STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525376	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Upland Hills Nursing and Rehab	800 Compassion Way Dodgeville, WI 53533

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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** 36253 Based on observation, interview, and record review, the facility did not ensure each resident receives adequate supervision and assistance devices to prevent accidents for 2 of 4 residents reviewed for accidents (R1 and R4.) R1 experienced a fall with major injury on 2/9/24 and again on 6/25/24. The facility noted R1's impulsivity, lack of using her call light and bell, and frequent attempts to self-transfer and did not put measures in place to ensure she was supervised. On 6/25/24, R1 was left alone in the dayroom while other staff tended to other residents and R1 got up, walked to her room, and fell , fracturing her hip. R4 had multiple falls due to self-transferring which resulted in a left wrist fracture. Findings include. The facility's falls policy states, in part: *The falls prevention team meets weekly and will review new admissions, any new falls, significant change, and on a quarterly basis. *Post fall, the falls prevention team will audit residents post fall to ensure new [NAME] II fall risk assessment was completed, ensure new interventions were put into place and are on the care plan, and ensure effectiveness of interventions. *In the event of a fall, staff working in that area will huddle to discuss any details regarding the fall and any precipitating factors. The focus is to find the root cause of the fall. *In the event of a fall, staff will complete a safety zone with all details of the event. *Interdisciplinary team meets daily Monday through Friday at which time falls, care plan changes, and any interventions are discussed. Example 1 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's Disease. Her most recent MDS (Minimum Dat Set), dated 5/23/24, includes a BIMS (Brief Interview for Mental Status) score of 9, indicating R1 is moderately cognitively impaired. R1's care plan states the following: *Scheduled toileting: Toilet upon rise in am (around 6:00 AM), before and after meals at HS, and on 1st or 2nd NOC rounds (initiated 2/6/23) *Ambulate: 1 assist with 4 wheeled walker in hallway (initiated 4/12/24) R1 spends most of her waking hours in her own recliner in the TV room/dayroom on her unit. A call bell is placed by R1 to use if she needs help. On 2/9/24, R1 fell in her room at approximately 8:45 PM as a result of self-transferring herself to the bathroom. R1 had been toileted and helped into bed at 8:30 PM by CNA C (Certified Nursing Assistant). Upon discovering R1, staff assessed her and sent her to the ED (Emergency Department). It was discovered that R1 had suffered fractures of the right femur and humerus, which required screw fixation on 2/12/24. The facility provided better gripper socks for R1 as an intervention. The facility documented the following progress notes for R1: *2/14/24 at 3:04 PM: Resident occasionally does use call light appropriately, but also forgetful and self-transfers at times. High fall risk per [NAME] II fall risk screen. *2/16/24 at 5:32 AM: Resident rang light to go to bathroom, CNA entered room and resident was sitting at side of bed and holding onto bedside table to pull herself up. Resident stated that she was going to take herself to the bathroom because she didn't want to wait for help. *3/18/24 at 5:52 AM: Resident self-transferring times 1 in living room and walked approximately 100 ft. Toileted and placed back into the bedroom with increased supervision throughout the night. *4/13/24 at 5:30 AM: Resident was found by CNA to be standing in front of recliner in living room, resident stated she was just going to take herself to the bathroom. Resident's bell was in front of resident; however, she did not attempt to use it. Staff had just stepped away from hallway to answer call light. *4/15/24 at 4:53 PM: RN notified by cleaning lady that resident was on the floor. RN found resident on her knees holding on to a chair in the TV room. The intervention for this fall was leaving R1's walker next to her recliner. *4/20/24 at 6:00 PM: Has been up frequently performing self-transfers and ambulating in hallway without assistance. Will sit down in recliner and within several minutes is up again. Intermittently telling staff that she is going home. *4/22/24 at 12:30 PM: Noted to have increased agitation, confusion, stating repeatedly that she is going to leave and go home today. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*4/24/24 at 2:40 PM: Writer was with resident 1:1 for about an hour. Resident repeated several times, If you don't get someone to take me home, I'll sue you. *4/24/24 at 7:58 PM: Resident has been 1:1 all shift. Continuously repeating I'm going home when you leave. Let's go. Don't try sneaking out either. You're keeping me against my will. *4/27/24 at 1:29 PM: Resident will not stay sitting in recliner. She is watching everyone go by asking to take her home. She is self-transferring walking around looking for someone to take her home. *5/26/24 at 1:56 PM: Has had several self-transfers today. Ambulated to the bathroom with walker independently this AM. When reminded to not get up by herself, replied, I know. I didn't want to p*** myself. *6/6/24 at 5:01 PM: Resident discussed in falls team due to quarterly assessment. 3 falls this quarter. Remains 1 assist with walker for transfers and ambulation. Does not use call light appropriately. *6/8/24 at 2:00 PM: Found ambulating in hallway with walker. Was taking self to the bathroom. Did not ding her bell for assistance. Reminded to call for assistance so she doesn't fall and get hurt. *6/12/24: .impulsive to transfer on own. Resident is a fall risk. On 6/25/24 at approximately 6:50 PM, R1 transferred herself from her recliner in the dayroom to her room and fell , fracturing her left hip, which required intramedullary nailing. According to facility documentation on the event, CNA C was 1:1 with R4 (who is not care planned as a 1:1) in the dayroom. CNA E was in another resident room who required 2 staff assist to transfer to bed. CNA E used her facility phone to call CNA D from a neighboring unit to assist. Around that time, R4 began to wander, so CNA C walked with R4 back to her room to toilet her. While CNA C was walking with R4, she (CNA C) saw R1 getting up out of her recliner in the dayroom and began to walk to her room. Moments later (time unknown), CNA D arrived to help CNA E but was interrupted by CNA C and told to go and assist R1, who had already made it into her room. At that time, R1 could be heard falling in her room. Upon arriving to R1's room, staff could see R1 had gotten clothes out and laid them on the bed. R1 stated she was going to go sit out front. It should be noted that during this time, the nurse was on a neighboring unit in an isolation room with another resident. After the fall, the facility's intervention for R1 was, Working with therapy, OT and PT as indicated on documentation provided to Surveyors. Surveyors gathered the following interviews on 7/10/24: *9:35 AM: CNA D stated that on 6/25/24, when she arrived on the unit, she was flagged by CNA C to go help R1. CNA D stated that she did not see R1 as she was already in her room at that time, but then heard her fall. *10:55 AM: CNA E stated that on 6/25/24 before she had gone into another resident's room to assist, she witnessed R1 sitting in her recliner in the TV room/dayroom. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*11:20 AM: CNA C stated that on the night of 6/25/24, she was 1:1 with R4 and R1 was in her recliner in the TV room/dayroom when R4 started to get up, so she (CNA C) took her to the bathroom. She then saw R1 getting up to walk to her room. CNA C stated that moments later she saw CNA D arriving on the unit and yelled at her to go assist R1, who had already gotten into her room. CNA C stated that although the facility has individual phones for staff as well as tracker devices to know where other staff are, she did not have one with her on the night of 6/25/24. CNA C stated it definitely would have helped in getting help to R1 faster. CNA C stated that it was maybe a minute or so between when she noticed R1 get up and when she was able to wave for help to CNA D. CNA C stated that NHA A (Nursing Home Administrator) had talked to her after the event about using better communication. CNA C also stated that R1 seems to wait for staff to leave the area before she gets up out of her recliner. CNA C stated that she has seen R1 often looking around for staff and then trying to get up. CNA C stated that R1 definitely needs to be prompted as she does not use her call bell. *1:30 PM: RN G (Registered Nurse) stated that she and other staff would routinely do 1:1 with R1, when able, due to R1's impulsiveness, behaviors, and self-transferring, but that was just with the staff they had scheduled. RN G stated she asked why R1 could not have a regular 1:1 and was told it was a scheduling issue. RN G stated that sometimes R1 would have a 1:1 from 6-8 in the morning but that was only when staff were able. RN G also stated that R1 would not use her call light or bell. *1:40 PM: RN F stated that R1 does not use her call bell in the dayroom. *1:52 CNA H stated that the plan after R1's most recent fall was just keep a close eye on her. CNA H stated that R1 self-transfers a lot, but only when people are not in the dayroom. CNA H stated that when she sees R1 self-transferring or walking around by herself, it is when she (CNA H) has left another room and notices the dayroom has no other staff. CNA D, CNA E, and CNA H all stated that they did not receive any education or guidance on how to monitor R1 after her most recent fall, nor did they receive any education on communication or ensuring they had their facility provided phones or other communication system. It should be noted that Surveyors observed the dayroom where R1 resides with no staff present from 1:40 PM to 1:50 PM on 7/10/24. On 7/10/24 at 11:52 AM, Surveyor interviewed NHA A who stated, We talked about communication after the fall on 6/25/24. NHA A stated this was done during stand up but there was no record of education. NHA A stated the information was passed along. On 7/10/24 at 2:48 PM, Surveyor interviewed DON B (Director of Nursing) who stated that the facility has enough phones for floor staff to communicate with one another. Additionally, DON B stated that they passed along information to staff about communication and supervising R1. When asked if CNA C should have helped R1 on the night of 6/25/24 when she saw her self-transferring to her room, DON B stated that because R4 was a 1:1, she believed CNA C did the right thing by staying with R4. DON B confirmed that R4 was not care planned as a 1:1 and that 1:1 is scheduled at certain times when only when additional staff are available. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility was aware that R1 had a history of fall with major injury, was impulsive, did not use her call bell, and would frequently self-transfer and did not put robust measures in place ensure her supervision. R1 was known to self-transfer when staff were not present. On 6/25/24, R1 was observed to be self-transferring, and staff did not attend to her timely, due to a lack of communication. The facility did not educate staff on the use of their available communication devices and the need to use them to promptly notify fell ow staff of emergencies or the need for assistance. 36192 Example 2 R4 was admitted to the facility on [DATE] with diagnoses that include Parkinson's disease with dyskinesia (involuntary erratic movements), Dementia, anxiety disorder, depression, history of falling and muscle weakness. R4 was diagnosed on [DATE] with an unspecified injury of the head, contusion of other parts of the head and unspecified injury of the neck. R4's MDS (minimum Data Set) dated 5/16/24 indicates R4 has a BIMS (brief interview of mental status) of 6 out of 15, indicating R4 is severely cognitively impaired. R4 has adequate hearing, is able to make self-understood, and usually understands others. Section GG indicates R4 needs substantial/maximal assistance for toileting, dressing and personal hygiene. R4's Care plan (CP) indicates the following: Resident has been admitted from (place name) for long term care related to Parkinson's, dementia, hospice care. (initiated 2/9/24) approaches/support actions: Scheduled toileting: toilet upon rise, before and after meals, at HS (bedtime) and on 2nd Noc rounds (initiated: 5/10/24) (no previous toileting schedule indicated on CP prior to 5/10/24) Week II: The resident has had an actual fall with injuries notes: 1) forehead hematoma, 2) abrasion to bridge of nose, 3) superficial abrasion to top of left knee and 4) small bump to back of neck/base of scalp. Dementia/confusion, impaired vision, poor balance (initiated 5/28/24, created 5/28/24, revision on 5/28/24). Goal: The resident's facial bruising will resolve without complications (5/28/24). Approaches/support actions: anti-rollback brakes to be added to wheelchair (5/28/24); Complete a new [NAME] II falls risk (5/28/24); Complete multidisciplinary progress note (5/28/24); complete safety zone with appropriate details (5/28/24) keep touch call light near hip to alert staff of movement during the night (7/10/24); notify MD of fall (5/28/24); PT/OT consult for strength and mobility (5/28/24). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Week II: the resident has had an actual fall with no injury d/t (due to) dementia/confusion, poor balance twice on 6/9/24. Date initiated 6/9/24. Created on: 6/9/24, revision on: 6/9/24. Goal: the resident will resume usual activities without further incident through the review date. Approaches/support actions: assist resident to call (name), son, every evening (6/12/24). Complete a new [NAME] II falls risk (6/9/24). Complete multidisciplinary progress note (6/9/24) complete safety zone with appropriate details (6/9/24). Follow standard of care for falls (6/9/24). If resident is up. night shift CNA should stay on unit until 630 to help watch resident to cover through nurse shift report. (6/9/24). Monitor vital signs and assess for injuries every shift (for) 72 hours. (6/9/24). PT (Physical Therapy) teaching restorative aid balance techniques to continue working with resident on. (6/12/24). Week II: The resident has had an actual fall with no injury r/t (related to) dementia/confusion (6/9/24). (initiated 6/9/24, created on 6/12/24, revision on 6/12/24). Goal the resident will resume usual activities without further incident through the review date. Approaches/support actions: 1:1 during increased busy times roughly 0600-0800 (6am to 8am), 1030-1200 (10:30am to 12PM), 1630-2000 (4:30pm - 8pm) (6/12/24). Huddle completed with all staff to discuss details regarding the fall and any precipitating factors. (6/12/24). Week II: The resident has had an actual fall with no injury r/t dementia/confusion. (Initiated 6/12/24, created on 6/19/24, revision on 6/19/24). Goal the resident will resume usual activities without further incident through the review date. Approaches/support actions: complete a new [NAME] II falls risk, complete multidisciplinary progress note; complete safety zone with appropriate details; (6/19/24). Family meeting pursuing memory care (6/28/24); monitor/document/report PRN x 72 h (as needed for 72 hours) to MD for s/sx (signs/symptoms): pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. (6/19/24); neuro-checks (6/19/24); notify MD of fall (6/19/24). Week II: The resident has had an actual fall with no injury r/t dementia/confusion 6/22/24. (Initiated 6/22/24, created on 6/25/24, revision on 6/25/24). Goal the resident will resume usual activities without further incident through the review date. Approaches/support actions: complete a new [NAME] II falls risk (6/22/24), complete multidisciplinary progress note (6/22/24); complete safety zone with appropriate details (6/22/24); Huddle completed with all staff to discuss details regarding the fall and any precipitating factors (6/22/24); monitor/document/report PRN x 72 h (as needed for 72 hours) to MD for s/sx (signs/symptoms): pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. (6/22/24); notify MD of fall (6/22/24). Week II: The resident has had an actual fall with no injury r/t dementia/confusion and unsteady gait. (Initiated 6/29/24, created on 6/29/24, revision on 6/29/24). Goal the resident will resume usual activities without further incident through the review date. Approaches/support actions: complete a new [NAME] II falls risk (6/29/24), complete multidisciplinary progress note (6/29/24); complete safety zone with appropriate details (6/29/24); Follow standards of care for falls (6/29/24); notify MD of fall (6/29/24); Orthostatic BPs, update PCP (7/1/24). Please note, that R4 has 6 different fall care plans on her care plan and several resolved. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/10/24 at 6:00 PM, R4's Nurses Note indicates: Has made several self-transfers today. had closed her room door earlier and was found walking in the bathroom with no walker. This afternoon prior to supper ambulated with walker independently into hall .Reminded that it is not safe to get up on her own. Instructed to use call light and staff would gladly go for a walk with her . Reminded if she fell , she could break a bone such as a hip. I certainly don't want to do that.instructed to call for staff if she wants to get up or needs something. Verbalized understanding I will. On 3/14/24 at 5:50 PM, R4's Nurses Note states in part: Type: Fall. Summary of Event: CNA heard resident Can I get some help in here? Resident sitting on floor with her feet towards the toilet. I thought I could go by myself.Fall prevention intervention: Reinforce use of call light. Of note, there is no indication in the fall note, when resident was last toileted or seen, if R4 was incontinent when staff found her, what footwear she was wearing, what the environment was like etc., Per R4's Fall timeline provided by DON B (Director of Nursing), R4 was found on the floor in the bathroom. Resident had been toileted after supper, 10 minutes prior to fall. Intervention was a sign hung in room to remind resident to call for assistance. On 3/22/24 at 11:59 AM, R4's Fall team note indicates: Resident was discussed in falls team d/t (due to) recent fall. Intervention: signs placed in room to remind resident to use call light for assistance. High fall risk. 1 assist with walker for transfers and ambulation. Does not always use call light appropriately. Care plan reviewed and updated. (Staff continue to remind R4 to call for assistance when found self-transferring, but there is no indication of any other interventions to help prevent/limit self-transferring when Resident is noted to not always use call light appropriately.) On 4/7/24 at 10:00AM R4's Nurses Note states in part: Type: Fall. Summary of Event: Resident had been toileted at 930 (9:30AM) and placed in recliner with call light. Reminded to call for assist and not get up alone if needed. Voiced understanding but memory is poor and does not retain. Blood noted to lt (left) sleeve of sweatshirt. Removed top. Skin tear noted .assisted into recliner with Hoyer (full body lift) and 3A (three assist). Ambulated into bathroom with walker. Checked skin. No other injuries noted .MD and Family notified: .informed of increase in self-transfers without use of walker. Notified of fall this am with skin tear Lt upper arm . Fall Prevention intervention: Spoke with (name) RN on call for hospice. Informed of fall with skin tear . notified that self-transfers are on the rise. Frequently walking without walker . Of note: it is unclear where R4 was found during this fall, what she was trying to do that resulted in her falling. Per R4's Fall timeline provided by DON B, on 4/7/24, R4 had been sitting in the recliner in her room and was found sitting on the floor next to recliner, leaning back against bedside table. On 4/10/24 at 10:54 AM, R4's Fall team note indicates resident was discussed in fall teams d/t recent fall. Intervention from fall: dycem to recliner; hospice is looking into getting her therapy. High risk for falls per fall risk screen. Resident uses call light appropriately at times but also forgets to use it at times. Care plan updated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525376	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Upland Hills Nursing and Rehab	800 Compassion Way Dodgeville, WI 53533

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	On 4/17/24 at 1:28 PM, R4's Nurses Note states in part: Type: Fall. Summary of event: Resident was heard yelling help from her room by RN and CNA in hallway @ (at) 1255 (12:55PM). Both entered Residents room and was found to be sitting on her but in her bathroom with her back against the wall with the lights off. Resident stated that she thought she could take herself to the bathroom. She stated she was on her way to the toilet when she lost her balance and fell on to her left hand and butt . Resident was last toileted approximately 45 minutes prior and was last seen sitting in her recliner approximately 5 minutes prior to fall. Resident did not have her shoes on, had taken them off when she sat in recliner to nap. Call light was clipped to her blanket on her lap, and she removed call light and placed it on the bedside table.Fall prevention intervention: intervention is to make sure resident has her gripper socks on whenever she is sitting in her recliner and does not have her shoes on . (Of note: this is the 2nd fall in the bathroom for R4.) Per R4's Fall timeline provided by DON B; the intervention is: Encourage resident to sit in recliner in living room; strongly encourage gripper sock at all times. On 4/19/24 at 12:06 PM, R4's Nurses note states in part: type: Fall team . Resident was discussed in falls team d/t recent fall. Intervention from fall - wear gripper socks when in recliner. High risk for falls .resident has been removing call light from herself or next to her when self-transferring . On 5/10/24 at 5:20 AM, R4's Nurses Note states in part: type: Fall. Summary of event: CNA walking by resident room, noticed bed was empty and walker was by the bed. CNA checked bathroom, bathroom light was off, and resident was sitting on floor with back against toilet and legs/feet pointing towards sink. Resident was sitting under grab bar. Resident had brief and nightgown off and had been incontinent of urine on the floor. Resident states she slid on the floor when standing up and fell on her butt, gripper socks were on. She bumped her left forehead above her eye on the grab bar when she fell resulting in a goose egg bruise.assisted off floor with three staff assist.ice applied to forehead, skin tear cleaned and 3 steri strips and Opti foam applied. Resident assisted to get washed up and dressed for the day and was brought out to living room. When resident asked why she didn't use call light, resident stated she didn't have a phone to call for staff assistance. Call light was clipped to resident in bed. [NAME] was next to resident bed. Resident was in bathroom at 0300 (3:00AM) and was last seen sleeping in bed 10 minutes prior to being found in bathroom . Fall prevention intervention: will discuss intervention with team . (Of note: this is the 3rd fall R4 has had in her bathroom) On 5/22/24 at 1:49 PM, R4's Fall team note indicates: Resident discussed in falls team d/t recent fall. Intervention from fall - trialed use of baby monitor (no screen) having it at the nurses station to hear resident when in room. Baby monitor did not work, too much static. Trial evening dose of lorazepam helped a little. Reached out to PCP and now have HS (bedtime) dose of lorazepam scheduled. Also trialing 1400 (2pm) dose of lorazepam as behaviors begin around 1600 (4pm). Resident does not use call light appropriately. Staff continue to educate her to use call light and try to anticipate her needs. Care plan reviewed and remains appropriate at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525376	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Upland Hills Nursing and Rehab	800 Compassion Way Dodgeville, WI 53533

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/27/24 at 3:32 PM, R4's Nurses Note states in part: Type: Fall. Summary of event: resident sitting at a card table in the living room folding napkins, CNA was 1:1 but walked away to throw her tissues away, was coming back when resident stood up. Resident decided to stand up to put the napkins on the dining room table herself. Possibly tripped over leg of table, resident wasn't for sure. She tipped over her walker and landed on her back. back of her head hit the bottom wheel of her walker. CNA witnessed fall Fall prevention intervention: will discuss with fall team . Of note: staff walked away from R4 to throw an item away when she was to be 1:1 supervision. On 5/28/24 at 12:48 AM (0048), R4's Nurses note indicates in bed resting with soft touch call light within reach, reminded and encouraged to use call light for assistance. On 5/28/24 at 12:47 PM, R4's Nurses Note states in part: Type: Fall. Summary of event: unit CNA alerted facility staff via emergency button .of resident falling to the floor around 1206 (12:06 PM) between her dining room table and kitchenet stove. Resident noted to have large hematoma to frontal forehead, slightly to the left side with an abrasion to the bridge of her nose. Superficial abrasion to top of left knee. Slight bump noted to back of neck at the base of skull. Resident reported feeling nauseous during assessment and that her head hurt really bad. EMS (emergency medical services) paged, and they arrived at facility around 1225 (12:25PM) to transfer resident to ER (emergency room) for further evaluation. Resident did report when asked how she fell that when she got up, she must have tripped over her feet. Resident did not specify why she got up from her wheelchair in the dining room. Pain assessment and intervention: Resident reported that she had 10/10 head/neck and left knee pain during her assessment when she was on the floor. Fall prevention intervention: anti-[NAME] back brakes to be added to wheelchair . On 5/30/24 at 5:35 AM, R4's Nurses Note indicates Resident found self-transferring three times during the night by staff. Reminded resident to use call light but resident states she doesn't need any help. staff