resident's cognition was severely impaired, and the resident was taking an antipsychotic, antidepressant and anticonvulsant medications. Review of a Psychotropic Medication Therapy Informed Consent Form dated 10/14/25 at 2:00 PM revealed the resident had an order for Cymbalta (medication used to treat depression) 60 mg for diagnosis of depression. Further review revealed no evidence to indicate how often the resident was to receive the medication, or that the facility had provided the representative with education as to the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of a Psychotropic Medication Therapy Informed Consent Form dated 10/14/25 at 2:00 PM revealed the resident had an order for Rexulti (medication used for agitation) 34 mg for diagnosis of Parkinsons. Further review revealed no evidence to indicate how often the resident was to receive the medication, or that the facility had provided the representative with education as to the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted before use of the medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Psychotropic Medication Therapy Informed Consent Form dated 10/15/25 at 1:00 PM revealed an order for Ativan 1 mg to be given every 6 hours as needed for increased anxiety with use of the medication to be evaluated in 6 months. Additional review revealed no evidence to indicate how often the resident was to receive the medication, or that the facility had provided the representative with education as to the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of a Psychotropic Medication Therapy Informed Consent Form dated 11/3/25 at 3:00 PM revealed the facility had obtained verbal consent from the resident's representative for administration of Wellbutrin (medication used to treat depression) for diagnosis of depression. Further review revealed no evidence as to how often the resident was to receive the medication and at what dosage, the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of the Resident's Medication Administration Record (MAR) dated 6/2026 revealed the resident continued to receive the following medications: -Wellbutrin 150 mg daily for major depressive disorder dated 11/3/25. -Rezulti 34 mg for diagnosis of Parkinson's dated 10/15/25. -Cymbalta 60 mg daily for diagnosis of major depressive disorder. -Ativan 1 mg every 6 hours as needed for anxiety re-ordered for 180 days on 2/12/26. During an interview on 6/24/26 at 2:09 PM, the DON confirmed the consent forms for the resident's psychoactive medications (Wellbutrin, Ativan, Rezulti and Cymbalta)) did not contain the required information as none of the consents identified the resident's symptoms, potential effects and/or side effects as well as the non-pharmacological interventions attempted prior to initiation of the medications. In addition, the consent forms for Wellbutrin did not identify how often the resident was to take the medications and at what dose and the Cymbalta, and Nuplazid did not indicate how often the medications were to be administered. D. Review of Resident 18's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnosis of Alzheimer's disease, Non-Alzheimer's dementia, anxiety disorder, and bipolar disorder. The resident was cognitively intact with no identified behaviors. The resident was receiving an antipsychotic, antidepressant, antianxiety, hypnotic and opioid medication. Review of a Psychotropic Medication Therapy Informed Consent Form dated 1/8/25 revealed the facility had received a verbal consent from the resident's representative for use of Trazadone for insomnia. Further review revealed no evidence as to how often the resident was to receive the medication or at what dosage, the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of a Psychotropic Medication Therapy Informed Consent Form dated 1/8/25 at 8:00 AM revealed the facility had obtained verbal consent from the resident's representative for use of Zyprexa for the resident's bipolar disorder. Further review revealed no evidence as to how often or at what dosage the resident was to receive the medication, the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Psychotropic Medication Therapy Informed Consent Form dated 5/5/25 at 1:00 PM revealed a verbal consent by the resident's representative for use of Ativan .5 mg for anxiety. Further review revealed no evidence as to how often the resident was to receive the medication, the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of a Psychotropic Medication Therapy Informed Consent Form dated 5/5/25 at 1:00 PM revealed the facility had obtained verbal consent for use of Zoloft 50 mg to be given for anxiety. Further review revealed no evidence as to how often the resident was to receive the medication, the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of the residents' MAR dated 6/2026 revealed Resident 18 continued to receive the following medications: -Zyprexa 7.5 mg 1 tablet daily for bipolar disorder dated 8/18/23. -Zoloft 50 mg 1 tablet daily for anxiety dated 5/6/25. -Trazadone 50 mg 1 tablet daily for insomnia. During an interview on 6/25/2026 at 8:51 AM, the DON confirmed the consent forms for the resident's psychoactive medications (Trazadone, Zyprexa, Ativan and Zoloft) did not contain the required information as none of the consents identified the resident's symptoms, potential effects and/or side effects as well as the non-pharmacological interventions attempted prior to initiation of the medications. In addition, the consent forms for Zyprexa and Trazadone did not identify how often the resident was to take the medications and at what dose and the Zoloft did not indicate how often it was to be administered. E. Review of Resident 5's MDS dated [DATE] revealed the resident had a diagnosis of Non-traumatic Brain Dysfunction, Non-Alzheimer's Dementia, and Depression with severe cognitive impairment and received hospice services. The resident had little interest or pleasure 12-14 days, trouble falling asleep 7-11 days and trouble concentrating 12-14 days. The resident took an antidepressant medication daily. Review of Resident 5's care plan with a revision date of 4/8/26 revealed the resident had impaired cognitive function related to dementia and received hospice care with a diagnosis of senile degeneration of brain. In addition, the resident used an antidepressant medication and the facility monitored for effectiveness and side effects every shift. Review of the resident's physician's orders revealed the following: -On 9/4/25 the provider ordered Paroxetine (antidepressant) 30mg one at bedtime for dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. -On 3/12/26 the hospice provider ordered Lorazepam (antianxiety) 0.5ml every 2 hours as needed for anxiety and restlessness. Review of Resident 5's Psychoactive Medication Therapy Informed Consent Form dated 9/4/25 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed consent to treat with the ordered medication Paroxetine 30mg, however there was no evidence an alternative treatment plan was devised or offered as an alternative to the use of the psychoactive medication. Review of Resident 5's medical record revealed that Resident 5 did not have a Psychoactive Medication Therapy Informed Consent Form completed for the medication Lorazepam. Review of Resident 5's MAR dated June 2026 revealed the resident received Paroxetine 30mg 1 tablet daily at bedtime. An interview with the DON on 6/24/26 at 10:35 AM confirmed the facility did not complete an informed consent for the use of Lorazepam and the informed consent for Paroxetine did not include an alternative treatment plan. F. Review of Resident 27's MDS dated [DATE] revealed the resident had Alzheimer's Dementia with severe cognitive impairment and rejected care 1-3 days in the prior week. The resident took antipsychotic, antianxiety, and antidepressant medication daily. Review of Resident 27's Care Plan with a revision date of 6/23/26 revealed the resident had impaired cognitive function related to dementia. In addition, the resident used antidepressant, anti-anxiety, and antipsychotic medications and the facility monitored for effectiveness and side effects every shift. The residents' targeted behaviors included rude comments, sexual behaviors toward staff, hitting/striking out, anxiety, refusal of care, and insomnia. Reviewed the facility Physician Records revealed the following: -On 2/21/25 the provider ordered Ativan (antidepressant) 0.5mg every 4 hours as needed and Ativan 0.5mg routinely at noon. In addition, Trazadone (antidepressant) 50mg at bedtime for insomnia.-on 2/27/26 the provider discontinued Quetiapine (antipsychotic) 25mg twice daily and order Quetiapine 50mg daily; in addition, the provider discontinued Sertraline (antidepressant) 50mg daily and ordered Sertraline 75mg daily. Review of Resident 27's Psychoactive Medication Therapy Informed Consent Form dated 2/21/25 revealed consent to treat with the ordered Medication Trazadone, however there was no dose of the medication stated and no evidence an alternative treatment plan was devised or offered as an alternative to the use of the psychoactive medication. Review of Resident 27's Psychoactive Medication Therapy Informed Consent Form dated 2/20/25 revealed a consent to treat with the anti-anxiety medication Lorazepam (Ativan), however there was no dose of the medication stated and no evidence an alternative treatment plan was devised or offered as an alternative to the use of the psychoactive medication. Review of Resident 27's Psychoactive Medication Therapy Informed Consent Forms dated 2/24/25, 3/13/25, and 3/18/25 revealed a consent to treat with the anti-psychotic medication Quetiapine (Seroquel), however there was no dose of the medication stated and no evidence an alternative treatment plan was devised or offered as an alternative to the use of the psychoactive medication. Review of Resident 27's Psychoactive Medication Therapy Informed Consent Form dated 2/17/26 revealed a consent to treat with the antidepressant medication Sertraline, however there was no dose of the medication stated and no evidence an alternative treatment plan was devised or offered as an alternative to the use of the psychoactive medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 27's Medication Administration Record (MAR) date June 2026 revealed the resident received the following psychotropic medications:-Lorazepam/Ativan 0.5mg 1 tablet daily at 2:00 PM and 1 tablet every 12 hours as needed (PRN) for treatment of anxiety.-Quetiapine/Seroquel 75 mg daily at bedtime and 50mg daily at noon for treatment of behavioral disturbances related to dementia. -Trazadone 50mg daily at bedtime for treatment of insomnia. -Sertraline 75mg daily in the morning for treatment of anxiety and depressed mood. During an interview on 6/24/26 at 3:07 PM the DON confirmed the facility did not complete informed consents for the use of psychotropic medications (Lorazepam/Ativan, Quetiapine/Seroquel, Trazadone, and Sertraline) for Resident 27 that included the current dose ordered and/or alternative treatment plans.

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F 0689 Level of Harm - Minimal harm or potential for 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** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(l)(i)(3) Based on record review and interviews; the facility failed to identify causal factors for falls and to develop fall prevention interventions based on causal factors to prevent ongoing falls for Resident 9. The sample size was 5 and the facility census was 32.Findings are: A. Review of the facility Fall Prevention Program with a revision date of 8/24 revealed it was the policy of the facility for each resident to be assessed for fall risk and for the residents to receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The following procedure was identified:-completion of a standardized risk assessment to determine a resident's fall risk. The risk assessment categorizes residents according to low, moderate or high risk.Upon admission the nurse was to complete a fall risk assessment along with the admission assessment to determine the resident's level of risk. The nurse would indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. -implementation of universal environmental interventions that decrease the risk of a resident falling which included, but not limited to: a clear pathway to the bathroom and bedroom doors; keep the bed locked and lowered to a level that allowed the resident's feet to be flat on the floor when the resident was sitting on the edge of the bed; the call light and frequently used items to be kept within reach; adequate lighting; and wheelchairs and assistive devices to be kept in good repair. -implement of routine rounding schedule.-monitor for changes in the resident's cognition, gait, ability to rise/sit, and balance.-encourage the resident to wear shoes or slippers with non-slip soles when ambulating.-ensure eyeglasses, if applicable are clean and the resident wears them when ambulating.-monitor vital signs in accordance with the facility policy.-complete a fall risk assessment every 90 days and as indicated if the resident's condition changes. If a resident would experience a fall, the facility would: -assess the resident.-complete a post-fall assessment. -complete an incident report.-notify the physician and the family.-review the resident's care plan and update as indicated.-document all assessments as actions. -obtain witness statements as indicated. B. Review of Resident 9's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 6/17/26 revealed the resident was admitted [DATE] with diagnoses of Non-Alzheimer's dementia, other fractures, malnutrition, depression, and anxiety. The following was assessed regarding the resident:-severe cognitive impairment.-no behaviors exhibited.-required staff assistance with all cares.-occasionally involuntary of bowel and frequently incontinent of urine.-received antipsychotic, antidepressant, and opioid medications. Review of an Incident Report dated 4/30/26 at 2:07 PM revealed the resident was found on the floor of the resident's room between the bed and the dresser. When questioned the resident stated, I just fell. Further review of the assessment revealed no causal factors were identified for the residents' fall. A sign was placed on the wall to remind the resident to call for staff assistance. Review of an Incident Report dated 5/4/26 at 6:50 PM revealed the resident was found lying on the floor in front of the bathroom door in the resident's room. The resident indicated moving the walker out of the way but the walker was at the resident's bedside and was not near where the resident had fallen. An intervention was listed for the Consultant Pharmacist to do a medication review. No further causal factors were identified. Review of the Consultant Pharmacist Monthly Medication Review (MMR) dated 5/7/26 at 4:04 PM revealed a request for the physician to complete a routine gradual dose reduction of psychoactive medications. Review of a facsimile from the residents' practitioner dated 5/8/26 at 9:39 AM revealed a new order to discontinue the resident's Alprazolam (medication used to treat anxiety) 0.25 milligram (mg) twice a day. Review of an Incident Report dated 5/25/26 at 1:20 AM revealed the resident was on the floor between the resident's bed and bathroom. The resident was barefoot at the time of the fall and feces was observed on the resident's brief and in the bathroom. The report indicated new orders dated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/23/26 related to the start of Trazadone (medication used to treat depression and insomnia) 25 mg daily at bedtime, Melatonin 5 mg at bedtime as needed and Alprazolam (medication used to treat anxiety) 0.5 mg for insomnia and increased verbal/physical aggressive behaviors. In addition, the facility requested the resident's provider review the resident's medications. Further review of the resident's medical record revealed no evidence the facility had implemented, and/or revised the bowel and bladder program to address the resident's incontinence of bowel. Review of an Incident Report dated 5/25/26 at 7:15 AM revealed the resident was found on the floor between the bed and the dresser. The report indicated there were no lights on in the resident's room and the resident was not wearing shoes or socks. A new fall prevention intervention was identified for the provider to review the residents' medications. Further review revealed no evidence the facility addressed the lack of lighting in the room, and the resident's refusal to wear gripper socks or shoes when ambulating. Review of a Progress Note dated 5/27/26 at 10:52 AM revealed an order to extend the Alprazolam 0.25 mg daily for 7 days and to start Seroquel (antipsychotic medication) 12.5 mg daily. Review of an Incident Report dated 6/4/26 at 1:51 AM revealed the resident was found on the floor next to the resident's bed. The resident had removed gripper socks and told the staff the resident was on the way to the bathroom when the resident fell. Interventions were identified for a video monitor to the resident's room, and sensor alarms to the resident's bed, wheelchair and recliner. However, there was no evidence the facility addressed the lack of lighting in the room, and the residents' refusal to wear gripper socks or shoes when ambulating. During an interview on 6/23/2026 10:20 AM, the Director of Nursing confirmed the following regarding the residents' falls:-4/30/26 at 2:07 PM no casual factors identified. New intervention for a sign on the resident's wall to remind to call for help. Verified the resident's cognition was severely impaired and reminding the resident to wait for staff assistance was not an effective intervention.-5/4/26 at 6:50 PM the resident reported trying to move the walker as a causal factor for the fall, however the walker was not by where the resident fell. No other causal factors identified. A new intervention was listed for a medication review by the Consultant Pharmacist. -5/25/26 at 1:20 AM the resident was found on the floor between the resident's bed and the bathroom. Feces was found in the bathroom and the resident's incontinence brief. No evidence the facility reviewed/revised the resident's toileting program.-5/25/26 at 7:15 AM the resident was found on the floor between the bed and the dresser. No lights were on in the room and the resident was barefoot. No evidence the facility addressed the low level of lighting in the room or the resident's refusal to wear gripper socks or shoes.-6/4/26 at 1:15 AM the resident was found on the floor by the bed. The resident had removed gripper socks and told the staff the resident was on their way to the bathroom before falling. New interventions were implemented for a video monitor and fall alarms however, the facility failed to address the residents' toileting schedule and refusal to wear gripper socks.