STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555557	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneers Memorial Skilled Nursing Center	320 Cattle Call Dr. Brawley, CA 92227

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on interview, and record review, the facility failed to ensure necessary care and services were provided according to the facility's fall policies and procedures for one resident (Resident 1) reviewed during a Facility Reported Incident (FRI) investigated after an unwitnessed fall. This deficient practice delayed Resident 1's necessary post-fall care and diagnosis (identifying injury from its signs and symptoms using tests) of multiple rib (chest bone) fractures that were sustained. Cross-Reference F-689 Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), per the admission record. A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 4/9/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 10 points out of 15 possible points, which indicated Resident 1 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. A record review of Resident 1 ' s comprehensive MDS dated [DATE] section GG indicated Resident 1 required maximum (helper lifts, holds, or supports limbs [arms and legs]and provides more than half the effort) assistance with toilet transfers, with most recent quarterly MDS, dated [DATE] indicating that Resident 1 had impairment to both lower extremities (legs). A review of Resident 1 ' s facility investigation note, titled UNWITNESSED FALL: [RESIDENT NAME] 4/10 ROOT CAUSE ANALYSIS was conducted. This record indicated: - On 4/10/25, .Resident fell on ,d+[DATE] with injuries to her right ribs . Put on neuros [neuro-checks; assessment that evaluates the brain, and spinal cord functioning, including vital signs, pain, muscle strength, balance, vision and cognitive alertness to think and reason] and monitoring for changes . (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 4/11/25, .Resident returned on 4/14 with Dx [diagnosis] of L2 compression and rib fractures, pain management .Findings: Resident appeared she may have hit the water faucets in the bathtub or the side of the bathtub. Left on the toilet without assist. Avoidable .Inservices [staff education]: Fall Management, do not leave resident unattended. A clinical chart review of Resident 1 ' s fall care plan was conducted. This record indicated: - Date initiated 1/3/25, .The resident is (High) risk for falls r/t [related to] Confusion, gait balance, poor communication/comprehension .Vision/hearing problems .Follow facility fall protocol . - Date initiated 4/11/25, The resident has had an actual fall with injury. 4/10/25 .4rth and 5th rib fractures right side acute (new/sudden) . On 4/28/25 at 12:47 P.M., an interview was conducted with Resident 1. Resident 1 stated that the fall incident happened in the bathroom. Resident 1 stated that the nursing staff put her on the toilet and that she lost balance and fell into the tub. Resident 1 stated she waited for about five minutes for staff to arrive and help her. Resident 1 stated she experienced rib pain after the fall (4/10/25). On 4/28/25 at 12:58 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that on the day of the unwitnessed fall (4/10/25), he was assigned to (care for) Resident 1. CNA 1 stated that the housekeeper heard Resident 1 yelling from the bathroom and said that Resident 1 fell . CNA 1 stated he was assisting another resident before he entered Resident 1 ' s room. CNA 1 stated that when he entered Resident 1 ' s room, he found Resident 1 in the bathtub in a sitting position with both feet hanging out the tub. CNA 1 stated that Resident 1 required minimal to maximal assistance with toileting and transfers. On 4/28/25 at 1:04 P.M., an interview and record review was conducted with licensed nurse (LN) 1. LN 1 stated that on 4/11/25 (one day after the fall) at 6:17 A.M., Resident 1 complained of pain on her right flank (rib area), and she discovered that Resident 1 had a new bruise on her right rib. LN 1 stated she notified Resident 1 ' s physician (MD) and responsible party (RP) on 4/11/25 at 2 P.M. (per the CHANGE OF CONDITION [COC] EVALUATION) about the unwitnessed fall, bruising on the rib area, and that the MD ordered to send the resident to the hospital for X-rays (images of the inside of the body). LN 1 stated they did not perform post-fall neuro-checks (neurological check; assessment that evaluates the brain, and spinal cord functioning to include vital signs, pain, muscle strength, balance, vision and cognitive alertness to think and reason) until the day (4/11/25) after the unwitnessed fall. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/28/25 at 1:18 P.M., an interview was conducted with LN 2. LN 2 stated that on the day of the unwitnessed fall (4/10/25), he assisted Resident 1 to her bathroom and onto the raised toilet seat. LN 2 stated he later saw Resident 1 in the tub with her feet dangling. LN 2 stated he thought that Resident 1 was her own RP (responsible party) and did not notify Resident 1 ' s RP. LN 2 stated he did not notify Resident 1 ' s MD or complete post-fall procedures for neuro-checks immediately after Resident 1 ' s unwitnessed fall, because the former Director of Nursing (DON) told him he did not have to do post fall procedures (i.e. notify MD/RP, neuro-checks, start COC evaluation and revise care plan). LN 2 stated he thought it was a fall, and further stated at any point if I place a patient on the toilet and she [Resident 1] was in another area from where I last placed her and sitting down or on the ground yelling out, in my book it ' s a fall and it should have been processed as an unwitnessed fall. LN 2 stated the fall incident with Resident 1 could have delayed necessary care, and that Resident 1 could have sustained worse complications. On 4/28/25 at 1:25 P.M., an interview with the (current) DON was conducted. The DON stated that the fall protocol and supervision should have been followed to prevent delayed care for Resident 1. The DON stated it was her expectation that the nursing staff followed the facility ' s fall policies and procedures and start neuro-checks immediately after a fall, to monitor for complications such as head injuries, bleeding, fractures that could result, along with death. A review of the facility's policy and procedure titled, FALL MANAGEMENT PROGRAM dated 3/13/21, indicated, .for an unwitnessed fall or witnessed fall with suspected or known head injury, the licensed nurse will complete neurological checks for 72 hours following the fall incident .The attending physician will be informed if there is a deviation from the Resident ' s baseline status for further instructions .15-20 minutes after a fall, the licensed nurse will initiate a Post-fall huddle as part of the Facility ' s internal quality assurance (QA) process .

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F 0689 Level of Harm - Minimal harm or potential for 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** 48263 Based on interview, and record review, the facility failed to provide supervision and maintain a safe environment to prevent accidents for one resident (Resident 1) which resulted in an unwitnessed fall. As a result, this deficient practice resulted in harm for Resident 1, who sustained multiple rib (chest bone) fractures and pain. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), per the Admission Record. A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 4/9/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 10 points out of 15 possible points, which indicated Resident 1 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. A record review of Resident 1 ' s comprehensive MDS dated [DATE], section GG, indicated Resident 1 required maximum (helper lifts, holds, or supports limbs [arms and legs]and provides more than half the effort) assistance with toilet transfers with most recent quarterly MDS dated [DATE] indicating Resident 1 had lower extremity (leg) impairments to both legs. A review of Resident 1 ' s facility investigation entitled, UNWITNESSED FALL: [RESIDENT NAME] 4/10 ROOT CAUSE ANALYSIS was conducted, and indicated: - On 4/10/25, .Resident fell on ,d+[DATE] with injuries to her right ribs . It was reported Resident was assisted to the toilet and waved the Nurse away for privacy while on the toilet . - On 4/11/25, .Resident returned on 4/14 with Dx [diagnosis] of L2 compression and rib fractures, pain management .Findings: Resident appeared she may have hit the water faucets in the bathtub or the side of the bathtub. Left on the toilet without assist. Avoidable .Inservices [staff education]: Fall Management, do not leave resident unattended. A clinical chart review of Resident 1 ' s fall care plan was conducted and indicated: - Date initiated 1/3/25, .The resident is (High) risk for falls r/t [related to] Confusion, gait balance, poor communication/comprehension .Vision/hearing problems .Follow facility fall protocol . - Date initiated 4/11/25, The resident has had an actual fall with injury. 4/10/25 .4rth and 5th rib fractures right side acute (new/sudden) . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/28/25 at 12:47 P.M., an interview was conducted with Resident 1. Resident 1 stated that the fall incident happened in the bathroom. Resident 1 stated that the nursing staff put her on the toilet. Resident 1 stated that after staff left the bathrrom, she lost balance and fell into the tub. Resident 1 stated she waited for about five minutes for staff to arrive and help her. Resident 1 stated she experienced rib pain after the fall (4/10/25). On 4/28/25 at 12:58 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that on the day of the unwitnessed fall (4/10/25), he was assigned to (care for) Resident 1. CNA 1 stated the housekeeper heard Resident 1 yelling from the bathroom and said Resident 1 fell . CNA 1 stated he was assisting another resident before he entered Resident 1 ' s room. CNA 1 stated that when he entered Resident 1 ' s room, he found Resident 1 in the bathtub in a sitting position with both feet hanging out the tub. CNA 1 stated Resident 1 required minimal to maximal assistance with toileting and transfers. On 4/28/25 at 1:18 P.M., an interview was conducted with LN 2. LN 2 stated that on the day of the unwitnessed fall (4/10/25), he assisted Resident 1 to her bathroom and onto the raised toilet seat. LN 2 stated that he later saw Resident 1 in the tub with her feet dangling. LN 2 stated he thought that Resident 1 was her own responsible party (RP). LN 2 stated, .at any point if I place a patient on the toilet and she [Resident 1] was in another area from where I last placed her and sitting down or on the ground yelling out, in my book it's a fall . On 4/28/25 at 1:25 P.M., an interview with the director of nursing (DON) was conducted. The DON stated it was necessary to provide a safe environment and supervision to prevent (residents from having) accidents/fall. A review of the facility's policy and procedure, titled FALL MANAGEMENT PROGRAM dated 3/13/21, indicated, .To provide residents a safe environment . The facility will implement . that supports providing an environment free from fall hazards .