

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Eastern Plumas Hospital- Portola Campus Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 500 First Street Portola, CA 96122	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly identify and notify the physician and responsible party of a change of condition for one of two residents (Resident 1) when Resident 1 had a fall which resulted in a new onset of pain.</p> <p>This resulted in an eight-hour delay in treatment for Resident 1 which caused unnecessary pain and suffering.</p> <p>Findings:</p> <p>A review of the facility ' s policy titled Change in Condition and Alert Charting revised 11/24, indicated A change in condition is defined as anytime an accident involving the resident results in injury which requires provider ' s intervention; there is a significant change in the resident ' s physical, mental, or psychosocial status or behavioral condition changes .It is the policy of [name of facility] to promptly recognize any resident changes in condition and implement alert charting. The nurse will conduct an assessment and notify the resident ' s primary provider, resident representative and the resident.</p> <p>A review of Resident 1 ' s admission record indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included Dementia (loss of memory, language, problem-solving and other thinking abilities), parkinsonism (a syndrome characterized by tremors, bradykinesia [slowness of movement], rigidity (stiffness), and postural instability [difficulty maintaining an upright posture and balance]), hearing loss, osteoporosis (weak and brittle bones) and traumatic brain injury. Resident 1 had a responsible party (RP) who made health care decisions for her.</p> <p>During an interview on 5/12/25, at 11:02 am, the Assistant Director of Nursing (ADON) indicated Resident 1 had a fall on 5/2/25 around 11:15 am.</p> <p>A review of Resident 1 ' s pain vitals (documentation of residents ' complaint of pain on a scale from 0-10 with 0 being no pain and 10 being the worst pain) from 4/24/25 at 4:13 am, through 5/2/25 at 5:27 am, showed that Resident 1 did not complain of pain for these eight days prior to the fall. On 5/2/25 Resident 1 complained of pain rating a six at 12:00 pm, a seven at 6:31 pm, and a nine at 7:10 pm.</p> <p>(continued on next page)</p>

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/12/25, at 12:35 pm, Housekeeper (HSK) A indicated that on 5/2/25 at around 11:00 am, she saw and heard Resident 1 fall from her chair and land on her left side while sitting at the nurse ' s station. HSK A indicated she went to get help from a nurse and then returned to Resident 1. HSK A indicated that as Licensed Nurse (LN) C and Certified Nursing Assistant (CNA) B was assisting Resident 1 back into her chair, Resident 1 was crying and stated, Leave me alone it hurts. HSK A indicated she informed LN C that Resident 1 had fallen.</p> <p>During an interview on 5/13/25, at 4:11 pm, LN C indicated that Resident 1 was noted to be sitting on the floor in front of the nurse ' s station on 5/2/25 around 11:00 am. LN C indicated that CNA B and herself lifted Resident 1 up off the floor and placed her back in a chair. LN C indicated Resident 1 had pain in her left side, was rigid and tense all over. LN C indicated that at noon that same day Resident 1 was wheeled to her room and stated, leave me alone and don ' t move me but was transferred to her bed by two staff members. LN C indicated that she did not notify the primary physician or Resident 1 ' s RP at that time and she should have. LN C indicated that she waited until the end of her shift to send an email to the Medical Director (MD, her primary physician).</p> <p>During an interview on 5/14/25, at 11:12 pm, MD indicated that he was first notified that anything was wrong on 5/2/25 at 5:33 pm, by a TEAM message and the message said that Resident 1 sat herself on the ground and had pain one hour after that and that Tylenol (Acetaminophen, a mild pain medication) helped. MD indicated that there was no time noted for the incident and no assessment included and there should have been. MD indicated that he had no idea that Resident 1 had fallen or had pain with movement. MD indicated he should have been notified right away, but instead he got an email on 5/2/25 at 7:10 pm (8 hours after incident), LN F wrote Resident 1 has been in pain, I administered Tylenol at 6:31(pm) when she complained of 7/10 (strong) pain. She (Resident 1) c/o (complained) pain in left arm and leg. The medication is ineffective, her (Resident 1 ' s) pain has increased 9/10 she has been lying in bed on her right side. She is in so much pain, myself and staff are unable to touch her or obtain VS (vital signs) or to get an assessment she cries out when we attempt care. She didn ' t touch her dinner tray and refused ensure.</p> <p>A review of Resident 1 ' s Emergency Department (ED) results dated 5/2/25 at 9:52 pm, indicated Resident 1 had an Acute Displaced subcapital left femoral neck fracture (left hip fracture).</p> <p>During an interview on 5/14/25, at 2:30 pm, RP indicated that she received a call on 5/2/25 at 7:30 pm, about what happened that day and that her mother was going to the emergency room. RP said it was her understanding that the facility was supposed to notify her when something happened to her mother. RP indicated that she was not notified earlier when her mother had fallen and was in pain.</p> <p>During a review of the facility ' s document titled Alert Charting -For Changes in Condition dated 5/2/25, Resident 1 was identified as having left leg pain and the sections identified as MD informed and documented and Family informed and documented was not signed as done.</p> <p>During an interview and record review with the Director of Nursing (DON) on 5/14/25, at 3:41 pm, the document titled Alert Charting-For Changes in Condition dated 5/2/25 and Resident 1 ' s progress notes dated 5/2/25 were reviewed. DON indicated there was no documentation in Resident 1 ' s progress notes or on the Alert Charting-For Changes in Condition that LN C had notified the primary physician of the change of condition when the incident happened, and she should have. The DON indicated that the RP should have been notified when Resident 1 had a change in condition.</p>		

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<p>F 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of two residents (Resident 1) sampled for falls was free from an avoidable fall. According to the facility's assessments, Resident 1 had difficulty maintaining an upright posture and poor safety awareness. Certified Nursing Assistant (CNA) B observed Resident 1 leaning over and reaching for the floor but did not help Resident 1 to a safe position and left Resident 1 unsupervised. Resident 1 had no post fall assessment and Resident 1's care plan did not provide interventions for what to do if Resident 1 was found on the floor unwitnessed.</p> <p>This fall resulted in Resident 1 falling and sustaining a broken left hip. Resident 1 required hospital admission for surgery. Resident 1 had a decline in her physical, social, and mental well-being due to increased pain.</p> <p>Findings:</p> <p>A review of the facility's policy, Resident Safety, dated 7/1/24, indicated, It is the policy of [name of facility] to ensure the optimum safety for all residents at all times by increasing staff awareness and encouraging strict adherence to practices that ensure optimum resident safety. A. Be alert for, and report promptly, any unsafe conditions or practices that you see.</p> <p>A review of Resident 1's undated admission Record indicated her admission to the facility on [DATE]. Her diagnoses included Dementia (loss of memory, language, problem-solving, and other thinking abilities), Parkinsonism (a condition causing tremors, slow movements, stiffness, and difficulty with balance), hearing loss, Osteoporosis (weak and brittle bones), and a traumatic brain injury (an injury to the brain caused by an external force, such as a blow, jolt, or impact to the head).</p> <p>A review of Resident 1's Quarterly Minimum Data Set (MDS, a data-driven resident clinical assessment), dated 2/8/25, indicated a score of 3 out of 15 on her Brief Interview for Mental Status (BIMS, an assessment of memory, thinking, and problem-solving that is scored from 0/worst to 15/best). This score indicated severe memory and decision-making problems. Resident 1 walked independently and could sit and stand with set up help (the helper assists the resident prior to, or after sitting or standing).</p> <p>A review of Resident 1's Fall Risk Evaluation, dated 1/28/25, indicated a score of 12, which was High Risk for falls. The Fall Risk Evaluation indicated the factors contributing to this risk included: sustaining 1 to 2 falls in the past three months, a balance problem while standing, disorientation to person, place, and time, and taking risperidone (an antipsychotic medication) that had potential adverse side effects of tremor, stiffness, restlessness, and involuntary movements.</p> <p>A review of Resident 1's At Risk for Falls care plan, revised on 4/6/25, indicated, [Resident 1] is [at] risk for falls r/t [related to] confusion, unaware of safety needs. Interventions included providing a safe environment, anticipating and meeting Resident 1's needs, providing activities to minimize falls, watching for signs of weakness and unstable gait (how a person walks), notifying the Physician (MD), and directing Resident 1 to a quiet area if she showed fatigue and sat or lay on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/2/25, at approximately 11:00 am, Housekeeper (HSK) A stated she observed Resident 1 fall from her chair onto her left side in the hallway. HSK A stated she heard a thud and ran to check for blood. HSK A stated she saw no staff in the hallway or at the nurse's station. HSK A stated she found Licensed Nurse (LN) C in the medication room and informed her of the fall. HSK A stated, Resident 1 was laying down on her left side and she never straightened her legs. HSK A stated, The nurse [LN C] said [to Resident 1] 'why you lay down on the floor this is not nice.' HSK A stated, I said [to LN C] she [Resident 1] did not lay down she fell. HSK A stated she witnessed Certified Nursing Assistant (CNA) B lift Resident 1 by placing her arms under Resident 1's armpits, and LN C push Resident 1 onto the chair with her knee. HSK A stated she heard Resident 1 cry and say, leave me alone it hurts. HSK A stated she informed LN C three times that Resident 1 had fallen. HSK A stated They (LN C and CNA B) did not assess her [Resident 1] or do vitals. HSK A stated that Resident 2 also witnessed the event.</p> <p>A review of Resident 2's undated admission Record indicated she was admitted to the facility on [DATE], with diagnoses including conduct disorder, dysphagia (difficulty swallowing), high blood pressure, and seizures.</p> <p>A review of Resident 2's Annual MDS dated [DATE] indicated a BIMS score of 14, signifying intact cognition (ability to think and reason).</p> <p>During an interview in Resident 2's room on 5/12/25, at 1:30 pm, Resident 2 stated, I saw lady [Resident 1's name] fall and I saw [LN C's name] and another person [unnamed] get her off the floor and she [Resident 1] said my leg, my back hurts then she spent the rest of the day in her room. Resident 2 stated, I saw her fall, I told [LN C's name] that she fell.</p> <p>During a telephone interview on 5/13/25, at 4:11 pm CNA B stated that on 5/2/25, around 11:00 am, just before Resident 1 was on the ground, she witnessed Resident 1 in a chair bending over, reaching for the ground like she was picking up something off of the floor. CNA B stated, I told her to sit up straight and told the nurse [LN C] at the desk that she was bending over then went into another resident's room [unknown]. CNA B indicated that Resident 1 would sit at the nurse's station for better supervision. CNA B stated, When I went by her and told her to sit up, I did not stop to make sure she was sitting up and in a safe position. CNA stated, I should have made sure she [Resident 1] was safe before I left her. When CNA B returned, Resident 1 was on the floor. CNA B stated that she and LN C picked Resident 1 up from the floor and placed her back in the chair. CNA B stated that Resident 1, who had walked earlier, was unable to bear any weight and said, it hurts! with a tight, uncomfortable expression.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/13/25, at 4:11 pm LN C stated that around 11:00 am on 5/2/25, she returned from the Medication Room to find Resident 1 on the floor. LN C stated Resident 1's care plan indicated she would sit herself on the floor. LN C stated, I did not know if she [Resident 1] fell or if she sat intentionally. LN C stated, I did not know if it was witnessed or unwitnessed. LN C stated she witnessed CNA B quickly lift Resident 1 by placing her arms under Resident 1's armpits. LN C stated, CNA B put Resident 1 on my knee then I pushed her onto the chair with my knee and hands. LN C stated she touched Resident 1's left shoulder and left hip, and Resident 1 was tense and pushed her away. LN C stated, [Resident 1] was rigid on the floor and was tense, so I did not move her extremities [assess range of motion of her arms and legs]. She would not move anything for me. I should have assessed her for a fall, but I did not. I gave her Tylenol because she said it hurt. LN C indicated that 20 minutes later, at lunchtime, Resident 1 stated, I do not want lunch. LN C stated that at noon, Resident 1 was wheeled to her room and stated, leave me alone and don't move me, but two staff members transferred her to her bed. LN C stated she did not notify the primary physician or Resident 1's responsible party at that time and should have. LN C stated she informed the Director of Nursing (DON) of the incident, and the DON told her that because Resident 1 had a care plan to sit on the ground, this was not considered a fall. LN C waited until the end of her shift on 5/2/25, at 5:33 pm to email MD. LN C stated she did not take vitals or assess Resident 1 while she was on the floor because Resident 1's care plan indicated she sat herself on the ground. LN C stated she did not see Resident 1 sit herself on the ground and did not remember anyone saying Resident 1 fell. LN C stated Resident 1 had pain, and she should have assessed Resident 1 and notified the MD at the time of the incident, but she did not.</p> <p>During an interview on 5/14/25, at 3:41 pm the Director of Nursing (DON) indicated that CNA B should have helped Resident 1 back into a safe sitting position before leaving her unsupervised, and she did not. The DON stated, There should have been an assessment when she (Resident 1) was on the floor and there was not. The DON stated that if staff found a resident on the floor and were unsure how it happened, they should consider it a fall. However, because Resident 1 had a care plan that said she sits herself on the ground, interventions to assess Resident 1 for a fall and injury did not happen. The DON stated, we did not follow our post fall policy, and we should have.</p> <p>A review of Resident 1's progress note titled Alert Note dated 5/2/25 LN F indicated on May 2, 2025, at 8:49 pm, When coming into this shift [I] received report from off going nurse [LN C] about resident [Resident 1] sitting on the floor, having pain in left leg and arm, [and] to monitor. Resident [1] was still c/o (complaining of) pain at 6:31 pm, this nurse gave Tylenol to resident c/o pain in left leg and arm. [Resident 1] refusing care and vital signs. The medication was ineffective at 7:10 pm. This nurse then informed Dr [MD's name] of these findings. Dr [MD's name] gave orders to this nurse to send resident out to ED (Emergency Department) for pain.</p> <p>A review of Resident 1's ED's CT (computed tomography- a computerized x-ray) scan of her left femur (large bone of the upper left leg) results, dated 5/2/25, at 9:52 pm, indicated Resident 1 had an Acute Displaced sub capital left femoral neck fracture (a broken left hip bone).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview at a Local Hospital (LH) with Resident 1's Hospital Occupational Therapist (OT) on 5/14/25, at 10:30 am Resident 1's Hospital Occupational Therapist (OT) indicated that Resident 1 came to LH's emergency department (ED) on 5/2/25 and was diagnosed with a broken left hip. The OT stated Resident 1 was then transferred to another hospital for surgery and then transferred back to LH. The OT stated Resident 1 was in significant pain and unwilling to participate in therapy and was taking OxyContin (a strong opioid [narcotic] pain medication used to relieve severe ongoing pain, which may lead to severe psychological or physical dependence and has abuse potential and can cause serious or life-threatening breathing problems and death) 5 mg (milligrams) for pain.</p> <p>During an interview with Resident 1's Hospital Nurse (HN) at the LH on 5/14/25, at 10:35 am, Resident 1's Hospital Nurse (HN) stated that Resident 1 was in significant pain and completely dependent on staff for assistance. The HN noted that OxyContin made Resident 1 very sleepy and foggy, so hospital staff were attempting to adjust her pain medication.</p> <p>During an observation and interview at LH on May 14, 2025, at 10:55 am, Resident 1 lay in bed with her right leg bent at the knee and her left leg flat. Resident 1 slightly moved her right leg but not her left. When asked how she was doing, Resident 1 replied, Not very good without opening her eyes. Resident 1's speech was weak and slow. She stated, I do not feel good. It hurts in different places. I cannot pinpoint it (where the pain was). Resident 1 never opened her eyes, smiled, or turned her head during the visit. Three hospital staff entered Resident 1's room to change her left hip dressing.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two residents (Resident 1) sampled for post-fall pain received the treatment and care to manage pain when:</p> <ul style="list-style-type: none"> * Staff did not promptly assess Resident 1 for a change of condition for a new onset of pain in her left arm and left hip after she was found on the floor. Staff picked Resident 1 up off the ground and put her into a chair while she complained of pain. * Staff gave Resident 1 medication ordered for mild pain when she experienced moderate pain. * The Physician (MD) was not immediately notified of Resident 1's fall and complaint of pain with movement. <p>These failures caused Resident 1 to experience moderate and severe left arm and left leg pain for eight hours, prevented her from eating lunch or dinner.</p> <p>Findings</p> <p>A review of the facility's policy, Change in Condition and Alert Charting, revised November 2024, indicated, A change in condition is defined as anytime an accident involving the resident results in injury which requires provider's intervention; there is a significant change in the resident's physical, mental, or psychosocial status or behavioral condition changes; or a need to alter treatment or add a new medication. The policy indicated, The following are some examples of adverse changes in resident condition: .Fall: witnessed or reported, . Any sudden and/or marked adverse change in signs/symptoms, or behavior exhibited by a resident The policy indicated, It is the policy of [name of facility] to promptly recognize any resident changes in condition and implement alert charting, and that The nurse will conduct an assessment and notify the resident's primary provider, resident representative and the resident.</p> <p>A review of the facility's policy, Pain Management in the Skilled Nursing Facility, revised November 2024, indicated, The goal of pain management is to minimize the amount, duration and intensity of pain The policy indicated, Residents will be assessed for the presence or absence of pain during the initial assessment and periodically thereafter. If pain is present at any initial assessment or following a pain producing event, it will be managed in accordance with this policy. The policy indicated, Pain level will be reassessed within 30-60 minutes after each pain management intervention with the post intervention pain rating documented on the Medication Administration Record (MAR). The policy indicated, Pharmacological (pertaining to medication) Management. a. Pain medication shall be administered utilizing the appropriate dosage as indicated by the provider's medication order and the 10-point Pain Scale: mild pain 0-3, moderate pain 4-7, severe pain 8-10. The policy indicated, Non-pharmacological (treatments other than medication) techniques will be used as appropriate and may include but not be limited to: Repositioning of the resident The policy indicated, Collaborate with the provider as needed regarding use of adjuvant medications (the use of other medications to aid in pain relief) The policy indicated, Initial pain assessments, b. Medication administration, c. Evaluation of the effectiveness of pain management interventions. D. Reportable conditions or adverse reactions on the appropriate event for and in the record.</p> <p>(continued on next page)</p>		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	<p>A review of the facility's policy, Fall Prevention and Post Fall Guidelines, revised September 2024, indicated a Post Fall Protocol that included, Perform an initial assessment immediately: 1. Vital signs (a group of the four to six most crucial medical signs that indicate the status of the body's vital functions) . 2. Initial Neuro Assessment (assessment of sensory and motor responses, especially reflexes, to determine whether the nervous system is impaired) . d. mobility (movement of extremities .). 3. Obvious injuries (e.g., . new pain with movement or palpation). C. Contact the physician immediately so that he/she can reassess the patient.</p> <p>A review of Resident 1's undated admission Record indicate she was admitted to the facility on [DATE], with diagnoses including Dementia (loss of memory, language, problem-solving and other thinking abilities), parkinsonism (a syndrome characterized by tremors, bradykinesia [slowness of movement], rigidity (stiffness), and postural instability [difficulty maintaining an upright posture and balance]), hearing loss, osteoporosis (weak and brittle bones), and traumatic brain injury (an injury to the brain caused by an external force, such as a blow, jolt, or impact to the head). Resident 1 had a responsible party (RP) who made health care decisions for her.</p> <p>A review of Resident 1's Quarterly Minimum Data Set (MDS- a standardized resident assessment) dated 2/28/25, indicated a Brief Interview for Mental Status (BIMS- a numerical representation of a person's ability to think and reason, assessed through a structured interview) score of 03, signifying severe cognitive impairment. Section GG (a standardized assessment used to evaluate a patient's self-care and mobility abilities) indicated that Resident 1 walked independently and could sit and stand with set-up help.</p> <p>During an interview on 5/12/25, at 11:02 am, the Assistant Director of Nursing (ADON) confirmed Resident 1 fell on 5/2/25, around 11:15 am.</p> <p>A review of Resident 1's progress note titled Alert Note dated 5/2/25, at 4:51 pm (5.5 hours after the incident), Licensed Nurse (LN) C documented on alert charting for left leg pain. resident (Resident 1) sat on the floor with no initial c/o (complaint) of pain. One hour later she stated pain, ACETAMINOPHEN (Tylenol) was given and effective. Re-eval 5/5/25.</p> <p>A review of Resident 1's progress note titled Alert Note dated 5/2/25, at 8:49 pm, LN F documented, When coming into this shift (I) received report from off going nurse (LN C) about resident (Resident 1) sitting on the floor, having pain in left leg and arm, (and) to monitor. Resident (Resident 1) was still c/o (complaining of) pain at 6:31 pm, this nurse gave Acetaminophen to resident c/o pain in left leg and arm. (Resident 1) Refusing care and vital signs. The medication was ineffective at 7:10 pm. This nurse then informed Dr (MD's name) of these findings.Dr (MD's name) gave orders to this nurse to send resident out to ED (Emergency Department) for pain.</p> <p>A review of Resident 1's ED CT (computerized x-ray) scan of her left femur results, dated 5/2/25, at 9:52 pm, indicated an Acute Displaced sub capital left femoral neck fracture (a broken left hip bone).</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/12/25, at 12:35 pm, Housekeeper (HSK) A stated that on 5/2/25, at approximately 11:00 am, she observed Resident 1 fall onto her left side in the hallway near the nurse's station. HSK A stated she heard a thud and ran to check for blood. HSK A stated she observed no staff in the hallway or at the nurse's station. HSK A stated she found LN C in the medication room, knocked on the door, and informed LN C that Resident 1 fell. HSK A stated, Resident 1 was laying down on her left side and she never straightened her legs. HSK A stated, The nurse (LN C) said (to Resident 1) 'why you lay down on the floor this is not nice.' HSK A replied, I said (to LN C) she (Resident 1) did not lay down she fell. HSK A witnessed Certified Nursing Assistant (CNA) B lift Resident 1 by placing her arms under Resident 1's armpits, and LN C push Resident 1 onto the chair with her knee. HSK A heard Resident 1 cry and say, leave me alone it hurts. HSK A informed LN C three times that Resident 1 had fallen. HSK A also noted that Resident 2 witnessed the event.</p> <p>A review of Resident 2's undated admission Record indicated she was admitted to the facility on [DATE], with diagnoses including conduct disorder, dysphagia (difficulty swallowing), high blood pressure, and seizures. Resident 2's annual MDS dated [DATE] indicated a BIMS score of 14, signifying intact cognition.</p> <p>During an interview in Resident 2's room on 5/12/25, at 1:30 pm, Resident 2 stated, I saw lady (Resident 1's name) fall and I saw (LN C's name) and another person (unnamed) get her off the floor and she (Resident 1) said my leg, my back hurts then she spent the rest of the day in her room. Resident 2 stated, I saw (Resident 1) fall, I told (LN) that she fell. Resident 2 stated, They (LN C and another person) picked her up and put her in a regular chair and then later they transferred her to a wheelchair and took her to her room. Resident 2 stated she heard Resident 1 say, let me go lay down I'm in pain; I want to lay down. Resident 2 stated, When she (Resident 1) was sitting in the chair I was rubbing her back because she kept saying 'it hurts.'</p> <p>During a phone interview on 5/13/25, at 4:00 pm, CNA B stated that on 5/2/25, around 11:00 am, she saw Resident 1 on the floor after returning from answering a call-light. CNA B and LN C picked Resident 1 up from the floor and placed her back in the chair. CNA B stated that Resident 1, who had walked earlier, was unable to bear any weight and said, it hurts! with a tight, uncomfortable expression. CNA B stated, I did not take her vitals. You're supposed to make sure she (Resident 1) is ok (before moving a resident), but I do not know if that happened. CNA B stated, around noon (Resident 1) was unable to walk because of the pain so we (LN C and CNA B) helped her lay down on the bed and she (Resident 1) was saying it hurt but she was not specific to where the pain was. CNA B stated, LN C and I tried to move her (Resident 1) in the bed and that's when she was saying it hurts, it hurts.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/13/25, at 4:11 pm, LN C stated that on 5/2/25, around 11:00 am, she returned from the Medication Room to find Resident 1 on the floor. LN C stated that Resident 1's At Risk For Falls care plan indicated she would sit herself on the floor. LN C stated, I did not know if she (Resident 1) fell or if she sat intentionally. LN C stated, I did not know if it was witnessed or unwitnessed. LN C stated she witnessed CNA B quickly lift Resident 1 by placing her arms under Resident 1's armpits. LN C stated, CNA B put Resident 1 on my knee then I pushed her onto the chair with my knee and hands. LN C stated she touched Resident 1's left shoulder and left hip, and Resident 1 was tense and pushed her away. LN C stated, (Resident 1) was rigid on the floor and was tense so I did not move her extremities (assess range of motion of her arms and legs). She would not move anything for me. I should have assessed her. I gave her [Acetaminophen] because she said it hurt. LN C stated that 20 minutes later, at lunchtime, Resident 1 stated, I do not want lunch. LN C stated that at noon, Resident 1 was wheeled to her room and stated, leave me alone and don't move me, but two staff members transferred her to her bed. LN C stated she did not notify the primary physician or Resident 1's responsible party at that time and should have. LN C stated she informed the DON of the incident, and the DON told her that because Resident 1 had a care plan to sit on the ground, this was not considered a fall. LN C stated she waited until the end of her shift on 5/2/25, at 5:33 pm (6 hours after the incident), to email the Physician (MD). LN C stated she did not take vitals or assess Resident 1 while she was on the floor because Resident 1's care plan indicated she sat herself on the ground. LN C stated she did not see Resident 1 sit herself on the ground and did not remember anyone saying Resident 1 fell. LN C stated Resident 1 had pain, and she should have assessed Resident 1 and notified the MD at the time of the incident, but she did not.</p> <p>During an interview on 5/14/25, at 1:29 pm, HSK D stated that on 5/2/25, around 11:00 am, she saw Resident 1 lying on the floor on her left side. HSK D stated she heard HSK A tell LN C that Resident 1 had fallen. HSK D stated she observed LN C and CNA B pick up Resident 1 and place her in the chair, and Resident 1 screamed that it hurt. HSK D stated that around noon, she saw the DON and LN C trying to help Resident 1 stand up, and Resident 1 resisted, saying, It is hurting.</p> <p>During an interview on 5/14/25, at 1:42 pm, CNA E, stated she was assigned to care for Resident 1 on 5/2/25. CNA E stated that around 12:00 pm, Resident 1 and Resident 2 were sitting in a chair at the nurse's station with LN C and the DON also present. CNA E stated, Resident 2 said 'she (Resident 1) fell, she fell.' CNA E stated she observed Resident 1 sitting in a chair with her legs curled up to the left. CNA E stated Resident 1 was not her normal self, not smiling, engaging, or looking back. CNA E stated she attempted to help Resident 1 walk to her room, which usually worked, but Resident 1 would not. CNA E stated she, LN C, and the DON tried to help Resident 1 stand up and transfer her to a wheelchair. CNA E stated, She (Resident 1) was holding her left hip. She was making moaning noises We (DON, LN C, and CNA E) then transferred Resident 1 to her bed, and she was moaning, and she said no, no, no. CNA E stated, When she (Resident 1) was in bed she had her legs curled up and was leaning to the right. The DON felt (Resident 1's name) left leg but we did not move her. Resident 1 did not want her legs straightened so we supported her back and left her lying there and she was moaning. She was saying no.no. no. CNA E added, At 2:00 pm she was still moaning and said the hip hurt and was still in the same position. I informed LN C, and she said they gave her (Resident 1) Acetaminophen. CNA E stated she felt Resident 1 was in more pain at 2:00 pm. CNA E continued to say that at 4:00 pm, she (CNA E) tried to get Resident 1 up for dinner, but she (Resident 1) was still curled up in the same position and she was holding her left hip, was moaning and did not eat lunch or dinner that day.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview at a Local Hospital (LH) with Resident 1's Hospital Occupational Therapist (OT) on 5/14/25, at 10:30 am, the OT stated that Resident 1 arrived at LH's emergency department (ED) on 5/2/25 and was diagnosed with a broken left hip. The OT stated that Resident 1 was then transferred to another hospital for surgery and subsequently returned to LH. The OT stated Resident 1 was in significant pain and unwilling to participate in therapy, taking OxyContin (a strong narcotic pain medication used to relieve severe ongoing pain, which may lead to severe psychological or physical dependence and has abuse potential and can cause serious or life-threatening breathing problems and death) 5 milligrams (mg-a unit of measure) for pain.</p> <p>During an interview with Resident 1's Hospital Nurse (HN) at the LH on 5/14/25, at 10:35 am, HN stated that Resident 1 was in significant pain and completely dependent on staff for assistance. HN stated that OxyContin made Resident 1 very sleepy and foggy, so hospital staff were attempting to adjust her pain medication.</p> <p>During an observation and interview on 5/14/25, at 10:55 am, Resident 1 lay in bed at LH with her right leg bent at the knee and her left leg flat. Resident 1 slightly moved her right leg but not her left. When asked how she was doing, Resident 1 stated, Not very good without opening her eyes. Resident 1's speech was weak and slow. Resident 1 stated, I do not feel good It hurts in different places I cannot pinpoint it (where the pain was). Resident 1 never opened her eyes, smiled, or turned her head during the visit.</p> <p>A review of Resident 1's Amount Eaten record for 5/2/25, indicated she did not eat lunch or dinner on that day.</p> <p>A review of Resident 1's Physician orders dated May 2025, indicated an order for Acetaminophen Tablet 325 mg (two tablets by mouth every six hours as needed for mild pain rating of 1-3), written on 10/25/24, by the MD. Physician orders for 5/2/25, contained no other physician orders for moderate pain levels (4-7) or severe pain levels (8-10).</p> <p>A review of Resident 1's May 2025 Medication Administration Record (MAR) indicated that on 5/2/25, at 12:00 pm, LN C administered Acetaminophen tablet 325 mg, ordered for mild pain (1-3), two tablets for Resident 1's pain level of six (moderate pain). On 5/2/25, at 6:30 pm, LN F administered another Acetaminophen tablet 325 mg, two tablets, for Resident 1's pain level of seven (moderate pain).</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent phone interview and review of Teams messages on 5/14/25, at 11:12 pm, the MD stated that on 5/2/25, at 5:33 pm (6 hours after the incident), he received a Teams message from LN C that read, [Resident 1] sat herself on the ground and had pain one hour after that and that Acetaminophen helped. The MD stated he received another Teams message on 5/2/25, at 7:10 pm (8 hours after the incident), from LN F, which stated, [Resident 1] has been in pain, I administered Acetaminophen at 6:31(pm) when she complained of 7/10 (moderate) pain. [Resident 1] c/o (complained of) pain in left arm and left leg. The medication is ineffective, [Resident 1's] pain has increased 9/10 (severe), she has been lying in bed on her right side (7 hours since placed in bed). She is in so much pain, staff and I are unable to touch her or obtain VS (vital signs) or to get an assessment she cries out when we attempt care. [Resident 1] didn't touch her dinner tray and refused ensure. The MD stated that after the second Teams message, he immediately called the nurse and had [Resident 1] sent to the ED. The MD stated, Later I found out that a fall (by Resident 1) was witnessed by the housekeeper. There was a lack of documentation about this. The (first) message was misleading. The nurse did not convey that it happened hours before (the 5:33 pm Teams message). She (LN C) indicated that she knew that [Resident 1] intentionally sat on the floor. I had no indication that [Resident 1] had a fall. If the nurse did not witness the incident, then she should have indicated that. If there was pain, then a fall assessment should have been done. If there was pain with movement then they (staff) should not have gotten [Resident 1] up. The MD indicated that if he had been notified right away of the situation, this would have minimized the time [Resident 1] was in pain.</p> <p>During an interview with the DON and record review on 5/14/25, at 3:41 pm, the DON reviewed Resident 1's May 2025 MAR, physician orders, and nurses' progress notes. The DON stated [Resident 1] should have been assessed for a fall when she was on the floor, and the physician should have been promptly notified of [Resident 1's] pain but was not. A review of Resident 1's MAR and physician orders for 5/2/25, indicated that Resident 1 had a pain level of six and seven and received Acetaminophen, which was not ordered for pain above a level of three, and the MD should have been notified to obtain an order for appropriate pain medication, but was not.</p>		