

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2025
NAME OF PROVIDER OR SUPPLIER Northern Lights Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 706 Bratley Dr Washburn, WI 54891	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not implement policies and procedures for ensuring the reporting of physical abuse in accordance with section 1150B of the Act when an allegation of physical abuse was not reported immediately, but no later than 2 hours to the administrator and local law enforcement in accordance with state law through established procedures for 2 of 3 residents (R) reviewed (R1 and R3). On 07/31/25, R3 had a fall resulting in fracture and treated in ER. The facility did not report this incident as possible neglect to State Agency (SA). On 10/10/25, the facility was made aware of a concern of neglect regarding R1's care. The facility did not report this allegation of neglect to State Agency. This is evidenced by: Facility policy, titled, Abuse, Neglect, and Exploitation, Suspected Crime, with a revised date of 08/2025, states in part: It is the policy of this community to take appropriate steps to prevent the occurrence of abuse, neglect, and misappropriation of resident property. It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator or the community. If the events that caused the allegation involve abuse or serious bodily injury, it must be reported to the State agency immediately, but no later than 2 hours after forming the suspicion per State and Federal regulations. Events that do not involve abuse and/or do not result in serious bodily injury must be reported to the State agency no later than 24 hours as per State and Federal regulations. 7. Reporting: a. Any employee who suspects an alleged violation immediately notifies administrator. The administrator notifies the appropriate state agency immediately, following state law. Example 1 R3 was admitted to the facility on [DATE] with pertinent diagnoses of neurocognitive disorder with Lewy bodies, dementia moderate with psychotic disturbance and agitation, difficulty walking, muscle weakness (generalized), and nondisplaced fracture of surgical neck of left humerus (07/31/25). R3's most recent MDS, dated [DATE], noted a BIMS score of 09, indicating moderate cognitive impairment. R3 had impaired ROM on one side of upper extremity. R3 required Partial/moderate assist with oral hygiene and walking up to 150 ft; Substantial/max assist with toileting hygiene, shower/bathe self, upper/lower dress, personal hygiene, rolling left to right, sit to lying, sit to stand, chair/bed transfer, and toilet transfer. R2 was frequently incontinent of bladder. R3 had one fall with major injury. Surveyor reviewed R3's medical record and noted the following: On 07/31/25 at 5:30 PM, R3 had unwitnessed fall in room. Nurse found R3 on floor while walking by R3's room. Nurse observed R3 on floor at foot of bed, lying on left side in a semi-fetal position. R3's head was toward doorway and feet toward windows. R3's left elbow bent with palm towards ceiling and up off floor about 30 degrees. R3 was yelling she hurts. R3 assessed and complained of pain in left shoulder, left hip, and all over. R3 stated trying to put footrest down on the recliner chair, turned around and fell. R3 stated she was not using her walker and hit her head twice on the floor. Provider, DON, and family notified. R3 was transferred to ER. IDT reviewed and investigation completed. -Hospital notes: 07/31/25: Chief complaint: left arm/shoulder pain related to fall. Discharge diagnosis: left nondisplaced humerus fracture. Discharge instructions: continuous use of left arm sling and swath; follow-up with primary provider. Surveyor reviewed facility's self-reported incidents. This incident was not reported to the State agency, and no Misconduct Report was initiated. On 11/12/25 at 8:06 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding reporting incidents. NHA A stated that the reporting of allegations and incidents are a shared responsibility of the NHA and Director of Nursing (DON). Surveyor asked NHA A which incidents should be reported to the State agency. NHA A stated all allegations of abuse, neglect, and misappropriation. Surveyor asked NHA A when a fall would be reported to the State agency. NHA A stated falls with a fracture without a known cause should be reported and investigated. NHA A stated the DON would be responsible for nursing-related incidents and reporting. On 11/12/25 at 10:22 AM, Surveyor interviewed DON B regarding reporting incidents to the State agency. DON B stated that the NHA is responsible for completing all incident reporting to the State agency. Surveyor asked DON B when a fall would be reported to the State agency. DON B stated being blurry and confused on which incidents to report regarding this. Surveyor asked DON B if the facility was able to immediately identify that R3's fall and resulting fracture did not occur due to abuse or neglect. DON B stated no, that an investigation had to be completed to ensure R3's care plan was followed to rule out neglect. Surveyor then asked DON B if this incident should have been reported to the State agency prior to completing an investigation. DON B stated yes. Example 2 R1 was admitted to the</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a potential allegation of neglect was thoroughly investigated for 2 of 3 residents (R) (R1 and R3) reviewed. On 10/10/25, the facility was made aware of a concern of neglect regarding R1's care. The facility did not ensure a thorough investigation was completed related to the allegation of neglect of R1. On 07/31/25, R3 had an unwitnessed fall in R3's room. The facility did not ensure a thorough investigation was completed. This is evidenced by: Facility policy, titled, Abuse, Neglect, and Exploitation, Suspected Crime, with a revised date of 08/2025, states in part: It is the policy of this community to take appropriate steps to prevent the occurrence of abuse, neglect, and misappropriation of resident property. It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator or the community. The community investigates each such alleged violation thoroughly and reports the results of all investigations to the administrator, as well as to state agencies and Adult Protective Services as required by state and federal law. Definitions: Neglect: Is the failure of the community, its employees, or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. Serious bodily injury: is defined in section 2011(19) of the Act and means an injury involving extreme physical pain, substantial risk of death, protracted loss or impairment of the function of a bodily member, organ or mental faculty, or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation. Procedure: 4. Identification: Incidents of possible abuse or neglect, such as suspicious bruising of residents, occurrences, patterns, and trends will be identified through ongoing assessment of resident conditions, incidents, resident interviews, family or resident councils, and verbal or written reports of observations. 5. Investigation: a. Any person who knows or has reasonable cause to suspect that a resident has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the administrator. b. The administrator, director of nursing, or designee will notify the appropriate regulatory, investigative, or law enforcement agencies immediately, in accordance with state regulations. c. Allegations of abuse, neglect, or exploitation will be thoroughly investigated. The investigation will be initiated upon receipt of the allegation. The administrator, or designee, will complete the investigation process. Example 1R1 was admitted to the facility on [DATE] with pertinent diagnoses of right lobe-lobar pneumonia, acute and chronic respiratory failure with hypoxia, emphysema, and diabetes mellitus type 2. R1's admission Minimum Data Set (MDS), dated [DATE], noted a Brief Interview for Mental Status (BIMS) score of 07/15, indicating severe cognitive impairment. Surveyor reviewed R1's medical record and noted the following: On 10/01/25, R1 tested positive for COVID-19. No signs or symptoms were present at this time. Daily assessments were to be completed monitoring for new or worsening COVID-19 symptoms and to notify provider of changes. On 10/03/25, R1 was assessed to have new symptoms of wheezes present. Provider was not notified. On 10/04/25, R1 was assessed to have worsening lung sounds of rales/crackles and new onset of non-productive cough. Provider was not notified. On 10/06/25 at 5:59 AM, R1 had a change of condition noting R1 was found unresponsive with Oxygen (O2) saturation of 88% on 5Liters Per Minute (LPM) via nasal cannula and respirations of 28 per minute. Provider and family was notified. R1 was transferred to the emergency room (ER) for evaluation. R1 was admitted with diagnoses of acute hypoxemic respiratory failure, hypoxia, COVID, fever, hypoxemic respiratory failure, and acute on chronic respiratory failure with hypercapnia. On 10/08/25, R1 returned to the facility. Surveyor reviewed facility's complaint/grievances and noted on 10/09/25, R1's Power of Attorney (POA) filed a complaint stating concern with the care R1 received prior to hospitalization on 10/06/25. R1's POA stated concern that R1's O2 sats dropped without staff doing anything until R1 was unconscious. R1's POA further stated R1's door was always closed and was hardly checked on. R1's POA stated she desired to have R1 transferred to another facility. The facility documented follow-up completed on 10/14/25 with interventions to check on R1 every 30 minutes to ensure safety and bed would be kept at low height for safety. R1's POA was still not satisfied with interventions and still wanted R1 transferred to another facility. -Of note: R1 was transferred to another facility on 10/21/25. No additional investigation was initiated related to R1's POA's allegation of neglect. Surveyor reviewed facility's self-reported incidents. This incident was not reported to the State agency, and no Misconduct Report was initiated. On 11/12/25 at 10:37 AM Surveyor interviewed Director of Nursing (DON) R regarding R1's care</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that a resident (R) received treatment and care in accordance with professional standards of practice for 1 out of 3 residents sampled. (R1) Facility did not consistently monitor and assess R1 for changes after testing positive for COVID-19. The provider was not notified when R1 began experiencing COVID-19 symptoms. This is evidenced by: Facility policy, titled, Notification of Change, with a revision date of 11/2022, states in part: The community will consult the resident's physician, nurse practitioner, or physician assistant and notify the resident representative or an interested family member when there is: .acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e. deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).a need to alter treatment significantly (i.e., a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment).Nursing judgment is an integral part of the skilled care provided in the community; therefore, such judgment must be applied in a case-by-case basis in keeping with acceptable nursing practice.R1 was admitted to the facility on [DATE] with pertinent diagnoses of right lobe-lobar pneumonia, acute and chronic respiratory failure with hypoxia, emphysema, and diabetes mellitus type 2.R1's admission Minimum Data Set (MDS), dated [DATE], noted a Brief Interview for Mental Status (BIMS) score of 07, indicating severe cognitive impairment. R1 received special treatment of continuous oxygen therapy.R1's care plan, dated 10/10/25, with a target date of 01/07/26, states, Resident has COVID-19 infection, signs and symptoms of COVID19, tested positive. Goal of free of serious complications and/or signs and symptoms of COVID-19 through review date and interventions of meds/labs/treatments as ordered, follow facility protocol for COVID-19 screening/precautions, ensure proper PPE/precautions/hygiene.R1's care plan, dated 09/26/25, with a target date of 01/07/26, states, Respiratory: diagnosis - COPD oxygen, with a goal of free of serious complications r/t diagnosis and/or medication use, and interventions: meds/labs/treatments as ordered, monitor/observe/document signs and symptoms of adverse side effects and complications related to diagnosis, review with MD for recommendations.R1's physician orders:09/25/25 Monitor for signs/symptoms (s/sx) of COVID-19 infection including Temp > 99.9F, Chills, Cough, Shortness of Breath, Difficulty Breathing, Fatigue, Muscle or Body Aches, Headache, New Loss of Taste or Smell, Sore Throat, Congestion or Runny Nose, Nausea or Vomiting, Diarrhea. every shift If any symptoms are noted, immediately implement enhanced COVID-19 precautions, including Contact & Droplet Precautions. Notify primary provider, family/responsible party administrator, & DON.09/25/25 Complete Comprehensive Skilled Note under Assessment Tab BID every evening and night shift for Medicare A.09/25/25 - 10/01/25 Supplemental Oxygen via NC at 2.5L/min.09/28/25 Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 4 hours as needed for pain or elevated temp. Not to exceed 3000 MG/day for all meds containing Acetaminophen/Tylenol.10/01/25 - 10/13/25 Supplemental Oxygen via NC at 2.5L/min. every shift10/01/25 - 10/11/25 Contact/Droplet Isolation r/t Positive Covid every shift for +Covid until 10/11/2025 23:59. May come out of room on 10/12/2025.10/01/25 - 10/11/25 Document s/sx of covid and respiratory status in progress note. every shift until 10/11/2025 23:59Surveyor reviewed R1's vital signs and MAR and noted: 09/26/25 - 09/30/25, R1's oxygen saturation with supplemental oxygen was documented between 94-97% and temperature average of 97.5.10/01/25 - 10/05/25, R1's oxygen saturation with supplemental oxygen was documented between 90-92%.10/01/25 - 10/03/25, R1's temperature was documented between 97.5 - 98.6. On 10/04/25 at 2:26 AM, R1 was administered acetaminophen. At 8:09 AM, med was noted as effective. No documentation of pain was noted at this time. Last documented temperature was on 10/03/25 at 12:21 PM of 98.On 10/04/25 at 5:55 AM, R1's temperature was 99.2.-Of note: No additional re-evaluation of temperature was documented for over 8 hours.On 10/04/25 at 3:14 PM, R1's temperature was 99.6.-Of note: No additional re-evaluation of temperature was documented for over 15 hours.On 10/05/25 at 7:27 PM, R1's temperature was 99.2.-Of note: No additional re-evaluation of temperature was documented for over 7 hours. Surveyor reviewed R1's Comprehensive Nursing Notes:09/29/25 5:17 PM: Temp 97.8 - 9/29/2025 06:00; Respiration 16.0 - 9/29/2025 06:00; Pulse 78 - 9/29/2025 06:00; Lung Sounds - Clear; NO Shortness of Breath or Trouble Breathing Noted when Sitting at Rest or Lying Flat Observed; NO cough; NO oxygen used. 10/01/25 03:35: Blood Pressure - 114/49 - 10/1/2025 03:14; Temperature - T 98.6 - 10/1/2025 03:14; Pulse - P 74 - 10/1/2025 03:14; Respiration - R 18.0 - 10/1/2025 03:14; O2 sat 91%; Lung Sounds - Clear; NO</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure the resident environment remains free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents for 3 of 3 residents (R) (R1, R2, R3) reviewed.R1 experienced a fall resulting in a head laceration and transfer to the emergency room (ER) for treatment. The facility did not complete a thorough investigation into root cause, implement new safety interventions, and assess head wound.R2 experienced numerous falls and the facility did not complete a thorough investigation into root cause or implement new safety interventions to prevent further falls.R3 experienced numerous falls, one with a major injury, and did not complete a thorough investigation into root cause or implement new safety interventions to prevent further falls.This is evidenced by:Facility policy, titled, Accidents/Falls-HDGR, with a reviewed date of 12/2024, states in part: The facility strives to promote safety, dignity, and overall quality of life for its residents by providing an environment that is free from any hazards for which the facility has control and by providing appropriate supervision and interventions to prevent avoidable accidents. Procedure: 1. For all residents, a fall risk assessment is conducted upon admission, upon readmission from the hospital, annually, and with any significant change to the resident's status which puts them at a greater risk for falls. Additionally, each resident's fall risk assessment is reviewed on a quarterly basis, and any significant changes in status result in a full reassessment. 5. Resident care plans should be evaluated and updated with each fall with a new and applicable intervention based on root cause. The focus is to be on prevention and maintaining a safe environment. 6. If a fall or other incident/accident should occur, nursing/emergency care is to be provided to the resident per the facility's policy/standard of practice. Neurological observation (Neuros) will be conducted following any observation of a resident hitting their head during a fall/incident/accident or if it is unknown/not observed whether a resident actually hit their head or not during a fall/incident/accident. It should be noted even if a resident reports that head was not hit in fall was not observed, neurological assessments are required to be completed. Additionally, if a resident is sent to ER, for observation without finding and returns within 72 hours post fall, neurological checks must resume for the duration of 72 hours. 7. Any episode of a fall or other incident/accident should be documented within Point Click Care within Risk Management/Incidents. The information should be recorded in factual observed detail and not supposition of what may have occurred. Each incident/accident or fall must be investigated and/or assessed to determine the root cause of the episode to prevent any further injury. Witness statements should be obtained as applicable. The administrator and Director of Nursing (DON)/Wellness should have knowledge of all reports. The interdisciplinary team will review all incident/accident. 8. The resident's physician and family/responsible person should be notified post fall/incident/accident as soon as possible, with contact documented in the resident's medical record. 9. A post-fall assessment will be conducted following any fall episode. Once the post-fall assessment is completed by nursing, the director of nurses or designee will seek additional input from the interdisciplinary team and other staff. DON/IDT [Interdisciplinary Team] Review Portion will be completed timely. The completed post-fall assessment will be maintained in the resident's medical record. 10. The resident's individualized care plan is to be updated with any changes or new interventions post fall/incident/accident, communicated to appropriate staff, and implemented.Example 1R1 was admitted to the facility on [DATE] with pertinent diagnoses of right lobe-lobar pneumonia, acute and chronic respiratory failure with hypoxia, emphysema, and diabetes mellitus type 2.R1's admission Minimum Data Set (MDS), dated [DATE], noted a Brief Interview for Mental Status (BIMS) score of 07/15, indicating severe cognitive impairment. R1 required setup assist with eating; supervision or touch assist with rolling left to right and sit to lying; Partial/moderate assist with oral hygiene, upper dress, lying to sitting, sit to stand, chair/bed transfer, toilet transfer; Substantial/max assist with toileting hygiene, shower/bathe self, lower dress, footwear, and personal hygiene. R1 had no falls.R1's care plan, dated 09/25/25, with a target date of 01/07/26, states, Actual/At Risk/ and/or Potential for Complications with OR falls with a goal to be free of falls, but if does free of serious injurie, reduced risk for falls, will have no falls through next review date, and not be injured in falls. Interventions include: 30 minute checks while in isolation (10/10/25), bed in lowest position when in bed, assistive device (grabber, toilet seat riser, bathroom bars), call light positioned for easy access, check for unmet needs - pain, toileting, hunger thirst, temperature, do not leave unattended in the bathroom, encourage/assist with non-skid shoes/socks, ensure environment is free of clutter, fall review per facility</p>		