STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525279	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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** 49011 Based on interview and record review, the facility did not ensure residents received adequate supervision to prevent accidents for 2 of 3 residents (R1 and R3) reviewed for falls. *R1 had four unwitnessed falls that were not thoroughly investigated to determine a root cause and develop interventions that addressed the cause to prevent future falls. R1 had a fifth unwitnessed fall that resulted in a displaced left femoral neck fracture. *R3 did not have wheelchair pedals on when moving in R3's wheelchair. R3 fell and received sutures on their forehead. Findings include: The facility's policy and procedure titled, Falls Management and Prevention last revised December 2024, documents: Purpose: Fall risk assessment, identification and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls . Policy: Residents are assessed for their risk of falling upon admission, significant change and quarterly thereafter. Residents with risk for falling will have interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the resident's condition, provides care for, safety and comfort. Procedure . 3. Residents at risk for falls have an individualized resident centered care plan developed. Care plan interventions are based on the finding of the fall risk assessment. 4. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist. (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	5. Residents are provided education, as appropriate, regarding her/his fall risk and interventions to reduce falls based on the fall risk assessment . Post Fall Procedure 1. When a resident falls the licensed nurse is notified. The nurse completes an assessment of the resident's condition including an interview, if possible, completion of vital signs and a body assessment . 5. The environment of the fall is evaluated for possible contributing factors and addressed. 6. The interdisciplinary team reviews the fall and care plan changes and may, if needed, implement additional interventions. 7. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist. 8. Documentation of the above items is completed . 1.) R1 was admitted to the facility on [DATE] on hospice services with pertinent diagnoses that include Pulmonary Heart Disease and Chronic Diastolic Heart Failure. R1's Admission Assessment Minimum Data Set (MDS) with an assessment reference date of 12/18/2024 documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. R1 was assessed as being understood by others and able to understand others with clear comprehension. R1 was assessed as having adequate vision. The MDS documents R1 was assessed to have no behaviors exhibited during the look back period and the behavior section indicates neither hallucinations or delusions were present. R1's MDS indicates there is no impairment to R1's upper or lower extremities and R1 uses a walker or wheelchair for mobility. R1 is occasionally incontinent of bowel and bladder, and per the MDS no trial of a toileting program was attempted. R1's Fall Risk Assessment completed on 12/21/24 documented R1 is at risk of falls with a score of 12. R1's care plan for Bowel and Bladder: I am incontinent of Bowel and Bladder at times. I require assistance with toileting was initiated on 12/13/2024 with the following interventions: -Bowel and bladder evaluation with screening on admission and quarterly with treatment plan annually and PRN. Created on: 12/13/2024 -Bowel medications as ordered. Record BMs every shift as they occur. Monitor bowel record daily for constipation. Notify NP/PA/MD should a pattern of constipation occur. Created on: 12/13/2024 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Provide adequate nutrition and hydration. Provide water at the bedside, encourage Resident to drink to remain hydrated. Created on: 12/13/2024 -Staff assist to transfer on/off toilet per mobility section of this Care Plan. Created on: 12/13/2024 -Staff assist with peri cares and manipulating clothing as needed. Created on: 12/13/2024 -Staff assist with toileting tasks per resident request. Created on: 12/13/2024 Surveyor noted there is no toileting plan identified in the bowel and bladder care plan. R1's care plan for Mobility: I need assist with Ambulation, transfers, and bed mobility due weakness. I am at risk for a decline in ambulation d/t (due to) respiratory failure was initiated on 12/13/2024 with the following interventions: -Provide assistance with bed mobility as necessary. Created on: 12/13/2024 -Staff assist of one to provide assist for resident to transfer using a gait belt and walker Created on: 12/13/2024 -Staff to ensure call light is in resident's reach while in room and encourage to use it to make needs known. Created on: 12/13/2024 Surveyor was unable to locate documentation of Staff assist to transfer on/off toilet per mobility section of this Care Plan information in the mobility section of R1's care plan. R1's Falls care plan: I am at risk for falls due to declining mobility, chronic respiratory failure was created on 12/13/2024 and initiated on 12/19/2024 and has the following pertinent interventions: -Fall risk evaluation on admission, quarterly, and PRN. Post fall evaluation PRN. Created on: 12/19/2024 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Monitor for side effects of medication: *Cardiac medication as ordered. Monitor weekly vital signs and labs as ordered. *Psychotropic medications as ordered. BIMS evaluation, sleep log, and behavior monitoring per protocol. *Narcotic pain medication as ordered. Monitor for side effects such as dizziness, lethargy, increased confusion, decreased respirations, and report to NP/PA/MD. Created on: 12/19/2024 -PT to eval and treat per hospice orders and company. Created on: 01/20/2025 o RESOLVED: Toileting per urinary/bowel section of this care plan. Created on: 12/19/2024 R1's care plan for I require a Transfer Restorative Nursing Program due to weakness was initiated on 12/20/24 with the following interventions: -Refer to Therapy if needed. Created on: 12/20/2024 -RN to evaluate the Restorative Nursing Program periodically and make changes if indicated. Created on: 12/20/2024 -Staff report changes in resident participation to nursing staff. Created on: 12/20/2024 R1's care plan for I require an ambulation Restorative Nursing Program due to weakness was initiated on 01/17/2025 with the following interventions: -Refer to Therapy if needed. Created on: 01/17/2025 -RN to evaluate the Restorative Nursing Program periodically and make changes if indicated. Created on: 01/17/2025 -Staff report changes in resident participation to nursing staff. Created on: 01/17/2025 Surveyor noted restorative walking was the intervention that was added after R1's 1/5/25 fall but was not added to R1's care plan until 1/17/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's care plan for I require an AROM Restorative Nursing Program due to weakness was initiated on 12/20/2024 with the following interventions: -Refer to Therapy if needed. Created on: 12/20/2024 -RN to evaluate the Restorative Nursing Program periodically and make changes if indicated. Created on: 12/20/2024 -Staff report changes in resident participation to nursing staff. Created on: 12/20/2024 Surveyor noted the post fall interventions for R1's toileting plan and call don't fall signs were not added to the care plan. The admission fall interventions of mat next to bed and bed in lowest position were not located in R1's care plan. Surveyor noted that the admission fall interventions of mat next to bed and bed in lowest position when resident is in it were on the Kardex which is used by Certified Nursing Assistants (CNA) to complete cares for residents. Surveyor noted that the interventions for sign posted call don't fall to remind resident to use call light for safety and toilet resident upon rising before and after meals at HS (bedtime) and prn. Toilet resident upon request were added to the Kardex only and not R1's care plan. Per an interview with the Nursing Home Administrator (NHA)-A on 4/23/25, at 12:16 PM, NHA-A had to reactivate R1's record to print the Kardex for Surveyor which changed all of the dates interventions were initiated to 4/23/25. R1's physician order dated 12/16/25 documents: Oxygen on at all times. Every shift. Surveyor noted no liter setting identified, or monitoring of resident oxygen saturation level included with order. R1's admission progress note written on 12/12/2024 documents: Resident is a new admit, from vitas hospice facility . primary diagnosis Pulmonary Heart Disease and Chronic Diastolic Heart Failure . Fall risk due to HX (history) of attempting to self transfer at night. Fall mat on floor and bed in lowest position. Resident is a 1 assist transfer with walker. Resident is on continuous O2 NC (oxygen nasal cannula) at 3L (liters), does take off at time and become Hypoxic with delusions of seeing a women named [NAME]. Resident is Regular diet, thin liquids allergy to lactose. Resident is on Vitas Hospice . resident is continent of bowel and bladder and noted as a fall risk with intervention of fall mat. Surveyor noted R1 was a known fall risk at admission with the interventions of fall mat and bed in low position in place on Kardex, but not in R1's care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R1's fall packet for the fall that occurred on 12/21/24 at 3:00 AM. This was an unwitnessed fall in which R1 was noted as attempting to self toilet and was found on the floor next to the bed which was in lowest position with fall mat next to it, call light noted as in reach. Per the report R1 was last toileted at 2:30 AM. An intervention for a toileting plan upon rising, before and after meals, at bedtime, and as needed was initiated on the Kardex, but not to R1's care plan. R1's progress note written on 12/21/2024, at 04:15 AM, documents:: Patient was found in the floor. 'Patient stated was trying to get to the bathroom and fell . Patient states not hitting her head and forgot to press the call light' . Bed was at lowest position floor mat next to bed, call light within reach. R1's interdisciplinary progress note written 12/23/2024, at 10:18 AM, documents:: IDT (interdisciplinary team) team met to review the fall. Intervention put in place to set up toilet plan. Offer toileting upon arising before and after meals before bed PRN and per resident request. Surveyor noted this fall occurred in the early morning, not when the resident was rising for the day. Surveyor noted the toileting plan was added to R1's Kardex but not R1's care plan. Surveyor reviewed R1's fall packet for the fall that occurred on 1/5/25 at 5:15 PM. It was documented that R1 was last seen at 5:10 PM in bed. The CNA reported R1 stated that she got up to move a plant and tripped over her own feet. Then got up, put on call light and laid in bed. An intervention to start restorative walking was initiated. R1's progress note written on 1/5/2025 at 5:56 PM, documents: Resident in bed CNA reports she has a large egg sized swelling of a hematoma to left forehead resident states she fell and got herself back in bed after attempting to move a plant to her dresser. She did not use her walker or use her call light until after the fall. Also she has a skin tear slightly larger than a pea to her left forearm with a hematoma approx (approximately) 1.5 inch in diameter . Hospice notified and they will send out a nurse for further eval (evaluation) . Hospice documented a Focus Visit on 1/5/25 at 9:25 PM, Resident had a fall with a golf ball sized hematoma to the left forehead above the eye with bruising surrounding. Patient rated pain/discomfort at 6/10 and stated that she had 2 more hours before she could have pain medication. MD (medical doctor) was called and gave new pain medication orders. Neuro (neurological) check was negative. ROM (range of motion) per resident baseline. Patient stated that she wanted to move her plants. The hospice Interdisciplinary Plan of Care Revision/Physician Order dated 1/5/25, documents: a change in the morphine order and ice packs to hematoma TID (three times per day) x 2 days for 20 minutes. Surveyor noted the IDT team met on 1/15/25 and determined the intervention of restorative walking was to be added. Surveyor reviewed R1's fall packet for the fall that occurred 1/6/25 at 4:05 AM. It was documented that R1 had an unwitnessed fall while attempting to self toilet. R1 was found on the floor next to R1's bed and fall mat. The CNA documented that the walker was in bathroom doorway and so was O2 (oxygen) cord. It was documented that the last time R1 was toileted was 3:00 AM. The intervention added was call don't fall sign to remind resident for safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note written on 1/6/2025 at 05:00 AM, documents: Staff heard resident calling out 'help.' She was found on the floor in the middle of her room lying slightly on her right side. Her walker and her nasal cannula were both in the bathroom. BP (blood pressure) was 139/63 and heart rate was 123. Spoke with Hospice Nurse and she is aware of VSS (vital signs stable). She stated resident does have a history of orthostatic hypotension and also A.fib (atrial fibrillation). They will send out a Hospice nurse sometime today. Resident denies pain/discomfort. Soft touch call light within reach right by her hand. She was instructed to use it. The interdisciplinary note written on 1/8/2025, at 11:53 AM, documents: The IDT meet to review fall. intervention will post signs call don't fall to remind resident to use call light for safety. Surveyor reviewed R1's fall packet for the fall that occurred on 1/15/25 at 6:45 AM. It was documented that R1 had an unwitnessed fall while attempting to self toilet. R1 was found in the bathroom on the floor. It was documented that R1 was last toileted 2 hours before and last seen 5-10 minutes prior. An intervention to ask hospice physical therapy to work with resident was initiated. R1's progress note written on 1/15/2025 at 07:41 AM, documents: Resident was found sitting on her bathroom floor leaning up against the wall. Her oxygen was on and in place. She stated 'I had to go to the bathroom but I don't know what happened.' Denied hitting her head. Old bruising and old hematoma noted to her L (left) temple and cheek from a previous fall in the recent past. She was incontinent of urine. BP was 99/59 and resident has a hx of Orthostatic Hypotension. She was hoyered back to the bed with assist of 2 . Hospice will be coming in to assess the resident. Hospice documented a Focus Visit on 1/15/25 at 5:45 PM; the Interventions Performed section documents: Patient had a scheduled visit for a follow up fall. Patient denied any pain/discomfort. No new onset of bruising/bleeding noted, VSS and WNL (within normal limits). Patient alert and oriented. ROM (range of motion) per patient baseline. The interdisciplinary note written on 1/15/2025 at 10:58 AM documents: IDT team met to review fall resident is in hospice but still feels like she can get up and wants to maintain as much as her functional status as she can. Resident has states use it or lose it despite education provided to resident to ask for assistance. Intervention: set resident up to work with restorative CNA to help with ambulation. R1's interdisciplinary note written on 1/16/2025 at 08:10 AM, documents: IDT met to review fall. Resident very much thinks she can do more then she can. Call placed to Hospice to get order for PT (physical therapy) eval for safety. Hospice got order and will send out their PT to work with resident. R1's progress note written on 1/17/2025, at 08:37 AM, documents: Hospice called . in regard to resident falling and her last fall on 1/15/2025. The IDT team would like to know about PT eval for safety since resident continues to want to be up and active as much as possible and she has had a few falls. Awaiting a return call from hospice. Surveyor noted that discrepancy of 1/16/25 IDT note reading hospice got order and will send out their PT and the 1/17/25 progress note that facility was awaiting a return call from hospice regarding PT. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Hospice documentation Nursing-Updated Comprehensive Assessment, dated 1/17/25, documents: in the Prevent falls section to assess environment, provide frequent checks, anticipate patients needs. Surveyor was unable to locate documentation of hospice providing physical therapy intervention. Surveyor reviewed R1's fall packet for the fall that occurred on 1/21/25 at 7:34 AM. It was an unwitnessed fall. It was documented that R1 states was sitting on edge of bed and slid down. It was documented that R1 was wearing socks, no floor mat was down, the bed was in lowest position. For the question last time resident toilet n/a (not applicable) was the answer. R1's progress note written by LPN-G on 1/21/2025 at 08:43 AM, documents: Resident is on the board for an UWF (unwitnessed fall) this AM shift at 0730. Writer was headed to another room and noticed room [ROOM NUMBER] call light was on. Writer knocked on the door to room [ROOM NUMBER] and resident was sitting on the floor next to bed. Bed was in the lowest position. Floor mat was not in place. Resident was dressed, but no shoes on. Resident had c/o (complaints of) pain to left leg. Left leg appears to be rotated out and shorter than right leg. PRN pain medication given. Writer checked ROM and started neuro checks. Writer called for assistance and CNA helped writer mechanical lift resident back into bed. Resident stated that she slid off the side of her bed onto the floor. X-Ray ordered (#46320150) . R1 was found on the floor by an LPN. The LPN and CNA used a hoyer to get R1 back into bed. A Registered Nurse (RN) did not assess R1 until after the transfer back to bed. R1's progress note written on 1/21/2025 at 11:11 AM, documents: Called trident care for an ETA (estimated time of arrival), ETA is about 11:40 AM. Called POA . Son does not wish for resident to be sent to the ER(emergency room). Would like to wait for in house X-Ray. Son does not want any surgical intervention just pain management at facility. Called and spoke with . Vitas hospice regarding the above . Hospice stated will be in for a visit shortly. Hospice documented a Focus Visit on 1/21/25 at 12:00 PM, The Interventions Performed section reads writer received call from DON stating patient had sustained a fall with possible hip fracture. DON stated mobile x ray was contacted and awaiting arrival. Writer called family to update and family instructed patient should not go to hospital . instead pain should be managed at facility. Doctor put in orders to increase morphine and add Ativan and senna. Writer went to facility to assess patient's pain level and discovered patient rated pain 20/10 when she is turned. Writer informed doctor and he suggested foley placement . R1's progress note written on 1/21/2025 at 1:20 PM, documents: X-Ray results are fracture of the LEFT femoral neck with displacement of the distal fragment. Femoral head appropriately positioned. Joint space narrowing. Mild soft tissue swelling. ROM intact. Conclusion is Acute, displaced left femoral neck fracture as noted. Hospice updated on X-Ray results. Surveyor noted in just over a month R1 had five falls at the facility. Three were recorded as self transfers to use the bathroom. The post fall statements do not document whether R1 was wearing oxygen at the time of falls, one documents: oxygen line was in bathroom, not on R1. At the time of the last fall, the intervention of floor mat was noted to not be in place resulting in R1 sustaining a displaced left femoral neck fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/23/25 at 1:53 PM, Surveyor interviewed Hospice Manager-J and confirmed R1's admission to hospice was for pulmonary heart disease. Hospice was notified of R1's previous falls and the nurse tried to do education with R1 not to self transfer. Hospice Team Manager-J shared that R1's quality of life changed after the fall. Before that, R1 was an assist of 1, then declined fast after the fall. Hospice Manager-J stated there is a correlation there that the fall expedited R1's death. On 4/23/25 at 2:52 PM, Surveyor interviewed Medical Doctor (MD)-K who stated that R1 had heart and respiratory issues. The last note MD-K had on R1 was dated 1/16/25 and at that time there had not been any changes in R1's condition. R1 had multiple issues, the fall could have accelerated R1's passing of course. Could R1 have lasted longer without the fall, it's possible, but can't say it was the cause of death. Pain control would have been MD-K's recommendation, no surgery at R1's age. On 4/24/25 at 9:32 AM, Surveyor interviewed NHA-A who is part of the interdisciplinary team and decision making for interventions after a fall. After the first fall, R1 stated that R1 still feels can get up and wants to use it so doesn't lose it. As falls progressed, facility felt R1 was so functional that they wanted restorative to help with ambulation and staff to walk with R1 to keep skills up. Surveyor asked why the signs to remind to call when R1 fell at 4 AM. Per NHA-A, R1 had toileted self and was on the way back to bed when fell . After they put R1 in bed they reminded R1 to use the call light and put it by R1's head. They then put the signs up as reminder to call for help. Per NHA-A since R1 was a hospice patient they asked hospice about therapy involvement because R1 is going to try to keep doing this. On 4/24/25 at 12:03 PM, Surveyor interviewed NHA-A regarding why some interventions were on the Kardex but not the care plan. Per NHA-A, nurses were used to putting interventions in the task list with old computer system. In Point Click Care, the new system, it's done differently. They did education with nurses back in July or August. Surveyor notes the training was months before R1 admitted to facility and nurses still weren't doing care plan correctly. On 4/24/25 at 1:20 PM, Surveyor interviewed NHA-A about R1 being monitored for delusions due to hypoxia per the admission progress note and was told that they were not monitoring R1, they had no reason to believe there was an issue. There is no documentation that supports the admission progress note statement about R1 taking off oxygen and becoming hypoxic with delusions. NHA-A was not sure where that came from. Surveyor asked after the 12/21/24 fall the intervention is a toileting plan, how was that assessed for. Per NHA-A, the IDT decided to try to keep R1's bladder empty so R1 wouldn't try to self toilet. The times were picked based on a normal person's needs. Surveyor asked why there was a delay from 1/5/25 to 1/17/25 for restorative ambulation to be added to the care plan. NHA-A cannot answer that, NHA-A was on vacation that week and the old DON must have been catching up on documentation, NHA-A is sure restorative had R1 in their program before the 17th. On 4/24/25 at 1:58 PM, during the exit meeting, Surveyor informed NHA-A, DON-B, the Regional Nurse and [NAME] President of concerns related to fall interventions not in place to prevent R1's fall that resulted in femur fracture. R1 was not assessed by an RN before being moved to the bed after the fall. The Kardex and care plan interventions do not match. Overall, root cause analysis was not used to develop pertinent interventions to prevent R1 from continued falls. No additional information was provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525279	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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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	21855 2.) R3 was admitted to the facility on [DATE] with a primary diagnosis of parkinsonism. R3's Admission Minimum Data Set (MDS) assessment completed 1/2025 documents that R3 has no cognitive impairment, upper extremity impairment on one side, wheelchair for mobility, does not walk and requires staff assistance with ADLs. R3's Care Area Assessment (CAA) for Falls documents under the Analysis of Findings section: The Fall CAA triggered related to recent fall at home with hospitalization . R3 requires maximum to moderate assist with most ADLs. There were falls reported at home prior to hospitalization and no falls in look back period. On 4/23/25 at 9:30 AM, Surveyor interviewed, and observed, R3 in R3's room. R3 was sitting in their wheelchair with their feet firmly on the ground. R3 had sneakers on their feet. R3 stated they had 2 falls in the facility. The first fall was from the wheelchair. R3 stated the staff told them a driver was here to transport them to an appointment. R3 thought the appointment was a video conference. R3 stated their foot got into the wheelchair wheel and they fell forward. R3 stated they had to get stitches on their head. R3 stated the second fall was from their bed. They remember something fell and they reached for it and kept going. R3 stated they did not have any injuries from the second fall. R3 has not had any falls since then. R3 stated these falls occurred just after their admission to the facility. R3 uses a wheelchair for mobility and requires staff assist with mobility. R3 does not propel self in wheelchair. R3 had a physical therapy evaluation completed on 1/20/25. This evaluation documents: - transfer with 2 staff and Sara Steady (sit-to-stand). - maximum assist with lower and upper dressing. - moderate staff assist with bed mobility. - is a fall risk. - spastic left upper extremity limiting functional ability. R3's progress notes on 2/4/25 at 2:55 PM, by Registered Nurse (RN)-C, document: RN-C was getting shift report and a Transport Driver arrived to pick up R3 for an appointment. They had Certified Nursing Assistant (CNAs) transfer R3 into their wheelchair. One CNA was pushing R3 in their wheelchair to their doorway. The second CNA had the wheelchair pedals in their hands to place on the wheelchair. Then the Transport Driver knocked on the Nurses Station window and told RN-C R3 had fallen. R3 was not sure what happened and just stated they went forward. R3 was bleeding from their forehead. After RN-C assessment, 911 was called, R3 was sent to the hospital. R3's emergency room (ER) record on 2/4/25 documents: R3 fell forward from their wheelchair and hit their forehead on the ground. R3 did not lose consciousness. R3 is on blood thinners. R3 received 4 sutures in their forehead and was discharged back to the facility. (continued on next page)

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	525279	A. Building B. Wing	04/23/2025

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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	R3's Plan of Care (POC) for Falls, created on 1/23/25, with a target date of 4/25/25. Interventions include: -2/5/25 bed in low position with mat on floor next to bed. Clip call light to resident's blanket/gown. (This was added after the fall from the bed.) - 1/23/25 Fall prevention/reduction precautions per facility protocol. - 2/5/25 Foot pedals to be applied (at time of sitting in chair) to wheelchair for out of facility appointments. (This was added from the fall from wheelchair.) -1/23/25 call light in reach. - 1/23/25 Labs when ordered, report abnormal findings to Nurse Practitioner/ Medical Doctor/Physician Assistant. - 1/23/25 Reinforce need to call for assistance. - 1/23/25 Toileting per urinary/bowel section of the care plan. R3's Plan of Care (POC) for Mobility, created on 1/23/25, with a target date of 4/25/25, Interventions include: - 1/23/25 Staff assist of two to transfer resident using the Sara Steady. - 1/20/25 unable to walk. R3 uses a wheelchair for mobility and is wheeled by staff. The wheelchair pedals were not applied with mobility. On 4/23/25 at 12:45 PM, Surveyor interviewed CNA-E. CNA-E was present when R3 fell from their wheelchair. CNA-E was getting R3's wheelchair pedals. R3 was being wheeled out of their room by CNA-D. CNA-E wanted to put the wheelchair pedals on in the hallway. CNA-E did not see what caused R3 to fall forward. The CNA-E typically applies wheelchair pedals. R3 fell before they could apply them. On 4/23/25 at 12:53 PM, Surveyor interviewed CNA-D. CNA-D stated they were wheeling R3 out of their room. They wanted to apply the wheelchair pedals in the hallway. CNA-D stated R3 just fell forward. They thought R3 passed out or something. R3 is alert and oriented, and did not say anything. CNA-D does not know how R3 fell out of the wheelchair. CNA-D stated CNA-E was behind them with the wheelchair pedals. CNA-D stated it happened fast and they could not stop R3 from