STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor-Shelby	401 N Morgan Street Shelby, NC 28150

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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	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 observations, record review, and resident, staff, and Nurse Practitioner interviews, the facility failed to provide care in a safe manner when staff were assisting a resident (Resident #1) with right side weakness and vascular dementia with incontinence care. The resident fell off the side of the bed onto the floor. The resident complained of mild pain to her right knee and right arm and was provided her as needed pain medication and an order was received for in-house x-rays of the right side. Resident #1's right wrist began to show some mild swelling, and she continued to complain of pain, scheduled pain medication was administered, and she was transferred to the hospital for treatment. A hospital x-ray (imaging test for body's internal structures) revealed Resident #1 had suffered a fractured right wrist and right knee during the fall. Resident #1 was admitted to the hospital on [DATE] for further treatment and discharged back to the facility on 2/09/26. Resident #1 stated that she believed this was the worst fall she had suffered. The deficient practice occurred for 1 of 3 residents for the prevention of accidents (Resident #1).Findings included: Resident #1 was admitted to the facility on [DATE] with diagnosis that included stroke, hemiplegia (paralysis) and hemiparesis (partial weakness) affecting the right dominant side and vascular dementia. Review of bed rail assessment dated [DATE] revealed Resident #1 was assessed for use of bilateral half side rails. Resident #1 demonstrated appropriate use of bed rails as an enabler to assist with positioning, mobility, and support in bed. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact, had been assessed as being dependent on staff for all activities of daily living, mobility, transfers, and was frequently incontinent of bladder and bowel. Review of revised care plan dated 1/02/26 revealed Resident #1 required assistance with all activities of daily living related to history of stroke with right side hemiplegia and vitamin deficiencies. Interventions included give verbal cues to help prompt and bilateral half side rails to bed to enhance mobility and safety. Review of Resident #1's MAR dated 1/31/26 revealed order for Percocet 10-325 milligrams (mg) (medication used to manage moderate to severe, acute, short-term pain) one (1) tablet by mouth 4 times daily (12:30 AM, 6:30 AM, 12:30 PM, 6:30 PM) for pain was administered by Nurse #1 at 6:30 AM with a reported pain level of 6. A telephone interview with Nurse Aide (NA) #1 on 3/11/26 at 3:35 PM revealed she had worked 3rd shift starting at 11:00 PM on 1/30/26 until 7:00 AM on 1/31/26 and was assigned to Resident #1. She stated that around 6:50 AM on the morning of 1/31/26 she had gone in to assist Resident #1 with her personal care. She revealed she had been standing on the side of the bed closest to door and was attempting to fix Resident #1's bed pad so she rolled her away from her towards the window assuming Resident #1 would grab and hold onto the half side rail like she normally did. NA #1 stated she believed while Resident #1's left leg was rolling over her right leg that her hand slipped off the side rail causing her legs to keep going and her falling onto the floor. She revealed she tried to grab and stop Resident #1 from falling but it happened so fast she was unable to stop her. She stated while Resident #1 was lying on the floor she checked on her to make sure she was okay and not bleeding or unconscious and then she immediately went and notified Nurse #1 and Nurse #2. NA #1 revealed both nurses came and assessed Resident #1 and she did not have any signs (continued on next page)

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	of injury and was only complaining of some pain to her right knee where she had a small abrasion present. She stated she and Nurse #1 assisted Resident #1 using the total lift off the floor and onto her bed and while Nurse #1 continued with her assessment she finished with her personal care. NA #1 revealed the fall was an accident and that Resident #1 had always been a one person assist for personal care due to her ability to use her side rails to help with turning but she should have also made sure Resident #1's hand was firmly secured on the side rail before rolling her. Review of nursing progress note dated 1/31/26 written by Nurse #1 revealed Resident #1 was observed lying partially on right abdomen area with face towards floor and right arm beneath torso. NA #1 verbalized she was turning Resident #1 and Resident #1 did not hold onto half side rails. NA #1 stated while Resident #1 was turning she kept going and rolled off the bed. Noted abrasion to Resident #1's right knee with no bleeding at site observed. No swelling was noted at this time. Resident #1 was able to follow commands and move extremities within her normal limits. She was able to perform active range of motion (ROM) per self to bilateral lower extremities with no deformities of extremities observed. No outward turning or difference in leg lengths observed during observation. Bed height was approximately 3 feet. Resident #1 was able to assist staff with turning to position for use of total lift. Resident #1 complained of pain to right knee upon movement but stated it would be alright; she did not mean to fall and did not hold onto side rail. Telephone call made to on call, notified of Resident #1's fall and received order to obtain x-ray of right knee related to complaint of discomfort. Initiated neurological checks. Resident #1 was encouraged to use side rails for safety purposes. Responsible person (RP) was notified. Review of nursing progress note dated 1/31/26 written by Nurse #1 revealed NA #2 came out of Resident #1's room and verbalized that it had looked like her right wrist was swelling a little bit. Nurse #1 went into Resident #1's room and noted swelling with no redness or warmth to right wrist area. Resident #1 was observed moving right arm at wrist joint. When asked to squeeze Nurse #1's hand, noted with weakness and facial grimacing. When asked about pain, Resident #1 stated it hurt a little bit, but it would be ok. On-call nurse practitioner (NP) was notified and added right wrist, right arm and right shoulder to x-ray order. Resident #1 declined cool compress to area. An interview with Nurse #1 on 3/11/26 at 1:45 PM revealed she worked at the facility every Friday, Saturday, Sunday on 3rd shift (6:45 PM- 7:15 AM) and had been assigned to Resident #1 the evening of 1/30/26 though the morning of 1/31/26. She stated on the morning of 1/31/26 around 6:55 AM while giving the report to Nurse #2, NA #1 had come up to the nurse's desk and stated while she had been providing Resident #1's care she had rolled off the bed and into the floor. Nurse #1 went to Resident #1's room and observed her bed was at a waist high position, half side rails were raised, she was lying on the floor beside her bed, facing the window, with her arm underneath her. She stated she immediately began assessing Resident #1 for any injuries and Resident #1 stated that she was fine and to get her up out of the floor, no complaints of pain at that time, or issues with her ROM. She revealed when she rolled Resident #1 over, she complained of knee pain and small abrasion was noted to the right knee but there were no complaints of pain to wrist and no swelling noted at that time. Nurse #1 stated she and NA #1 utilized the total lift and assisted Resident #1 back into her bed and finished with her assessment. She revealed Resident #1 was able to use her hands to grip and denied any pain. Nurse #2 notified Resident #1's RP of the fall and contacted the on-call NP and received orders for x-rays and fall protocol for neuro checks were initiated. Nurse #1 stated as she was getting ready to leave the facility she heard NA #2 inform Nurse #2 that Resident #1's wrist was starting to swell so on her way to the time clock she checked in on Resident #1 and verified to Nurse #2 that Resident #1's right wrist was starting to show some mild swelling and then Nurse #1 clocked out and left. Nurse #1 stated that when she asked NA #1 what happened she stated that she was turning Resident #1 during care and Resident #1 was not able to get a hold of the side rail and her legs kept going over and she fell onto the floor. She revealed Resident #1 told her the same thing that her hand had slipped while trying to grab onto the side rail and she fell into the floor. She stated Resident #1 was a one person assist during care and while turning and repositioning due to her ability to utilize (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	her side rails and assist with her care. Review of Resident #1's medication administration record (MAR) dated 1/31/26 revealed an order for Acetaminophen 325 mg (medication used for temporary relief of mild to moderate pain) 2 tablets by mouth every 6 hours as needed for pain was administered by Nurse #2 at 7:30 AM. An interview with NA #2 on 3/11/26 at 1:35 PM revealed she had worked 1st shift (7 AM- 3 PM) at the facility for the past year and had been assigned to work with Resident #1 on Saturday 1/31/26. She stated on the morning of 1/31/26 she had arrived at the facility around 6:55 AM and Nurse #2 informed her that Resident #1 had fallen onto the floor. She revealed she went straight to Resident #1's room and observed Resident #1's bed was at waist level, her bilateral half side rails were raised, Resident #1 was lying on the floor beside her bed and Nurse #1 and NA #1 were assisting her off of the floor using the total lift. NA #2 stated she assisted Nurse #1 and NA #1 with getting Resident #1 back into her bed and Resident #1 was moaning some when moved or touched, she had a scrape on her right knee, but she did not observe any swelling to her knee or her wrist during that time. She revealed to her knowledge, the on-call physician had been notified and ordered x-ray to right knee and her as needed pain medication had been provided. NA #2 stated she had performed checks on Resident #1 about every 30 minutes and during one of her checks she noticed her right wrist was showing some mild swelling, so she informed Nurse #2 about the swelling and then went to provide care to her other residents. She revealed when she went into Resident #1's room for her 30-minute check, Resident #1 was upset and had been talking on the phone with her son and stated her son wanted her sent out and had called emergency medical services (EMS). NA #2 revealed when she asked NA #1 how Resident #1 had fallen, NA #1 stated that she had been rolling her to provide her care and was going to fix her bed pad under her and Resident #1's hand slipped when trying to grab the bed rail and her legs just kept going and she fell onto the floor. NA #2 stated when she asked Resident #1 how she fell, she also stated that her hand slipped off the bed rail and she just kept going into the floor. NA #1 stated Resident #1 was a one person assist while providing care in bed due to her ability to use her bed rails and assist with her turning and repositioning. Review of nursing progress note dated 1/31/26 written by Nurse #2 revealed she was receiving report from Nurse #1 when NA #1 notified both nurses that Resident #1 had fallen out of bed. Upon assessment, Resident #1 was on the floor, lying on her right side, beside her bed. Resident #1 denied hitting her head and verbally voiced that she had pain in her right knee. Nurse #2 left room to call Resident #1's responsible person (RP) and notify him of fall. Review of nursing progress note dated 1/31/26 written by Nurse #2 revealed Resident #1 received scheduled pain medication, related to complaints of pain due to fall. Resident #1 voiced pain related to right knee and right wrist at this time. Review of Resident #1's MAR dated 1/31/26 revealed order for scheduled Percocet 10-325 mg one tablet by mouth 4 times daily (12:30 AM, 6:30 AM, 12:30 PM, 6:30 PM) for pain was administered by Nurse #2 at 11:30 AM with a reported pain level of 10. A telephone interview with Nurse #2 on 3/11/26 at 2:45 PM revealed she worked at the facility every Saturday and Sunday on 1st shift (6:45 AM- 7 PM) and had been assigned to Resident #1 on the morning of 1/31/26. She stated while she was receiving the morning report from Nurse #1, NA #1 came to the nurse's desk and stated Resident #1 had fallen out of her bed onto the floor. She revealed when she entered Resident #1's room she observed the bed in waist high position, half side rails were raised, and Resident #1 was lying on the floor beside her bed, facing the window with her right arm under her body. She stated that while Nurse #1 assessed Resident #1 she left the room and attempted to call Resident #1's RP to notify him of fall. Nurse #2 revealed Nurse #1 contacted the on-call physician and received the order for the in-house x-ray on the right side. She stated Resident #1 had received her scheduled pain medication just prior to her fall and then she administered her as needed pain medication. She revealed later that morning NA #2 informed her that Resident #1's wrist was looking a little swollen, so she called Nurse #3 to come and assess Resident #1's wrist. Resident #1 then requested her scheduled pain medication and Nurse #2 administered her scheduled pain medications around 11:00 AM. Nurse #2 stated not long after she had administered Resident #1's scheduled pain medications EMS arrived at the facility stating Resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	#1's son had called asking for Resident #1 to be taken to the hospital and she left for the hospital. She revealed she did ask NA #1 how Resident #1 had fallen out of bed and NA #1 stated that she assumed Resident #1 had a hold of her bed rails but apparently her hand had slipped off so when she rolled her over away from her to provide her care her legs just kept going and she fell onto the floor. She stated when she spoke with Resident #1 about the fall, she stated that NA #1 was rolling her onto her side to provide her care and fix her bed pad and when she went to grab onto her bed rail her hand slipped but her legs kept going causing her to fall into the floor. Review of nursing progress note dated 1/31/26 written by Nurse #3 revealed emergency medical services (EMS) arrived at the facility for Resident #1. They had been called by Resident #1's son. Nurse #3 had spoken with Resident #1 around 10:45 AM and she had complaints of pain. Nurse #3 assessed Resident #1 and noticed slight swelling to the right wrist. Resident #1 was able to move her wrist and did not complain of pain with movement. Resident #1 also had a small amount of swelling to right knee to which she had chronic pain. Nurse #3 had told Resident #1 it was about time for her scheduled pain medication and they were waiting for x-ray to come and complete her x-rays. Resident #1 stated she would try her scheduled pain medication first and see if that helped. Resident #1 did not inform Nurse #3 about any pain after the scheduled pain medication was given. RP and on-call NP notified. A telephone interview with Nurse #3 on 3/11/26 at 2:52 PM revealed she was the weekend nurse supervisor on 1st shift (7AM-7 PM) and was working on Sunday 1/31/26 when Resident #1 suffered a fall. She stated on 1/31/26 around 10:45 AM she was notified by Nurse #2 that earlier that morning around 6:55 AM Resident #1 had suffered a fall from her bed while receiving care and that her wrist was now showing some signs of mild swelling and pain, on-call physician had been notified, and x-ray of right side had been ordered. Nurse #3 revealed she went into Resident #1's room and observed mild swelling to her right wrist. She completed some range of motion assessments with Resident #1's arms and legs and she appeared at baseline (able to move arms, hands, legs) with no complaints. She stated Resident #1 only complained of normal pain in her arms and bottoms of legs. Nurse #3 revealed she contacted the on-call physician to inform of the mild swelling to the right wrist and ensured the order for x-rays to right side included her right hand and wrist. She stated she informed Resident #1 of the ordered x-rays and discussed receiving her scheduled pain medication now and if those did not work and her pain continued then they would send her out to the hospital. Nurse #3 revealed Resident #1 agreed and her scheduled pain medication was administered. She stated before she could go back to assess Resident #1 and see if the pain medication she was administered had helped, her son had called EMS, and they were at the facility to take her to the hospital. Nurse #3 revealed she did not ask Resident #1 about the fall but did speak with Nurse #1 and Nurse #2 who informed her that while NA #1 was rolling Resident #1 onto her right side to provide care, NA #1 assumed Resident #1 had a hold of her half rail on the side of her bed but Resident #1's hand slipped off the rail so when NA #1 was rolling her leg just kept going and Resident #1 fell into the floor. Review of hospital admission summary dated [DATE] revealed Resident #1 presented for evaluation after a fall. Resident #1 experienced a fall that morning, landing on her hip and legs, did not lose consciousness and reported no head injury. Resident #1 stated she attempted to grab side rail but missed it which resulted in her fall. She was able to sit up independently and reported pain in her right arm and hand and pain in her knee extending down her left side. She reported she had received pain medications for pain management, but they had not provided relief. X-rays were ordered for the right and left side. Review of hospital Discharge summary dated [DATE] revealed Resident #1was admitted following a fall resulting in bilateral leg pain and right arm pain. Imaging revealed a left femoral neck fracture (break to the upper thigh bone, just below the hip ball, also known as hip fracture) probable right patellar fracture (break in kneecap) with knee effusion (swelling or blood in the joint) and prepatellar soft tissue swelling (inflammation of the fluid-filled sac in front of kneecap), and acute distal radial (larger thumb-side forearm bone) and ulnar (smaller pinky side bone) fractures of right wrist. Orthopedic consultation was obtained and advised Resident #1 did not have a left femoral neck fracture. Recommended knee immobilizer for patella (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	fracture and a splint for the right radius/ulnar fracture and orthopedic follow-up. Nursing facility reported she wore 2 to 3 liters of oxygen at baseline. Recommend outpatient follow-up with primary care physician and orthopedics. Review of nursing progress note dated 2/09/26 revealed Resident #1 had returned to facility from hospital via emergency medical services (EMS). Soft cast to right upper extremity. Immobilizer to right lower extremity. No signs of distress noted, continue to monitor, and care would be ongoing. An interview with the Director of Therapy on 3/11/26 at 3:21 PM revealed he was familiar with Resident #1 and provided her therapy services off and on since her admission. He stated Resident #1 was more than capable of utilizing her half side rails to include being able to grab and hold onto the rails to assist with her bed mobility, turning, and repositioning. He revealed due to Resident #1's ability to utilize her half side rails to assist with her care she would only require 1-person assistance while providing her care. The Director of Therapy stated that although Resident #1 was able to grab and hold-on to the side rail to assist with her mobility she would still need to be assisted by staff in making sure her hand was secured onto the bed rail prior to her being turned or repositioned. An interview with the Director of Nursing (DON) on 3/11/26 at 4:42 PM revealed she was familiar with Resident #1 and the fall that occurred on 1/31/26. She stated on 1/31/26 she believed she was notified Nurse #3 that while NA #1 was rolling Resident #1 away from her towards Resident #1's right side to provide her care, Resident #1 hand was not on or had slipped off the side rail while her legs continued to roll over and caused her to suffer a fall onto the floor. She revealed to her knowledge Resident #1 did not at first show any signs of pain or swelling, the on-call physician was notified and ordered x-rays of the right side. She stated a few hours later after the fall, Resident #1's right wrist began to show signs of swelling, so nursing notified the on-call physician again and x-ray orders were modified to include the right wrist and as needed pain medications were provided. The DON stated Resident #1 had been administered her scheduled pain medication prior to her fall, as needed pain medication right after her fall, and then her scheduled pain medications were given early to assist with her pain. She revealed Resident #1's son called EMS and requested that she be taken to the hospital instead of waiting on the in-house x-rays to be completed. She also revealed Resident #1 did suffer a fractured right knee and right wrist because of the fall and had to wear a knee immobilizer and wrist splint as treatment. The DON stated during her interview with NA #1 about the fall, NA #1 told her she had raised the bed waist level, bilateral half side rails were raised, and she was standing on the side of the bed closest to the door and was rolling Resident #1 away from her towards the window so that she could provide her care and fix her bed pad. She revealed NA #1 stated that she assumed Resident #1 had grabbed the side rail when she started rolling her left leg over her right and believed Resident #1's hand must have slipped off the side rail and her legs continued going over side of bed resulting in her fall. She stated when she interviewed Resident #1, she told her the same thing and stated that her hand slipped off the side rail and her legs just kept going and fell onto the floor. The DON stated NA #1 should have assured Resident #1's safety by making sure her hand was secured onto the side rail before beginning her care or fixing the bed pad. An interview with the Nurse Practitioner (NP) on 3/12/26 at 11:00 AM revealed she was familiar with Resident #1 and was made aware of her fall on 1/31/26. She stated Resident #1 was able to demonstrate and utilize her half side rails by grabbing and holding onto them for bed mobility, turning, and repositioning. She revealed staff should assist Resident #1 in making sure her hand was securely placed onto the side rail prior to turning her and that staff should follow their facility protocol in assuring residents' safety and appropriate use of side rails during care and notify nursing of any changes. NP stated in her opinion no one should ever suffer a break from a fall but Resident #1 did suffer from demineralization (reduction of mineral content in bones leading to weakened structures) and had a history of Vitamin D deficiency (insufficient levels of nutrient) which would make her more likely to suffer a fracture or break during a fall than someone who did not suffer from those issues. She revealed to her knowledge nursing staff followed protocol, notified the on-call physician who ordered x-rays of the right side. She stated typically if a resident suffers a fall but there were no (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	immediate signs of a fracture or displaced bones then they would order x-rays in-house prior to sending them out to hospital and since Resident #1 had a scheduled and as needed pain medication the on-call physician would not have ordered another pain medication. The facility provided the following Corrective Action Plan: Address how corrective actions will be accomplished for those residents to have been affected by the deficient practices.On 1/31/26 Nurse Aide (NA) #1 was providing incontinent care and repositioning Resident #1 in bed. During care Resident #1 had two half siderails in place, and while NA#1 was turning Resident #1 away from her, Resident #1 rolled out of bed to the floor. NA #1 did not instruct or ensure Resident #1 had reached over and used the half side rail during the turning action. Resident #1 was assessed by Nurse #1 and Nurse #2 after the fall, then the on-call provider was contacted by Nurse #1, and x-ray orders were received in-house. Resident representative was notified of the fall by Nurse #2, and order for x-rays was obtained. Resident #1 was then assessed by Nurse #3 related to complaints of pain; pain medication was then administered. Then Resident #1 was later transferred to local hospital for further evaluation and treatment. X-rays were obtained at local hospital, it was noted that Resident #1 had sustained right knee fracture, right wrist fracture. Resident #1 was then admitted to the hospital for further treatment. Treatment for the left knee fracture was an immobilizer and a splint for the right wrist fracture that Resident #1 was to wear at all times until seen by orthopedics and orders changed.Resident #1 was readmitted to facility on 2/9/26 and her care plan was updated and reviewed on 2/9/26 and then again on 2/12/26 for her quarterly assessment. This was completed by the Interdisciplinary Team (IDT) team, which included Administrator, Director of Nursing, Social Services, Activities, and the Nurse Assessment Coordinator. Address how the facility will identify other residents having the potential to be affected by the same deficient practiceDirector of Nursing (DON) and or designees began audits on 2/3/26 through 2/04/26 to ensure all residents were receiving incontinent care and activities of daily living (ADL) care in bed safely, mobility statuses were up to date, turning and repositioning instructions were being followed, and assistive devices were being used properly. To determine safe ADL and incontinent care residents transfer and repositioning statuses were audited to ensure the lift status was accurate along with proper staff needed for turning/repositioning. There were 36 residents identified with an overdue lift assessment in the facility, these were updated/corrected on 2/3/26 and 2/4/26 by the safety nurse. Any updated/changed assessments were updated on the resident's door sticker outside of the room per facility policy for staff communication. An audit was completed by the Director of Nursing for any overdue safe resident handling assessments on 2/3/26. This audit assesses the residents' transfer status and repositioning/ADL care while in bed, this assesses how much staff is needed in the room to ensure safe ADL care and repositioning while in bed. Any overdue assessments were completed/updated on 2/3/26 through 2/4/26 by the Safety Nurse. Door stickers were updated by the safety nurse on the day the assessment was completed on 2/3/26 through 2/4/26 with any revised safe handling assessment to ensure proper communication with staff. The Director of Nursing reviewed the overdue assessments due to all others in the building being up to date and accurate at the time of the audit.The incident/accident log was reviewed by the Director of Nursing, and this incident was the only fall identified from the bed where staff were present and involved turning and repositioning. The incident/accident log was reviewed from August of 2025 to current. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recurDirector of Nursing investigated the fall on 2/3/26 with staff involved and collected witness statements. On the same day the Director of Nursing, Administrator and Regional nurse consultant spoke and decided to implement a plan of correction. Resident audits and Nursing staff education started on 2/3/26 and was completed by 2/9/26. Education included proper/bed safety, not leaving residents unattended during incontinent or ADL care while in bed, that any safety devices ordered for the resident are used during incontinence/ADL care to ensure safety, and proper number of staff are utilized while providing care including turning and repositioning in bed. Education was provided by the Director of Nursing (DON) or designee to all nursing staff, including nurses and nurse aides. The (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	training focused on safe care practices in bed. Staff were reminded not to leave residents unattended during incontinent care or ADLs. They were also instructed on proper use of safety devices, such as side rails, and to make sure residents use or hold them during care when ordered. In addition, staff were reminded to use the correct number of caregivers when providing care and to follow turning and repositioning protocols. The education that was provided on the turning and repositioning protocol included staff reading the door sticker outside of the door at each resident's room to identify their lift status and the number of staff needed for turning/repositioning. The letter R on the door designates the number of staff needed for repositioning. Staff were instructed to follow the turning and repositioning policy and that they are to follow the number of staff and lift status posted outside the door to ensure safety during resident transferring and ADL care/repositioning. Education was completed on 2/9/26, the sticker on the outside of the door is per the facility's policy and allows any staff member entering the room to know the residents' lift status and how many staff are needed for assisting with turning/repositioning. The restorative/safety registered nurse or designee in her absence was responsible for updating the assessments along with updating the sticker on the door. Upon returning to the facility Resident #1 was assessed to need two staff members to assist with turning/repositioning and the door sticker was updated to reflect the assessment changes.Proper bed height was determined to be about waist level of the staff member providing the care, this was included in the staff education, education started on 2/3/26 and was completed on 2/9/26 and was completed by the Director of Nursing/Designee. All employees were able to verbalize understanding of education provided back to the educator via in person or over the phone. This ensures the bed is at the appropriate level for back safety and safety of the residents while in bed receiving care. Verbal education via phone was completed with nursing staff that were not in the facility by the Director of Nursing/Designee. Staff educated in-person and via phone were able to verbalize understanding of above education topics. Education was completed by 2/9/26. Newly hired nursing staff will receive this education during their job specific orientation prior to performing resident care. Education will be provided by the Director of Nursing or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.A monitoring tool for resident safety during ADL/incontinent care while in bed was started on 2/3/26 with four resident observations completed weekly for twelve weeks by the DON or designees. The audit being performed by the Director of Nursing and or Designee monitors safe bed height, proper staff is in the room during care, and if side rails are ordered/assessed for the resident they are being used properly. These audits will take place on all three shifts including weekends.Falls are reviewed each morning in our daily quality improvement stand-up meeting, and no further falls have involved staff being present in the room at the time of incident nor have the falls involved turning and repositioning.Plan of Correction and weekly monitoring findings are discussed in regular weekly quality assurance and performance improvement (QAPI) meetings starting on 2/6/26 and continuing for twelve weeks. There have been no further falls with injury related to bed mobility or safety since this incident on 1/31/26. Date of Compliance: 2/10/2026 On 3/12/26, the facility's corrective action plan effective 2/10/26 was validated by the following: Observations of resident's ability to use assistive devices during care including side rails, staff turning and repositioning, and resident beds being in a safe position while in use with no issues or concerns noted. Nursing staff interviews revealed they had received education on providing incontinent care to residents safely prior to providing care, making sure all assistive devices (side rails) for residents were being used appropriately and safely, turning and repositioning to include making sure residents are being turned safely, correct number of staff required to provide assistance was being utilized, notification of changes with mobility or ability to use side rails safely, fall protocol being followed to include notifying superv