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	04/28/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise fall care plans with resident-specific interventions that addressed supervision needs for two of three residents (Resident 1 and 2) after falls occurred.As a result, there was the potential Resident 1 and 2 to experience further falls.Findings:1. A review of Resident 1's Face Sheet indicated the resident was admitted on [DATE] and re-admitted on [DATE] with diagnoses to include unspecified dementia (progressive brain disorder causing cognitive decline, memory loss, confusion, and behavioral changes), impulse disorder (mental health condition characterized by inability to resist urges or impulses that may harm oneself), anxiety disorder, and a history of falling.A review of Resident 1's Minimum Date Set Assessment (MDS, a comprehensive assessment tool) dated 1/12/26, indicated the resident had a brief interview of mental status (BIMS - a standardized cognitive assessment to measure memory, orientation, and attention) score of three out of 15 which meant the resident was cognitively impaired. The same MDS assessment, Section GG, indicated the resident required maximal assistance provided by one staff to stand up from a seated position and was totally dependent on one or more staff assistance to transfer from chair to bed.A review of Resident 1's progress notes indicated the resident had falls on the following dates:7/11/23 at 7:30 P.M., Resident fell in the hallway in front of the nurses' station.Resident slid out of his wheelchair and onto the ground.4/6/24 at 5:47 A.M., .Fall was not witnessed. Fall occurred in resident's room. Resident complained of pain and was sent to the hospital for evaluation.10/18/24 at 6:40 P.M., .CNA [certified nursing assistant] reported.that resident was found on his knees on the floor mat hanging on to the wheelchair inside the resident's room.11/4/24 at 3:20 A.M., .Resident was found on the floor mat sitting.9/5/25, Patient had an unwitnessed fall in patient's room.patient was recently put back to bed.was later found on the next 30 minutes rounds.sitting on the floor.was sent to ER [emergency room] for further eval.patient do [sic] have history of being impulsive and attempts to transfer without staff assistance.2/16/26 at 2:30 P.M., .Resident sent out 911 to [hospital name].due to unwitnessed fall.3/26/26 at 5:33 A.M., .Resident had an unwitnessed fall in the hallway with two lacerations to forehead and possible right shoulder injury.911 call activated.On 4/13/26 at 3:23 P.M., a joint interview and record review was conducted with the DSD. The DSD stated Resident 1 could not follow directions, did not recognize time, and did not have situational awareness. The DSD stated Resident 1 does what he wants when he wants. The DSD stated Resident 1 could play with the call light but could not use the call light in a purposeful manner. The DSD stated Resident 1 needed someone next to him when he was agitated and trying to stand up. The DSD stated Resident 1 was a high risk for falls and had a higher need for supervision which was why he was placed in front of the nurse's station on 3/26/26. The DSD stated residents were placed in front of the nurses' station in order to have close supervision. The DSD reviewed Resident 1's written care plans for falls. The care plans indicated the following:Care Plan for: Risk for Falls initiated 12/5/25 indicated the goals were to minimize environmental hazards and the resident will be free of falls. The care plan interventions were: Assess fall risk on admission and with any change in condition. Assist Resident with ambulation and transfers, utilizing therapy (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations. Determine Resident's ability to transfer. floor mats to be used for injury prevention. If fall occurs, alert provider. If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. Implement fall precautions per facility protocol. Maintain clutter-free room and clear pathways.Care Plan for: The resident had an actual witnessed fall on 2/16/2026 with (no injury) Poor communication/comprehension initiated 2/17/2026 indicated the goal was for the resident to resume usual activities without further incidents. The care plan interventions were: Medication review. Monitor/document/report PRN [as needed] x 72h [times 72 hours] to MD [Medical Doctor] for s/sx [signs and symptoms]: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Neuro-checks x (72 hours). non skid shoe wear on [sic].The DSD stated the fall precautions in Resident 1's care plans should have been more specific. The DSD stated there was nothing individualized for fall prevention on Resident 1's 12/5/25 fall care plan and neither care plan addressed the resident's supervision needs. The DSD stated the interventions on Resident 1's 2/16/26 fall care plan did not prevent the resident from falling and only addressed care during an actual fall. The DSD stated Resident 1's care plans were not preventative of falls. The DSD reviewed Resident 1's fall care plan dated 3/26/26 and revised 3/27/26, which indicated the following interventions: Contacted hospice MD if authorized to send resident to [hospital]. Monitor/document/report PRN [as needed] x 72h [times 72 hours] to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Neuro-checks x (72 hours).Sent out to ER for further evaluation. The DSD stated the interventions on Resident 1's fall care plan dated 3/26/26 did not prevent any further falls. The DSD stated Resident 1's fall care plans should have been revised with individualized interventions based on the resident's needs.On 4/27/26 at 7:29 A.M., a joint interview and record review was conducted with UM 2. UM 2 stated the interdisciplinary team (IDT) met after each fall to investigate the fall, determine its cause, to gather as much information as possible, and to make proper care plans with interventions that were relevant to the residents' needs.UM 2 then reviewed Resident 1's written care plans for: Risk for Falls initiated 12/5/25, and the resident had an actual witnessed fall on 2/16/2026 with (no injury). UM 2 stated Resident 1's care plans did not address the supervision he needed to prevent falls from occurring. UM 2 stated there was no assessment done to determine Resident 1's supervision needs and this should have been done and appropriately care planned.2. A review of Resident 2's admission Record indicated the resident was admitted on [DATE] with diagnoses to include Alzheimer's Disease (irreversible brain disorder that destroys memory, thinking skills, and ability to carry out daily tasks), unspecified dementia, difficulty walking, and muscle weakness.A review of Resident 2's MDS assessment dated [DATE] indicated the resident had a BIMS score of 5 out of 15 which meant the resident was cognitively impaired. The same MDS assessment, Section GG, indicated the resident required moderate assistance provided by one staff to perform transfers from chair to bed and sitting to standing position.A review of Resident 2's progress notes indicated the resident had falls on the following dates/times:9/28/23, .Resident sustained an assisted fall on 9/25/23.while resident was up in bathroom.9/30/23 at 11:30 P.M., .Resident fell.in her room.Resident hit back of head on the floor.11/18/23 at 3:20 A.M., .Resident found in [sic] floor beside her commode in her room. resident unable to give coherent recall. Resident was bleeding from her head and face.911 called.1/19/24 at 9:45 P.M., .Resident had a witnessed fall. CNA saw her sit on the side of the bed and stood up. CNA asked charge nurse if patient is supposed to get up. While walking back to the patient's room.resident slipped and slowly fell.2/5/24, .Resident sustained a fall on 2/2/24 at [7:50 A.M.].sustained an unwitnessed fall in her room.found lying on top of floor mat.transferred to [hospital name] for evaluation.4/9/24 at 12:35 A.M., .Nurse was alerted to hallway.by CNA to report unwitnessed fall. [Resident 2] was found lying on her left side by her wheelchair, towards the wall, by patio doors.Skin tear noted on [left] elbow.12/12/24 at 7:50 A.M., .Guided fall onto floor mat by two staff members.1/15/26, .Notified AM nurse that resident had an unwitnessed fall next to her wheelchair [at] 6:40 A.M. At the time of the fall AM nurse had been giving report.Resident was found lying on top (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the footrests.Resident reported to have pain to her right buttocks.Resident was unsuccessful in describing pain rate.3/5/26, .[12:19 P.M.] Resident fall [sic] in front nurse station, called 911.3/30/26, .Staff member notified nurse of fall at the dining room.Resident was noted to be sitting on one of the footrests, and the head of the resident was resting on the side of the wheelchair.Resident.has been able to verbalize pain to [left] shoulder, headache, and backache at this time. Called 911.On 4/28/26 at 12:12 P.M., a joint interview and record review was conducted with UM 1. UM 3 was also present. UM 1 stated Resident 2 wanted to remain independent but that the resident had confusion, was frail, and required staff to monitor her every 15 minutes to make sure she was not trying to get up on her own.UM 1 reviewed Resident 2's fall risk evaluation and stated the last fall risk evaluation done before her 1/15/26 fall was in June 2025. The UM stated Resident 2 should have been reassessed for fall risk when her quarterly MDS assessments were done. UM 1 stated her last MDS assessment before her fall was in December 2025. UM 1 reviewed Resident 2's written care plans and stated the care plan for The Resident Is (High) Risk for Falls R/T [related to] Confusion, Gait/Balance Problems, Poor Communication/Comprehension, Unaware of Safety Needs had been created on 9/25/23 with revisions made to the care plan on 9/9/24 and 1/16/26. UM 1 stated this care plan was in place at the time of Resident 2's fall on 1/15/26, and that it was vague. UM 1 reviewed the care plan intervention, If resident is a fall risk, initiate fall precautions. UM 1 stated the resident's fall risk should have been determined a long time ago and had clear fall precautions. UM 1 stated the care plan intervention, Determine Residents ability to transfer, should have been determined a long time ago. UM 1 stated the care plan intervention, increase rounding frequency, date initiated 1/26/26, should have been more clear to include who was responsible for doing the rounding and that it should be at 15 minute intervals. UM 1 reviewed the care plan intervention initiated 1/26/26, .When resident is up on w/c [wheelchair], resident is placed at nursing station. UM 1 stated Resident 2 should not have had another unwitnessed fall on 3/5/26 after being placed in front of the nurses' station for supervision. UM 1 stated adequate supervision should have been provided when Resident 2 was placed in front of the nurses' station.UM 1 reviewed Resident 2's IDT note dated 1/16/26, indicated the IDT met to discuss the resident's fall that occurred on 1/15/26. The IDT note included the confirmation of the resident's compression fracture (occurs when a spinal bone collapses) but lacked any discussion as to the root cause of the fall and had no recommendations to prevent further falls from occurring.On 4/28/26 at 2:55 P.M., a telephone interview was conducted with the interim director of nursing (DON). The DON stated she was hired about two weeks ago. The DON stated, All the residents' falls should not be happening. The DON stated this week she began asking, What are we doing about it? The DON stated she reviewed documentation of residents who had falls over the last few months including Resident 1 and Resident 2 and that there had not been thorough investigations into the cause of the falls. The DON stated the IDT documentation of the falls she reviewed just described the fall but there had been no determination of the root cause. The DON stated, If you don't determine how the fall happened, you can't put relevant interventions in the care plan to prevent further falls. The DON stated falls needed to be investigated and the cause had to be determined. The DON stated care plans should have been updated with individualized interventions after falls occurred to address fall risk and to prevent more from happening.On 4/28/26 at 3:37 P.M., an interview was conducted with the medical records director (MRD). The MRD stated the facility did not have a policy for care plan development or revision.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a registered nurse/unit manager (UM) 2 provided care and services to one of three residents (Resident 1) according to acceptable standards of nursing practice when she falsified a fall interdisciplinary team (IDT) note for Resident 1.As a result of this deficient practice, UM 2's falsified documentation misrepresented the facility's investigation into Resident 1's fall and fall aftercare.Findings:A review of Resident 1's Face Sheet indicated the resident was admitted on [DATE] and re-admitted on [DATE] with diagnoses to include unspecified dementia (progressive brain disorder causing cognitive decline, memory loss, confusion, and behavioral changes), impulse disorder (mental health condition characterized by inability to resist urges or impulses that may harm oneself), anxiety disorder, and a history of falling.A review of Resident 1's IDT Progress Note-Falls dated 4/13/26 at 10:48 A.M., indicated the IDT was composed of the director of rehabilitation, social services director, the director of staff development, infection preventionist, quality assurance nurse, and the MDS coordinator. The IDT note further indicated, .Resident experienced an unwitnessed fall in front of the nurse's station.IDT reviewed the incident and contributing factors, including fall risk status, environment and current care plan. The following interventions will be implemented/reinforced: 30-minute rounding and floor mats.On 4/13/26 at 3:23 P.M., a joint interview and record review was conducted with the director of staff development (DSD). The DSD stated that an IDT meeting was supposed to be conducted after a resident fell in the facility. The DSD stated that there was no IDT conducted to investigate Resident 1's fall on 3/26/26. The DSD reviewed Resident 1's IDT Progress Note-Falls dated 4/13/26. The IDT note indicated the DSD had attended and participated in the IDT meeting. The DSD stated she was not aware of this IDT meeting on 4/13/26 and she was not present during the IDT meeting. On 4/27/26 at 7:29 A.M., a joint interview and record review was conducted with UM 2. UM 2 stated the IDT team met after each fall to investigate the fall, determine its cause, to gather as much information as possible, and to make proper care plans with interventions that were relevant to the residents' needs. UM 2 reviewed documentation of the IDT conducted on 4/13/26 to investigate Resident 1's fall that occurred on 3/26/26. UM 2 stated Resident 1's IDT meeting actually did not occur, and his fall was not investigated. UM 2 stated she was the author of Resident 1's fall IDT note dated 4/13/26. UM 2 stated the IDT members were too busy to conduct Resident 1's fall IDT meeting. UM 2 stated she was aware surveyors were looking into Resident 1's fall and that the IDT for the resident's fall needed to be done. UM 2 stated Resident 1's fall IDT never happened and, It's falsified. UM 2 stated documentation of an IDT meeting should be factual and accurate, reflecting what occurred.On 4/28/26 at 2:38 P.M., an interview was conducted with the administrator (ADM). The ADM stated falsifying resident documentation was unacceptable. The ADM stated his main objective as an administrator of the facility was to promote telling the truth. The ADM stated, We don't lie. We take our lumps and learn from them.On 4/28/26 at 2:55 P.M., a telephone interview was conducted with the interim director of nursing (DON). The DON stated IDT notes and other clinical documentation should be true and accurate.A review of the facility's Position Description for Registered Nurse revised 4/7/25, indicated, .Provides nursing care as prescribed by physicians/health care professionals following the legal scope of practice, any Board of Licensing restrictions, and within established standards of care, policies, and procedures. Administers professional services. Records care information accurately, timely, and concise manner.

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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** Based on observation, interview, and record review, the facility failed to ensure two of three residents (Resident 1 and 2), who were cognitively impaired and had a history of repeated falls, were free from falls with injury when:-Resident 1 and Resident 2's supervision needs were not assessed and care planned with individualized interventions to prevent falls.-Adequate supervision was not provided to Resident 1 and Resident 2.-The root cause of Resident 1 and Resident 2's falls were not thoroughly investigated.As a result:-Resident 1, who was placed in front of the nursing station for supervision, fell from his wheelchair on 3/26/26 after he made repeated attempts to stand up without staff being close enough to intervene. Resident 1 sustained two lacerations to his forehead, had to be sent to the hospital for evaluation, and was then airlifted to a trauma center which revealed the resident had a fracture of his first cervical vertebrae (broken neck near where the spine connects to the head).-Resident 2, who was placed in front of the nursing station for supervision, fell from her wheelchair on 1/15/26 while unsupervised. Resident 2 had to be sent out to the hospital for evaluation which revealed the resident sustained a compression fracture to the first and second lumbar vertebrae (broken back near the middle of the spine). Resident 2 then fell two more times on 3/5/26 and 3/30/26 while unsupervised.Cross reference: F657, F697, F725, F838, F842, F867Findings:1. A review of Resident 1's Face Sheet indicated the resident was admitted on [DATE] and re-admitted on [DATE] with diagnoses to include unspecified dementia (progressive brain disorder causing cognitive decline, memory loss, confusion, and behavioral changes), impulse disorder (mental health condition characterized by inability to resist urges or impulses that may harm oneself), anxiety disorder, and a history of falling.A review of Resident 1's Minimum Date Set Assessment (MDS, a comprehensive assessment tool) dated 1/12/26, indicated the resident had a brief interview of mental status (BIMS - a standardized cognitive assessment to measure memory, orientation, and attention) score of three out of 15 which meant the resident was cognitively impaired. The same MDS assessment, Section GG, indicated the resident required maximal assistance provided by one staff to stand up from a seated position and was totally dependent on one or more staff assistance to transfer from chair to bed.A review of Resident 1's physician's [facility name] History and Physical dated 12/5/25, indicated the resident, .Does not have capacity to understand and make decisions .A review of Resident 1's progress notes indicated the resident had falls on the following dates:7/11/23 at 7:30 P.M., Resident fell in the hallway in front of the nurses' station.Resident slid out of his wheelchair and onto the ground.4/6/24 at 5:47 A.M., .Fall was not witnessed. Fall occurred in resident's room. Resident complained of pain and was sent to the hospital for evaluation.10/18/24 at 6:40 P.M., .CNA [certified nursing assistant] reported.that resident was found on his knees on the floor mat hanging on to the wheelchair inside the resident's room.11/4/24 at 3:20 A.M., .Resident was found on the floor mat sitting.9/5/25, Patient had an unwitnessed fall in patient's room.patient was recently put back to bed.was later found on the next 30 minutes rounds.sitting on the floor.was sent to ER [emergency room] for further eval.patient do [sic] have history of being impulsive and attempts to transfer without staff assistance.2/16/26 at 2:30 P.M., .Resident sent out 911 to [hospital name].due to unwitnessed fall.3/26/26 at 5:33 A.M., .Resident had an unwitnessed fall in the hallway with two lacerations to forehead and possible right shoulder injury.911 call activated.3/26/26 at 1:20 P.M., .The resident has a C1 [first cervical vertebrae - neck bone] fx [fracture] and is being flown out to [trauma hospital] for a neurosurgical (surgery of the nervous system i.e. brain and spinal cord) evaluation.A review of Resident 1's hospital documentation titled Radiology/Diagnostics-Referral dated 3/26/26 at 4:35 PM., indicated, .s/p [status post] fall off wheelchair earlier in the day. Patient has a history of dementia.AOx1 [alert and oriented only to self] at baseline. After the fall, patient presented to [local hospital] where CT [computed tomography - a medical imaging test] C [cervical] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	spine showed a C1 fracture.Pain due to trauma.On 4/13/26 at 9:35 A.M., an observation was conducted inside Resident 1's room. Resident 1 was lying in bed with his eyes closed and the resident did not respond to interview attempts. On 4/13/26 at 9:55 A.M., a telephone interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated Resident 1 was frequently agitated, confused, and often would try to get out of bed. CNA 5 stated Resident 1 could not follow instructions and was not able to use the call light in a purposeful manner. CNA 5 stated when Resident 1 was agitated and trying to get out of bed, staff would need to stay with him and supervise him. CNA 5 stated this was because Resident 1 had fallen several times before the incident on 3/26/26.On 4/13/26 at 10:50 A.M., an interview was conducted with CNA 6. CNA 6 stated Resident 1 could become aggressive during care and would require two-person assistance. CNA 6 stated Resident 1 would attempt to pull out his urinary catheter (a tube that goes into the bladder to remove urine) and take off his clothes while agitated. CNA 6 stated Resident 1 could not clearly communicate his needs and could only say mama and sometimes yes or no. CNA 6 stated Resident 1 would lean forward in his wheelchair while attempting to get up. CNA 6 stated Resident 1 was at risk for falls.On 4/13/26 at 11:10 A.M., video footage of the nursing station on Unit B on 3/26/26 was reviewed. The administrator (ADM), Director of Staff Development (DSD), and the unit manager (UM) 1 for Station B were present. The DSD played the video footage which indicated:At 12 A.M., Resident 1 was brought out of his room in his wheelchair and was placed in front of the nurses' station.At 4:52 A.M., Licensed Nurse (LN) 8 was sitting next to Resident 1 while he was in front of the nurses' station.Resident 1 was observed sitting in his wheelchair in front of the nurses' station continuously from midnight to 5 A.M. Then, at 5:01 A.M., Resident 1 was observed trying to get up from his wheelchair. Staff brought Resident 1 back to his room.At 5:11 A.M., staff brought Resident 1 out of his room in his wheelchair and placed him back in front of the nurses' station. Resident 1 was observed leaning forward in his wheelchair. The DSD stated when Resident 1 was observed leaning forward in the wheelchair, this was an attempt to stand up.At 5:25 A.M., Resident 1 was observed trying to stand up. LN 8 assisted the resident to sit back down in his wheelchair. LN 8 left the resident's side to attend to other tasks. Resident 1 immediately attempted to get back up from his wheelchair.At 5:26 A.M., Resident 1 was observed leaning forward in his wheelchair. The resident then stood up from his wheelchair. LN 8 rushed over to the resident to assist him back to a sitting position in his wheelchair. LN 8 then left the resident's side to attend to other tasks. Resident 1 immediately attempted to get back up from his wheelchair.At 5:27 A.M., Resident 1 stood up from his wheelchair. LN 8 rushed over to the resident to assist him back to a sitting position in his wheelchair. LN 8 left the resident's side to attend to other tasks. Resident 1 immediately attempted to get back up from his wheelchair.At 5:28 A.M., Resident 1 was observed leaning forward and trying to get back up from his wheelchair.At 5:29 A.M., LN 8 was observed in the nurses' station with her back turned away from the resident while doing other tasks. Resident 1 stood up from his wheelchair and then fell forward and was no longer in view of the camera. LN 8 rushed over to the resident's last known position. Other staff were observed gathering around the resident's last known position and tending to the resident.At 5:40 A.M., an emergency response team arrived at the facility.At 5:46 A.M., the emergency response team placed Resident 1 on a gurney and took him from the facility.On 4/13/26 at 2:46 P.M., an interview was conducted with LN 7. LN 7 stated Resident 1 was confused and did not understand instructions and could not follow directions. LN 7 stated Resident 1 often attempted to get up from his wheelchair. LN 7 stated Resident 1 needed somebody to calm him down and to sit with him side by side when he was awake, like a babysitter, for his own safety. LN 7 stated when Resident 1 continuously attempted to stand up, the resident needed a staff member to be right next to his side to prevent the fall.On 4/13/26 at 3:23 P.M., a joint interview and record review was conducted with the DSD. The DSD stated Resident 1 could not follow directions, did not recognize time, and did not have situational awareness. The DSD stated Resident 1 does what he wants when he wants. The DSD stated Resident 1 could play with the call light but could not use the call light in a purposeful manner. The DSD stated Resident 1 needed someone next (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	to him when he was agitated and trying to stand up. The DSD stated Resident 1 was a high risk for falls and had a higher need for supervision which was why he was placed in front of the nurse's station on 3/26/26. The DSD stated residents were placed in front of the nurses' station in order to have close supervision. The DSD reviewed Resident 1's written care plans for falls. The care plans indicated the following:Care Plan for: Risk for Falls initiated 12/5/25 indicated the goals were to minimize environmental hazards and the resident will be free of falls. The care plan interventions were: Assess fall risk on admission and with any change in condition. Assist Resident with ambulation and transfers, utilizing therapy recommendations. Determine Resident's ability to transfer. floor mats to be used for injury prevention. If fall occurs, alert provider. If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. Implement fall precautions per facility protocol. Maintain clutter-free room and clear pathways.Care Plan for: The resident had an actual witnessed fall on 2/16/2026 with (no injury) Poor communication/comprehension initiated 2/17/2026 indicated the goal was for the resident to resume usual activities without further incidents. The care plan interventions were: Medication review. Monitor/document/report PRN [as needed] x 72h [times 72 hours] to MD [Medical Doctor] for s/sx [signs and symptoms]: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Neuro-checks x (72 hours). non skid shoe wear on [sic].The DSD stated the fall precautions in Resident 1's care plans should have been more specific. The DSD stated there was nothing individualized for fall prevention on Resident 1's 12/5/25 fall care plan and neither care plan addressed the resident's supervision needs. The DSD stated the interventions on Resident 1's 2/16/26 fall care plan did not prevent the resident from falling and only addressed care during an actual fall. The DSD stated Resident 1's care plans were not preventative of falls. The DSD reviewed Resident 1's fall care plan dated 3/26/26 and revised 3/27/26, which indicated the following interventions: Contacted hospice MD if authorized to send resident to [hospital]. Monitor/document/report PRN [as needed] x 72h [times 72 hours] to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Neuro-checks x (72 hours).Sent out to ER for further evaluation. The DSD stated the interventions on Resident 1's fall care plan dated 3/26/26 did not prevent any further falls. The DSD stated Resident 1's fall care plans should have been individualized and based on the resident's needs.On 4/14/26 at 2:12 P.M., a telephone interview was conducted with LN 8. LN 8 stated Resident 1 was not alert and could only say yes or no. LN 8 stated Resident 1 could not use the call light and could not verbalize what he wanted or needed. LN 8 stated Resident 1 could become restless and agitated. LN 8 stated Resident 1 had been having a lot of falls. LN 8 stated she had to bring Resident 1 out of his room around midnight on 3/26/26 because she could not see what the resident was doing inside his room. LN 8 stated Resident 1 would need a sitter to stay with him in his room. LN 8 stated Resident 1 needed to be supervised closely in front of the nurses' station so he would not fall in his room. LN 8 stated Resident 1 kept attempting to get up from his wheelchair on 3/26/26. LN 8 stated she was busy doing nursing tasks when Resident 1 fell from his wheelchair. LN 8 stated when Resident 1 kept attempting to stand up, he needed 1:1 supervision (staff to provide continuous supervision to the resident). LN 8 stated there was not enough staff to provide the 1:1 supervision Resident 1 required at that time. LN 8 stated she could not tell if Resident 1 was in pain after his fall and that she did not know how to recognize the resident's expression of pain. LN 8 stated if she hit her head and had a laceration, it would hurt. LN 8 stated there was not enough staff to attend to the residents requiring supervision. LN 8 stated they needed more staff when she was doing med pass and when CNAs were doing showers and changing briefs. LN 8 stated there had been a lot of falls during these times when staff were busiest from 8 P.M. to 10 P.M. and 5 A.M. to 7 A.M. LN 8 stated there were incidents of residents falling in front of the nurses' station because staff were distracted by other tasks and there was not a designated staff to supervise them. LN 8 stated when she asked for additional staff to help the night shift, she was told there were no staff available to work.On 4/16/26 at 3:54 P.M., a telephone interview was conducted with Resident 1's family member (continued on next page)

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Pioneers Memorial Skilled Nursing Center	320 Cattle Call Dr. Brawley, CA 92227

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(FM). The FM stated Resident 1's fall on 3/26/26 was not the first fall. The FM stated Resident 1 was confused and someone should always stay with the resident to supervise him. The FM stated Resident 1 had pain in the lower back and would try to stand up and move to alleviate his pain. The FM stated Resident 1 would get agitated and aggressive when he was in pain. The FM stated she did not think staff knew when Resident 1 was in pain.On 4/21/26 at 12:11 P.M., a telephone interview was conducted with Resident 1's responsible party (RP). The RP stated Resident 1 had dementia and could not remember who he was and where he was. The RP stated Resident 1 had back pain. The RP stated Resident 1 would get agitated at nighttime. The RP stated Resident 1 had weak legs and had fallen many times in the facility. The RP stated the facility would place Resident 1 in front of the nurses' station for supervision. The RP stated the facility did not have enough staff to take care of Resident 1. The RP further stated a facility staff told her the facility was short staffed.On 4/27/26 at 6:32 A.M., an interview was conducted with unit manager (UM) 2 while on Unit A. UM 2 stated the residents with dementia, confusion, agitation, or those who were making attempts to get out of bed, were brought out to the nurses' station. UM 2 stated they were placed in front of the nurses' station for visual monitoring and supervision. UM 2 stated nursing staff were unable to provide the level of continuous supervision residents needed when placed at the nurses' station because nursing staff were too busy from 4 A.M. to 7 A.M. taking care of other residents.On 4/27/26 at 7:04 A.M., an interview was conducted with Licensed nurse (LN) 12. LN 7 was also present. LN 12 stated, There's a big staffing problem here. LN 12 stated there had been A lot of falls related to not enough staff to supervise. LN 12 stated, Residents are brought out to the nurses' station for supervision, how is it they fall and it's unwitnessed? LN 12 stated Resident 1 fell on 3/26/26 because there were not enough staff to watch him close enough. LN 7 nodded her head and stated, Yes, exactly.A review of Resident 1's interdisciplinary team (IDT) Progress Note-Falls dated 2/17/26, .Resident had a unwitnessed fall on 2/16/26 while doing 30 minute rounding CNA found resident sitting on the floor mat. Recommendation medication review, 30 minute rounding, non-skid foot wear, follow up with urology.antibiotic treatment. Care plan updated. The IDT did not determine the root cause of the fall, and it was unclear how the recommendations were determined or if they were pertinent. A review of Resident 1's interdisciplinary team (IDT) Progress Note-Falls dated 4/13/26 at 10:48 A.M., indicated the IDT team was composed of the director of rehabilitation, social services director, the director of staff development, infection preventionist, quality assurance nurse, and the MDS coordinator. The IDT note further indicated, .Resident experienced an unwitnessed fall in front of the nurse's station.IDT reviewed the incident and contributing factors, including fall risk status, environment and current care plan. The following interventions will be implemented/reinforced: 30-minute rounding and floor mats. The IDT note did not determine the root cause of the fall and the interventions to be implemented were not relevant to where and how the fall occurred.On 4/27/26 at 7:29 A.M., a joint interview and record review was conducted with UM 2. UM 2 stated the interdisciplinary team (IDT) met after each fall to investigate the fall, determine its cause, to gather as much information as possible, and to make proper care plans with interventions that were relevant to the residents' needs. UM 2 reviewed the IDT conducted on 4/13/26 to review Resident 1's fall that occurred on 3/26/26. UM 2 stated the IDT was not timely and should have been conducted when Resident 1 was readmitted after his fall on 4/8/26. UM 2 stated Resident 1's IDT actually did not occur, and his fall was not investigated. UM 2 stated she was the author of Resident 1's fall IDT note dated 4/13/26 and, It's falsified. UM 2 stated documentation of an IDT meeting should be factual and accurate, reflecting what occurred. UM 2 further stated the recommendations she documented on the IDT note were not relevant and that 30 minute rounding was not sufficient to meet Resident 1's needs. UM 2 reviewed Resident 1's IDT note dated 2/17/26 for the 2/16/26 fall and stated Resident 1 needed more supervision than every 30 minutes and that was not effective in preventing a fall.UM 2 then reviewed Resident 1's written care plans for: Risk for Falls initiated 12/5/25, and the resident had an actual witnessed fall on 2/16/2026 with (no injury). UM 2 stated Resident 1's care plans did not address the supervision he needed to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	prevent falls from occurring. UM 2 stated there was no assessment done to determine Resident 1's supervision needs and this should have been done and appropriately care planned.On 4/27/26 at 11:08 A.M., a joint interview and record review was conducted with UM 1. UM 1 stated she was familiar with Resident 1 and that the resident expressed pain by facial grimacing or grabbing at his back and saying, mama. UM 1 stated when Resident 1 kept trying to stand up on 3/26/26, the LN should have assessed him to see if he had pain. UM 1 stated Resident 1 had been antsy the night of 3/26/26 and he would frequently try to move or get up out of bed when in pain. UM 1 reviewed Resident 1's clinical record and stated the resident had not been assessed for pain when he presented as agitated on 3/26/26.On 4/27/26 at 1:50 P.M., another interview was conducted with UM 1. UM 1 stated residents were brought to the nurses' station because they had an increased need for monitoring and supervision and were at high risk for falls. UM 1 stated the facility was not staffing according to the residents' supervision needs and residents were getting hurt. UM 1 stated nursing staff on the floor were too busy to supervise those residents at the nurses' station and that she had seen this while reviewing video footage of prior fall incidents. UM 1 stated she noticed falls were happening frequently around the change of shift (5 A.M. to 7 A.M.) because there was no one to focus on supervision.On 4/28/26 at 12:12 P.M., a joint interview and record review was conducted with UM 1. UM 3 was also present. UM 1 stated conducting a resident fall risk evaluation quarterly and after a fall occurred was required for developing pertinent interventions on residents' care plans to prevent falls from occurring. UM 1 stated it was important that the fall risk evaluation be accurate. UM 1 reviewed Resident 1's Fall risk evaluation dated 2/16/26 and stated the evaluation was inaccurate. UM 1 stated Resident 1 was assessed to be alert/oriented x3 (a person with no cognitive impairment) and ambulatory. UM 1 stated Resident 1 was confused all the time since admission and was chairbound since the beginning of this year. UM 1 stated the fall risk evaluation's clinical suggestions were for the resident to have a pressure sensor alarm (device to alert staff when a resident was getting up), non-skid shoes for ambulation, and to utilize a toileting program. UM 1 stated clinical suggestions based off the fall evaluation were to be placed on a resident's care plan. UM 1 stated the clinical suggestions based off Resident 1's fall risk evaluation were not applicable and did not address his specific needs. UM 1 stated the facility did not use sensor alarms as they were considered a restraint. UM 1 stated Resident 1 used a urinary catheter and due to cognitive impairment, would not benefit from a toileting program. UM 1 stated the assessment did not help prevent the fall from occurring on 3/26/26 and should have accurately addressed Resident 1's supervision needs.On 5/4/26 at 3:40 P.M., a telephone interview was conducted with Resident 1's medical doctor (MD). The MD stated Resident 1 had very advanced dementia. The MD stated Resident 1 had a neck fracture because of his fall on 3/26/26. The MD stated Resident 1's health condition had been steadily declining which could be due to neck pain from the fracture. The MD stated Resident 1, due to his cognitive issues, could not articulate his pain. The MD stated Resident 1 had been less impulsive with his behavior since his fall on 3/26/26. The MD stated Resident 1's declining health status after his 3/26/26 fall was a combination of both advancing dementia and the fall with fracture.2. A review of Resident 2's admission Record indicated the resident was admitted on [DATE] with diagnoses to include Alzheimer's Disease (irreversible brain disorder that destroys memory, thinking skills, and ability to carry out daily tasks), unspecified dementia, difficulty walking, and muscle weakness.A review of Resident 2's MDS assessment dated [DATE] indicated the resident had a BIMS score of 5 out of 15 which meant the resident was cognitively impaired. The same MDS assessment, Section GG, indicated the resident required moderate assistance provided by one staff to perform transfers from chair to bed and sitting to standing position.A review of Resident 2's physician's [facility name] History and Physical exam dated 1/23/26, indicated the resident did not have capacity to understand and make decisionsA review of Resident 2's progress notes indicated the resident had falls on the following dates/times:9/28/23, .Resident sustained an assisted fall on 9/25/23.while resident was up in bathroom.9/30/23 at 11:30 P.M., .Resident fell.in her room.Resident hit back of head on the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	floor.11/18/23 at 3:20 A.M., .Resident found in [sic] floor beside her commode in her room. resident unable to give coherent recall. Resident was bleeding from her head and face.911 called.1/19/24 at 9:45 P.M., .Resident had a witnessed fall. CNA saw her sit on the side of the bed and stood up. CNA asked charge nurse if patient is supposed to get up. While walking back to the patient's room.resident slipped and slowly fell.2/5/24, .Resident sustained a fall on 2/2/24 at [7:50 A.M.].sustained an unwitnessed fall in her room.found lying on top of floor mat.transferred to [hospital name] for evaluation.4/9/24 at 12:35 A.M., .Nurse was alerted to hallway.by CNA to report unwitnessed fall. [Resident 2] was found lying on her left side by her wheelchair, towards the wall, by patio doors.Skin tear noted on [left] elbow.12/12/24 at 7:50 A.M., .Guided fall onto floor mat by two staff members.1/15/26, .Notified AM nurse that resident had an unwitnessed fall next to her wheelchair [at] 6:40 A.M. At the time of the fall AM nurse had been giving report.Resident was found lying on top of the footrests.Resident reported to have pain to her right buttocks.Resident was unsuccessful in describing pain rate.3/5/26, .[12:19 P.M.] Resident fall [sic] in front nurse station, called 911.3/30/26, .Staff member notified nurse of fall at the dining room.Resident was noted to be sitting on one of the footrests, and the head of the resident was resting on the side of the wheelchair.Resident.has been able to verbalize pain to [left] shoulder, headache, and backache at this time. Called 911.A review of Resident 2's hospital discharge documentation dated 1/22/26, indicated, . [Resident 2] with advanced dementia .was admitted after a mechanical fall from her wheelchair.Initial evaluation revealed a compression fracture of the lumbar (lower back) spine (L1-L2), which was managed conservatively with pain control.On 4/27/26 at 8:57 A.M., an interview was conducted with UM 1. UM 1 stated there was video footage of Resident 2's fall on 1/15/26; however, at this time, the footage was no longer retrievable and had been automatically deleted. UM 1 stated she did view the video footage at the time of the incident and stated Resident 2 had been sitting in her wheelchair in front of the nurses' station. UM 1 stated two nurses had been nearby, but they were in the process of doing report (process where nurses handoff their assignment to the next nurse and update the oncoming nurse). UM 1 stated the nurses had been busy and distracted. UM 1 stated it was during that time; Resident 2 stood up from her wheelchair and then fell. UM 1 stated Resident 2 sustained a back fracture from the fall.On 4/28/26 at 10:44 A.M., an interview was conducted with CNA 13. CNA 13 stated she was quite familiar with Resident 2. CNA 13 stated Resident 2 often would stick to herself, was quiet, and forgetful. CNA 13 stated Resident 2 was able to listen and follow directions but would often want to do things her own way. CNA 13 stated Resident 2 liked to do things herself and frequently would not ask for help. CNA 13 stated Resident 2 would get up and change positions independently without letting staff know. CNA 13 stated because of this, Resident 2 should have more frequent monitoring at least every 15 minutes to ensure she did not try to get up without asking for help. CNA 13 stated checking up on Resident 2 every 30 minutes was too long to catch her trying to get up. CNA 13 stated there was not enough staff to provide more frequent supervision. CNA 13 stated CNAs did not have time to document the care they provided to residents and had to stay after their shift to catch up on that. CNA 13 stated they did not have enough staff to monitor Resident 2 every 15 minutes.On 4/28/26 at 11:07 A.M., an interview was conducted with CNA 14. CNA 14 stated Resident 2 was confused but was still able to listen and follow directions. CNA 14 stated Resident 2 was very independent and seemed unaware of her own frailty and need for assistance. CNA 14 stated Resident 2 had poor safety awareness and, She won't wait if she wants to do something. CNA 14 stated Resident 2 was able to use the call light but often chose not to. CNA 14 stated Resident 2 does not usually ask for help and will transfer herself. CNA 14 stated Resident 2 should have monitoring every 15 minutes because she will get up without asking for help. CNA 14 stated the facility did not have enough staff to provide the level of supervision Resident 2 needed. CNA 14 stated she was responsible for 17 residents today, with 5 residents needing showers, and seven residents who required the use of a mechanical lift (residents who cannot get out of bed on their own and require a greater degree of staff assistance with care). CNA 14 stated, Staffing here's a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	big problem. We're tired. It's too much.On 4/28/26 at 12:12 P.M., a joint interview and record review was conducted with UM 1. UM 3 was also present. UM 1 stated Resident 2 wanted to remain independent but that the resident had confusion, was frail, and required staff to monitor her every 15 minutes to make sure she was not trying to get up on her own. UM 1 stated, We can't staff to meet her supervision needs and those of other residents needing increased supervision. UM 1 reviewed Resident 2's fall risk evaluation and stated the last fall risk evaluation done before her 1/15/26 fall was in June 2025. The UM stated Resident 2 should have been reassessed for fall risk when her quarterly MDS assessments were done. UM 1 stated her last MDS assessment before her fall was in December 2025. UM 1 reviewed Resident 2's written care plans and stated the care plan for The Resident Is (High) Risk for Falls R/T [related to] Confusion, Gait/Balance Problems, Poor Communication/Comprehension, Unaware of Safety Needs had been created on 9/25/23 with revisions made to the care plan on 9/9/24 and 1/16/26. UM 1 stated this care plan was in place at the time of Resident 2's fall on 1/15/26, and that it was vague. UM 1 reviewed the care plan intervention, If resident is a fall risk, initiate fall precautions. UM 1 stated the resident's fall risk should have been determined a long time ago and had clear fall precautions. UM 1 stated the care plan intervention, Determine Residents ability to transfer, should have been determined a long time ago. UM 1 stated the care plan intervention, increase rounding frequency, date initiated 1/26/26, should have been more clear to include who was responsible for doing the rounding and that it should be at 15 minute intervals. UM 1 reviewed the care plan intervention initiated 1/26/26, .When resident is up on w/c [wheelchair], resident is placed at nursing station. UM 1 stated Resident 2 should not have had another unwitnessed fall on 3/5/26 after being placed in front of the nurses' station for supervision. UM 1 stated adequate supervision should have been provided when Resident 2 was placed in front of the nurses' station.UM 1 reviewed Resident 2's IDT note dated 1/15/26, indicated the IDT met to discuss the resident's fall that occurred on 1/15/26. The IDT note did not include any discussion as to the root cause of the fall and had no recommendations to prevent further falls from occurring.UM 1 reviewed Resident 2's IDT note dated 1/16/26, indicated the IDT met to discuss the resident's fall that occurred on 1/15/26. The IDT note included the confirmation of the resident's compression fracture (occurs when a spinal bone collapses) but lacked any discussion as to the root cause of the fall and had no recommendations to prevent further falls from occurring.UM 1 stated the IDT notes did not indicate that a thorough investigation was done, did not determine a root cause of the fall, and did not recommend interventions to prevent further falls. UM 1 stated this should have been done.On 4/28/26 at 2:21 P.M., an observation and interview was conducted with Resident 2 while inside the resident's room. Resident 2 was observed lying in bed. Resident 2 stated she did not remember having any falls in the facility. Resident 2 stated she did not recall having a fall and injuring her back. R

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pain management was provided to one of three residents (Resident 1) according to acceptable standards of practice, when:1. Resident 1's pain was not assessed on 3/26/26 when the resident was behaving in an agitated and antsy manner.2. Resident 1's pain assessments were based off a self-rated numeric scale (resident self-rates their pain level with 10 being the most pain possible and zero being no pain) when the resident was not cognitively able to express pain that way.3. Resident 1's pain care plan was not individualized or resident specific.As a result of these deficient practices, there were nursing staff who were unaware of how Resident 1 expressed pain. This had the potential for Resident 1's pain to go unmanaged.Findings:A review of Resident 1's admission record indicated the resident was admitted on [DATE] and re-admitted on [DATE] with diagnoses to include unspecified dementia (progressive brain disorder causing cognitive decline, memory loss, confusion, and behavioral changes), impulse disorder (mental health condition characterized by inability to resist urges or impulses that may harm oneself), anxiety disorder, and a history of falling.A review of Resident 1's Minimum Date Set Assessment (MDS, a comprehensive assessment tool) dated 1/12/26, indicated the resident had a brief interview of mental status (BIMS) score of three out of 15 which meant the resident was cognitively impaired. A review of Resident 1's physician's [facility name] History and Physical dated 12/5/25, indicated the resident, .Does not have capacity to understand and make decisions. A review of Resident 1's progress notes dated 3/26/26 at 5:33 A.M., indicated, .Resident had an unwitnessed fall in the hallway with two lacerations to forehead and possible right shoulder injury.911 call activated.A review of Resident 1's progress notes dated 3/26/26 at 1:20 P.M., indicated, .The resident has a C1 [first cervical vertebrae] fx [fracture] and is being flown out to [trauma hospital] for a neurosurgical evaluation.On 4/13/26 at 10:50 A.M., an interview was conducted with certified nursing assistant (CNA) 6. CNA 6 stated Resident 1 could become aggressive during care and would require two-person assistance. CNA 6 stated Resident 1 would attempt to pull out his urinary catheter (a tube that goes into the bladder to remove urine) and take off his clothes while agitated. CNA 6 stated Resident 1 could not clearly communicate his needs and could only say mama and sometimes yes or no. CNA 6 stated Resident 1 would lean forward in his wheelchair while attempting to get up. CNA 6 stated Resident 1 was at risk for falls.On 4/13/26 at 11:10 A.M., video footage of nursing station B on 3/26/26 was reviewed. The administrator (ADM), Director of Staff Development (DSD), and the unit manager (UM) 1 for Station B were present. The DSD played the video footage which indicated:At 12 A.M., Resident 1 was brought out of his room in his wheelchair and was placed in front of the nurses' station.At 4:52 A.M., Licensed Nurse (LN) 8 was sitting next to Resident 1 while he was in front of the nurses' station.Resident 1 was observed sitting in his wheelchair in front of the nurses' station for five hours. Then, at 5:01 A.M., Resident 1 was observed trying to get up from his wheelchair. Staff brought Resident 1 back to his room.At 5:11 A.M., staff brought Resident 1 out of his room in his wheelchair and placed him back in front of the nurses' station. Resident 1 was observed leaning forward in his wheelchair. The DSD stated when Resident 1 was observed leaning forward in the wheelchair, this was an attempt to stand up. At 5:25 A.M., Resident 1 was observed trying to stand up. LN 8 assisted the resident to sit back down in his wheelchair. LN 8 left the resident's side to attend to other tasks. Resident 1 immediately attempted to get back up from his wheelchair.At 5:26 A.M., Resident 1 was observed leaning forward in his wheelchair. The resident then stood up from his wheelchair. LN 8 rushed over to the resident to assist him back to a sitting position in his wheelchair. LN 8 left the resident's side to attend to other tasks. Resident 1 immediately attempted to get back up from his wheelchair.At 5:27 A.M., Resident 1 stood up from his wheelchair. LN 8 rushed over to the resident to assist him back to a sitting position in his wheelchair. LN 8 left the resident's side to attend to other tasks. Resident 1 immediately attempted to get back up from his wheelchair.At 5:28 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A.M., Resident 1 was observed leaning forward and trying to get back up from his wheelchair.At 5:29 A.M., LN 8 was observed in the nurses' station with her back turned away from the resident while doing other tasks. Resident 1 stood up from his wheelchair and then fell forward and was no longer in view of the camera. LN 8 rushed over to the resident's last known position. Other staff were observed gathering around the resident's last known position and tending to the resident.At 5:40 A.M., emergency response team arrived at the facility.At 5:46 A.M., the emergency response team placed Resident 1 on a gurney and took him from the facility.On 4/14/26 at 2:12 P.M., a telephone interview was conducted with LN 8. LN 8 stated Resident 1 was not alert and could only say yes or no. LN 8 stated Resident 1 could not use the call light and could not verbalize what he wanted or needed. LN 8 stated Resident 1 could become restless and agitated. LN 8 stated Resident 1 had been having a lot of falls. LN 8 stated she had to bring Resident 1 out of his room around midnight on 3/26/26 because she could not see what the resident was doing inside his room. LN 8 stated Resident 1 would need a sitter to stay with him in his room. LN 8 stated Resident 1 needed to be supervised closely in front of the nurses' station so he would not fall in his room. LN 8 stated Resident 1 kept attempting to get up from his wheelchair on 3/26/26. LN 8 stated she was busy doing nursing tasks when Resident 1 fell from his wheelchair. LN 8 stated when Resident 1 kept attempting to stand up, he needed 1:1 supervision (staff to provide continuous supervision to the resident). LN 8 stated she could not tell if Resident 1 was in pain after his fall and that she did not know how to recognize the resident's expression of pain.On 4/16/26 at 3:54 P.M., a telephone interview was conducted with Resident 1's family member (FM). The FM stated Resident 1 had pain in the lower back and would try to stand up and move to alleviate his pain. The FM stated Resident 1 would get agitated and aggressive when he was in pain. The FM stated she did not think staff knew when Resident 1 was in pain.On 4/27/26 at 11:08 A.M., a joint interview and record review was conducted with UM 1. UM 1 stated she was familiar with Resident 1 and that the resident was cognitively impaired and expressed pain by facial grimacing or grabbing at his back and saying, mama. UM 1 stated when Resident 1 kept trying to stand up on 3/26/26, the LN should have assessed him to see if he had pain. UM 1 stated Resident 1 had been antsy the night of 3/26/26 and he would frequently try to move or get up out of bed when in pain. UM 1 reviewed Resident 1's clinical record and stated the resident had not been assessed for pain when he presented as agitated. UM 1 stated he could have been in pain which was why he was trying to get up. UM 1 stated if she had been sitting in a wheelchair since midnight, her back may be hurting, too. UM 1 reviewed Resident 1's written care plan for Resident at Risk for Pain dated 2/26/24, and stated the care plan did not identify the way the resident expressed pain and did not include relevant ways to assess his pain and personalized interventions to address it. UM 1 reviewed Resident 1's written care plan for Acute Pain/Chronic Pain dated 5/7/24, and stated the care plan was not individualized to the way the resident expressed pain and also included administering pain medications via a self-rating scale. UM 1 reviewed Resident 1's MAR for March and April 2026.Resident 1's March and April 2026 MARs indicated:-Monitor for pain every shift and chart intensity of pain using 1-10 numeric pain scale 0=no pain, 1-4 =mild pain, 5-7 =moderate pain, 10=excruciating. The MAR indicated Resident 1 had self-rated his pain as zero on 3/1 through 3/25/26 and 4/8 through 4/26/26.-Morphine Sulfate (a controlled pain medication) 20 mg/ml (milligrams per milliliter) give 0.25 ml every three hours as needed for pain. The MAR indicated Resident 1 had self-rated his pain on 3/1/26 as 10 out of 10 and on 3/2/26 at 1:31 A.M., self-rated his pain as 10 out of 10, and at 11:22 P.M., self-rated his pain as 7 out of 10. Resident 1's pain was self-rated as 8 out of 10 on 3/20/26 and 5 out of 10 on 3/21/26. Resident 1's pain was self-rated as 8 out of 10 on 4/14/26, and 5 out of 10 on 4/15/26.UM 1 stated Resident 1's pain being recorded as numerical self-ratings made her question the validity of the pain assessment. UM 1 stated Resident 1 was not capable of self-rating his pain. UM 1 stated even self-rating of zero was questionable. UM 1 stated when it came to the numeric scale, He can't use it.On 4/28/26 at 2:55 P.M., a telephone interview was conducted with the interim director of nursing (DON). The DON stated Resident 1 was (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not capable of self-rating his pain using a numerical scale. The DON stated Resident 1's pain management should have been individualized to meet his needs.On 5/4/26 at 3:40 P.M., a telephone interview was conducted with Resident 1's medical doctor (MD). The MD stated Resident 1 had very advanced dementia. The MD stated Resident 1 had a neck fracture because of his fall on 3/26/26. The MD stated Resident 1's health condition had been steadily declining which could be due to neck pain from the fracture. The MD stated Resident 1, due to his cognitive issues, could not articulate his pain. The MD stated Resident 1 could have been experiencing discomfort from sitting in his wheelchair for five hours on 3/26/26. The MD stated LN 8 should have assessed if Resident 1 had been experiencing pain when he kept trying to get up from his wheelchair on 3/26/26.A review of the facility's policy titled Pain Management revised November 2016, indicated, . To ensure the assessment and management of the resident's pain to the extent possible when such services are required.Facility staff will help the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain to the extent possible.If the resident cannot verbalize the intensity of their pain, the licensed nurse will assess the resident's pain based on non-verbal cues. (examples of non-verbal cues : grimacing, increased confusion, restlessness, distressed behavior, guarding of a body part, refusal of care and repositioning, not eating or sleeping, increased heart rate, blood pressure, or respirations) .

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure it had sufficient nursing staff on duty to provide supervision to 14 of 14 residents who were at high risk for falls and needed increased supervision due to cognitive impairment when:1. Resident 1, who was placed in front of the nurses' station on 3/26/26 for supervision, made repeated attempts to stand up from his wheelchair while staff were busy performing other tasks. Resident 1 had an unwitnessed fall at 5:29 A.M. while in front of the nurses' station.2. Resident 2, who was placed in front of the nurses' station for supervision on 1/15/26, had an unwitnessed fall at 6:30 A.M. while staff were busy performing other tasks.3a. Residents 40, 41, 42, 3, and 44, were placed in front of the nurses' station on Unit B for supervision on 4/27/26. Consistent supervision was not provided to these residents.3b. Residents 2, 20, 21, 30, 23, 25, 27, and 29, were placed in front of the nurses' station on Unit A for supervision on 4/27/26. Consistent supervision was not provided to these residents.As a result of these failures:1. Resident 1 sustained two lacerations to his forehead, had to be sent to the hospital for evaluation, and was then airlifted to a trauma center which revealed the resident had a fracture of his first cervical vertebrae (broken neck near where the spine connects to the head).2. Resident 2 had to be sent out to the hospital for evaluation which revealed the resident sustained a compression fracture to the first and second lumbar vertebrae (broken back near the middle of the spine). Resident 2 then fell two more times on 3/5/26 and 3/30/26 while unsupervised.3a. and 3b. The facility did not have enough staff on duty to provide supervision for Residents 40, 41, 42, 3, 44, 2, 20, 21, 30, 23, 25, 27, and 29 who were placed in front of the nurses' station on Unit A and Unit B. This had the potential to create an unsafe environment which put the residents at risk for falls.Cross reference: F689, F732, F838, and F867.Findings: 1. A review of Resident 1's Face Sheet indicated the resident was admitted on [DATE] and re-admitted on [DATE] with diagnoses to include unspecified dementia (progressive brain disorder causing cognitive decline, memory loss, confusion, and behavioral changes), impulse disorder (mental health condition characterized by inability to resist urges or impulses that may harm oneself), anxiety disorder, and a history of falling. A review of Resident 1's Minimum Date Set Assessment (MDS, a comprehensive assessment tool) dated 1/12/26, indicated the resident had a brief interview of mental status (BIMS - a standardized cognitive assessment to measure memory, orientation, and attention) score of three out of 15 which meant the resident was cognitively impaired. The same MDS assessment, Section GG, indicated the resident required maximal assistance provided by one staff to stand up from a seated position and was totally dependent on one or more staff assistance to transfer from chair to bed. A review of Resident 1's physician's [facility name] History and Physical dated 12/5/25, indicated the resident, .Does not have capacity to understand and make decisions. A review of Resident 1's progress notes indicated the resident had falls on the following dates: 7/11/23 at 7:30 P.M., Resident fell in the hallway in front of the nurses' station.Resident slid out of his wheelchair and onto the ground. 4/6/24 at 5:47 A.M., .Fall was not witnessed. Fall occurred in resident's room. Resident complained of pain and was sent to the hospital for evaluation. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	10/18/24 at 6:40 P.M., .CNA [certified nursing assistant] reported.that resident was found on his knees on the floor mat hanging on to the wheelchair inside the resident's room. 11/4/24 at 3:20 A.M., .Resident was found on the floor mat sitting. 9/5/25, Patient had an unwitnessed fall in patient's room.patient was recently put back to bed.was later found on the next 30 minutes rounds.sitting on the floor.was sent to ER [emergency room] for further eval.patient do [sic] have history of being impulsive and attempts to transfer without staff assistance. 2/16/26 at 2:30 P.M., .Resident sent out 911 to [hospital name].due to unwitnessed fall. 3/26/26 at 5:33 A.M., .Resident had an unwitnessed fall in the hallway with two lacerations to forehead and possible right shoulder injury.911 call activated. 3/26/26 at 1:20 P.M., .The resident has a C1 [first cervical vertebrae – neck bone] fx [fracture] and is being flown out to [trauma hospital] for a neurosurgical (surgery of the nervous system i.e. brain and spinal cord) evaluation. A review of Resident 1's hospital documentation titled Radiology/Diagnostics-Referral dated 3/26/26 at 4:35 PM., indicated, .s/p [status post] fall off wheelchair earlier in the day. Patient has a history of dementia.AOx1 [alert and oriented only to self] at baseline. After the fall, patient presented to [local hospital] where CT [computed tomography – a medical imaging test] C [cervical] spine showed a C1 fracture.Pain due to trauma. On 4/13/26 at 9:55 A.M., a telephone interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated Resident 1 was frequently agitated, confused, and often would try to get out of bed. CNA 5 stated Resident 1 could not follow instructions and was not able to use the call light in a purposeful manner. CNA 5 stated when Resident 1 was agitated and trying to get out of bed, staff would need to stay with him and supervise him. CNA 5 stated this was because Resident 1 had fallen several times before the incident on 3/26/26. On 4/13/26 at 11:10 A.M., video footage of the nursing station on Unit B on 3/26/26 was reviewed. The administrator (ADM), Director of Staff Development (DSD), and the unit manager (UM) 1 for Station B were present. The DSD played the video footage which indicated: At 12 A.M., Resident 1 was brought out of his room in his wheelchair and was placed in front of the nurses' station. At 4:52 A.M., Licensed Nurse (LN) 8 was sitting next to Resident 1 while he was in front of the nurses' station. Resident 1 was observed sitting in his wheelchair in front of the nurses' station continuously from midnight to 5 A.M. Then, at 5:01 A.M., Resident 1 was observed trying to get up from his wheelchair. Staff brought Resident 1 back to his room. At 5:11 A.M., staff brought Resident 1 out of his room in his wheelchair and placed him back in front of the nurses' station. Resident 1 was observed leaning forward in his wheelchair. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	The DSD stated when Resident 1 was observed leaning forward in the wheelchair, this was an attempt to stand up. At 5:25 A.M., Resident 1 was observed trying to stand up. LN 8 assisted the resident to sit back down in his wheelchair. LN 8 left the resident's side to attend to other tasks. Resident 1 immediately attempted to get back up from his wheelchair. At 5:26 A.M., Resident 1 was observed leaning forward in his wheelchair. The resident then stood up from his wheelchair. LN 8 rushed over to the resident to assist him back to a sitting position in his wheelchair. LN 8 then left the resident's side to attend to other tasks. Resident 1 immediately attempted to get back up from his wheelchair. At 5:27 A.M., Resident 1 stood up from his wheelchair. LN 8 rushed over to the resident to assist him back to a sitting position in his wheelchair. LN 8 left the resident's side to attend to other tasks. Resident 1 immediately attempted to get back up from his wheelchair. At 5:28 A.M., Resident 1 was observed leaning forward and trying to get back up from his wheelchair. At 5:29 A.M., LN 8 was observed in the nurses' station with her back turned away from the resident while doing other tasks. Resident 1 stood up from his wheelchair and then fell forward and was no longer in view of the camera. LN 8 rushed over to the resident's last known position. Other staff were observed gathering around the resident's last known position and tending to the resident. At 5:40 A.M., an emergency response team arrived at the facility. At 5:46 A.M., the emergency response team placed Resident 1 on a gurney and took him from the facility. On 4/13/26 at 2:46 P.M., an interview was conducted with LN 7. LN 7 stated Resident 1 was confused and did not understand instructions and could not follow directions. LN 7 stated Resident 1 often attempted to get up from his wheelchair. LN 7 stated Resident 1 needed somebody to calm him down and to sit with him side by side when he was awake, like a babysitter, for his own safety. LN 7 stated when Resident 1 continuously attempted to stand up, the resident needed a staff member to be right next to his side to prevent the fall. On 4/13/26 at 3:23 P.M., a joint interview and record review was conducted with the DSD. The DSD stated Resident 1 could not follow directions, did not recognize time, and did not have situational awareness. The DSD stated Resident 1 does what he wants when he wants. The DSD stated Resident 1 could play with the call light but could not use the call light in a purposeful manner. The DSD stated Resident 1 needed someone next to him when he was agitated and trying to stand up. The DSD stated Resident 1 was a high risk for falls and had a higher need for supervision which was why he was placed in front of the nurse's station on 3/26/26. The DSD stated residents were placed in front of the nurses' station in order to have close supervision. The DSD reviewed Resident 1's written care plans for falls. The care plans indicated the following: Care Plan for: Risk for Falls initiated 12/5/25 indicated the goals were to minimize environmental hazards and the resident will be free of falls. The care plan interventions were: Assess fall risk on admission and with any change in condition. Assist Resident with ambulation and transfers, utilizing (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	therapy recommendations. Determine Resident's ability to transfer. floor mats to be used for injury prevention. If fall occurs, alert provider. If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. Implement fall precautions per facility protocol. Maintain clutter-free room and clear pathways. Care Plan for: The resident had an actual witnessed fall on 2/16/2026 with (no injury) Poor communication/comprehension initiated 2/17/2026 indicated the goal was for the resident to resume usual activities without further incidents. The care plan interventions were: Medication review. Monitor/document/report PRN [as needed] x 72h [times 72 hours] to MD [Medical Doctor] for s/sx [signs and symptoms]: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Neuro-checks x (72 hours). non skid shoe wear on [sic]. The DSD stated the fall precautions in Resident 1's care plans should have been more specific. The DSD stated there was nothing individualized for fall prevention on Resident 1's 12/5/26 fall care plan and neither care plan addressed the resident's supervision needs. On 4/14/26 at 2:12 P.M., a telephone interview was conducted with LN 8. LN 8 stated Resident 1 was not alert and could only say yes or no. LN 8 stated Resident 1 could not use the call light and could not verbalize what he wanted or needed. LN 8 stated Resident 1 could become restless and agitated. LN 8 stated Resident 1 had been having a lot of falls. LN 8 stated she had to bring Resident 1 out of his room around midnight on 3/26/26 because she could not see what the resident was doing inside his room. LN 8 stated Resident 1 would need a sitter to stay with him in his room. LN 8 stated Resident 1 needed to be supervised closely in front of the nurses' station so he would not fall in his room. LN 8 stated Resident 1 kept attempting to get up from his wheelchair on 3/26/26. LN 8 stated she was busy doing nursing tasks when Resident 1 fell from his wheelchair. LN 8 stated when Resident 1 kept attempting to stand up, he needed 1:1 supervision (staff to provide continuous supervision to the resident). LN 8 stated there was not enough staff to provide the 1:1 supervision Resident 1 required at that time. LN 8 stated she could not tell if Resident 1 was in pain after his fall and that she did not know how to recognize the resident's expression of pain. LN 8 stated if she hit her head and had a laceration, it would hurt. LN 8 stated there was not enough staff to attend to the residents requiring supervision. LN 8 stated they needed more staff when she was doing med pass and when CNAs were doing showers and changing briefs. LN 8 stated there had been a lot of falls during these times when staff were busiest from 8 P.M. to 10 P.M. and 5 A.M. to 7 A.M. LN 8 stated there were incidents of residents falling in front of the nurses' station because staff were distracted by other tasks and there was not a designated staff to supervise them. LN 8 stated when she asked for additional staff to help the night shift, she was told there were no staff available to work. On 4/16/26 at 3:54 P.M., a telephone interview was conducted with Resident 1's family member (FM). The FM stated Resident 1's fall on 3/26/26 was not the first fall. The FM stated Resident 1 was confused and someone should always stay with the resident to supervise him. The FM stated Resident 1 had pain in the lower back and would try to stand up and move to alleviate his pain. On 4/21/26 at 12:11 P.M., a telephone interview was conducted with Resident 1's responsible party (RP). The RP stated Resident 1 had dementia and could not remember who he was and where he was. The RP stated Resident 1 had back pain. The RP stated Resident 1 would get agitated at nighttime. The RP stated Resident 1 had weak legs and had fallen many times in the facility. The RP stated the facility would place Resident 1 in front of the nurses' station for supervision. The RP stated the facility did not have enough staff to take care of Resident 1. The RP further stated a facility staff told her the facility was short staffed. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 4/27/26 at 7:29 A.M., a joint interview and record review was conducted with UM 2. UM 2 reviewed Resident 1's written care plans for: Risk for Falls initiated 12/5/25, and the resident had an actual witnessed fall on 2/16/2026 with (no injury). UM 2 stated Resident 1's care plans did not address the supervision he needed to prevent falls from occurring. UM 2 stated there was no assessment done to determine Resident 1's supervision needs and this should have been done and appropriately care planned. On 5/4/26 at 3:40 P.M., a telephone interview was conducted with Resident 1's medical doctor (MD). The MD stated Resident 1 had very advanced dementia. The MD stated Resident 1 had a neck fracture because of his fall on 3/26/26. The MD stated Resident 1's health condition had been steadily declining which could be due to neck pain from the fracture. The MD stated Resident 1, due to his cognitive issues, could not articulate his pain. The MD stated Resident 1 had been less impulsive with his behavior since his fall on 3/26/26. The MD stated Resident 1's declining health status after his 3/26/26 fall was a combination of both advancing dementia and the fall with fracture. 2. A review of Resident 2's admission Record indicated the resident was admitted on [DATE] with diagnoses to include Alzheimer's Disease (irreversible brain disorder that destroys memory, thinking skills, and ability to carry out daily tasks), unspecified dementia, difficulty walking, and muscle weakness. A review of Resident 2's MDS assessment dated [DATE] indicated the resident had a brief interview of mental status (BIMS) score of 5 which meant the resident was cognitively impaired. The same MDS assessment, Section GG, indicated the resident required moderate assistance provided by one staff to perform transfers from chair to bed and sitting to standing position. A review of Resident 2's physician's [facility name] History and Physical exam dated 1/23/26, indicated the resident did not have capacity to understand and make decisions A review of Resident 2's progress notes indicated the resident had falls on the following dates/times: 9/28/23, .Resident sustained an assisted fall on 9/25/23.while resident was up in bathroom. 9/30/23 at 11:30 P.M., .Resident fell.in her room.Resident hit back of head on the floor. 11/18/23 at 3:20 A.M., .Resident found in [sic] floor beside her commode in her room. resident unable to give coherent recall. Resident was bleeding from her head and face.911 called. 1/19/24 at 9:45 P.M., .Resident had a witnessed fall. CNA saw her sit on the side of the bed and stood up. CNA asked charge nurse if patient is supposed to get up. While walking back to the patient's room.resident slipped and slowly fell. 2/5/24, .Resident sustained a fall on 2/2/24 at [7:50 A.M.].sustained an unwitnessed fall in her room.found lying on top of floor mat.transferred to [hospital name] for evaluation. 4/9/24 at 12:35 A.M., .Nurse was alerted to hallway.by CNA to report unwitnessed fall. [Resident 2] was found lying on her left side by her wheelchair, towards the wall, by patio doors.Skin tear noted on [left] elbow. 12/12/24 at 7:50 A.M., .Guided fall onto floor mat by two staff members. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	1/15/26, .Notified AM nurse that resident had an unwitnessed fall next to her wheelchair [at] 6:40 A.M. At the time of the fall AM nurse had been giving report.Resident was found lying on top of the footrests.Resident reported to have pain to her right buttocks.Resident was unsuccessful in describing pain rate. 3/5/26, .[12:19 P.M.] Resident fall [sic] in front nurse station, called 911. 3/30/26, .Staff member notified nurse of fall at the dining room.Resident was noted to be sitting on one of the footrests, and the head of the resident was resting on the side of the wheelchair.Resident.has been able to verbalize pain to [left] shoulder, headache, and backache at this time. Called 911. A review of Resident 2's hospital discharge documentation dated 1/22/26, indicated, . [Resident 2] with advanced dementia .was admitted after a mechanical fall from her wheelchair.Initial evaluation revealed a compression fracture of the lumbar (lower back) spine (L1-L2), which was managed conservatively with pain control. On 4/27/26 at 8:57 A.M., an interview was conducted with UM 1. UM 1 stated there was video footage of Resident 2's fall on 1/15/26; however, at this time, the footage was no longer retrievable and had been automatically deleted. UM 1 stated she did view the video footage at the time of the incident and stated Resident 2 had been sitting in her wheelchair in front of the nurses' station. UM 1 stated two nurses had been nearby, but they were in the process of doing report (process where nurses handoff their assignment to the next nurse and update the oncoming nurse). UM 1 stated the nurses had been busy and distracted. UM 1 stated it was during that time; Resident 2 stood up from her wheelchair and then fell. UM 1 stated Resident 2 sustained a back fracture from the fall. On 4/28/26 at 10:44 A.M., an interview was conducted with CNA 13. CNA 13 stated she was quite familiar with Resident 2. CNA 13 stated Resident 2 often would stick to herself, was quiet, and forgetful. CNA 13 stated Resident 2 was able to listen and follow directions but would often want to do things her own way. CNA 13 stated Resident 2 liked to do things herself and frequently would not ask for help. CNA 13 stated Resident 2 would get up and change positions independently without letting staff know. CNA 13 stated because of this, Resident 2 should have more frequent monitoring at least every 15 minutes to ensure she did not try to get up without asking for help. CNA 13 stated checking up on Resident 2 every 30 minutes was too long to catch her trying to get up. CNA 13 stated there were not enough staff to provide more frequent supervision. CNA 13 stated CNAs did not have time to document the care they provided to residents and had to stay after their shift to catch up on that. CNA 13 stated they did not have enough staff to monitor Resident 2 every 15 minutes. On 4/28/26 at 11:07 A.M., an interview was conducted with CNA 14. CNA 14 stated Resident 2 was confused but was still able to listen and follow directions. CNA 14 stated Resident 2 was very independent and seemed unaware of her own frailty and need for assistance. CNA 14 stated Resident 2 had poor safety awareness and, She won't wait if she wants to do something. CNA 14 stated Resident 2 was able to use the call light but often chose not to. CNA 14 stated Resident 2 does not usually ask for help and will transfer herself. CNA 14 stated Resident 2 should have monitoring every 15 minutes because she will get up without asking for help. CNA 14 stated the facility did not have enough staff to provide the level of supervision Resident 2 needed. CNA 14 stated she was responsible for 17 residents today, with 5 residents needing showers, and seven residents who required the use of a mechanical lift (residents who cannot get out of bed on their own and require a greater degree of staff assistance with care). CNA 14 stated, Staffing here's a big problem. We're (continued on next page)

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Pioneers Memorial Skilled Nursing Center	320 Cattle Call Dr. Brawley, CA 92227

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F 0725 Level of Harm - Actual harm Residents Affected - Few	tired. It's too much. On 4/28/26 at 12:12 P.M., a joint interview and record review was conducted with UM 1. UM 3 was also present. UM 1 stated Resident 2 wanted to remain independent but that the resident had confusion, was frail, and required staff to monitor her every 15 minutes to make sure she was not trying to get up on her own. UM 1 stated, We can't staff to meet her supervision needs and those of other residents needing increased supervision. UM 1 reviewed Resident 2's written care plans and stated the care plan for The Resident Is (High) Risk for Falls R/T [related to] Confusion, Gait/Balance Problems, Poor Communication/Comprehension, Unaware of Safety Needs Unwitnessed Fall of 1/15/26 with a care plan intervention dated 1/26/26, .When resident is up on w/c [wheelchair], resident is placed at nursing station. UM 1 stated Resident 2 should not have had another unwitnessed fall on 3/5/26 after being placed in front of the nurses' station for supervision. UM 1 stated adequate supervision should have been provided when Resident 2 was placed in front of the nurses' station. 3a. A review of the facility's census by unit dated 4/26/26 indicated there were 33 residents on Unit B. A review of staff assignment on Unit B dated 4/26/26 indicated there was one nurse and two CNAs on Unit B. A review of Resident 40, 41, 42, 3, and 44's Face Sheets and MDS assessments indicated the following: Resident 40's Face Sheet indicated the resident was admitted on [DATE] with diagnoses to include unspecified dementia and history of falling. Resident 40's MDS assessment dated [DATE], indicated the resident had a BIMS score of 12 out of 15 which meant the resident was mildly impaired. Resident 41's Face Sheet indicated the resident was admitted on [DATE] with diagnoses to include Alzheimer's disease, dementia, and history of falling. Resident 41's MDS assessment dated [DATE], indicated the resident had a BIMS score of 5 out of 15 which meant the resident was cognitively impaired. Resident 42's Face Sheet indicated the resident was admitted on [DATE] with diagnoses to include Alzheimer's disease and dementia. Resident 42's MDS assessment dated [DATE], indicated the resident had a BIMS score of 6 out of 15 which meant the resident was cognitively impaired. Resident 3's Face Sheet indicated the resident was admitted on [DATE] with diagnoses to include dementia, Alzheimer's disease, and cognitive communication deficit. Resident 3's MDS assessment dated [DATE], indicated the resident had a BIMS score of 6 out of 15 which meant the resident was cognitively impaired. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Resident 44's Face Sheet indicated the resident was admitted on [DATE] with diagnoses to include dementia, and unspecified fall. Resident 44's MDS assessment dated [DATE], indicated the resident had a BIMS score of 4 out of 15 which meant the resident was cognitively impaired. A review of the facility provided list of residents falls from 1/1/26 through 3/30/26 indicated the following: -The facility had 46 falls, of which 34 were unwitnessed (staff were not present to see what happened). -Resident 3 had an unwitnessed fall on 3/2/26 at 6:50 P.M. in his room. On 4/27/26 at 5:10 A.M., an observation was conducted at Unit B in front of the nurses' station. Resident 40 and an unsampled resident (Resident 45) were observed sitting in their wheelchairs by the hallway in front of the nurses' station. Resident 40 was covered with a blanket, and he had his eyes closed. The nurses' station's lights were off. The computers by the nurses' station were off. There were no staff by the nurses' station. LN 9 was observed at her medication cart down the hall and she could not see the residents at the nurses' station. At 5:45 A.M., another resident (Resident 41) was brought out and placed in front of the nurses' station. By 5:46 A.M., Residents 42, 3, and 44 were observed in front of the nurses' Station along with Resident 40, 41, and 45. Resident 3 was leaning on the right side of his wheelchair with his eyes closed. No nursing staff were within visual range of the nurses' station. At 5:55 A.M., director of nursing (DON) and CNA 15 asked Resident 3 to reposition upright in his wheelchair. At 5:56 A.M., the nurses' station's lights were still off and there were no staff by the nurses' station. CNAs were observed to go in and out of residents' rooms. CNAs were observed to come out of resident's rooms to dispose linens and head back to the residents' rooms. On 4/27/26 at 6:37 A.M., an interview was conducted with LN 9. LN 9 stated residents were lined up at the nurses' station for close supervision. LN 9 stated Resident 3 was a fall risk. On 4/27/26 at 6:44 A.M., an interview was conducted with CNA 15. CNA 15 stated most residents lined up by the nurses' station were confused. CNA 15 stated Resident 3 was a fall risk and needed close supervision. CNA 15 stated they did not have enough staff to provide Resident 3 with close supervision. CNA 15 stated it would be a big help if they had more staff. On 4/27/26 at 7:13 A.M., an interview was conducted with CNA 16. CNA 16 stated some of the residents who were placed in front of the nurses' station were confused and were at risk for falls. CNA 16 stated they needed more staff especially in the morning when residents were getting up from bed. CNA 16 stated residents were lined up in front of the nurses' station to be closely supervised by the nurse. 3b. A review of the facility's census dated 4/26/26, indicated there were 40 residents on Unit A. A review of staff assignment dated 4/26/26 (night shift) for Unit A, indicated there were three CNAs and one nurse on duty. A review of Resident 2, 20, 21, 30, 23, 25, 27, and 29's admission Records and MDS assessments (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	indicated the following: Resident 2's admission Record indicated the resident was admitted on [DATE] with diagnoses to include Alzheimer's Disease (irreversible brain disorder that destroys memory, thinking skills, and ability to carry out daily tasks), unspecified dementia, difficulty walking, and muscle weakness. Resident 2's MDS assessment dated [DATE] indicated the resident had a brief interview of mental status (BIMS) score of 5 out of 15 which meant the resident was cognitively impaired. Resident 20's admission Record indicated the resident was admitted on [DATE] with diagnoses to include Alzheimer's Disease, dementia, epilepsy (seizure disorder), and history of traumatic fracture. Resident 20's MDS assessment dated [DATE], indicated the resident had a BIMS score 4 out of 15 which meant the resident was cognitively impaired. Resident 21's admission Record indicated the resident was admitted on [DATE] with diagnoses to include Alzheimer's Disease, dementia, palliative care (comfort care near the end of one's life), and history of falling. Resident 21's MDS assessment dated [DATE], indicated the resident had a BIMS score 5 out of 15 which meant the resident was cognitively impaired. Resident 30's admission Record indicated the resident was admitted on [DATE] with diagnoses to include palliative care, anxiety, and a fall encounter during stay. Resident 30's MDS assessment dated [DATE], indicated the resident had a BIMS score 5 out of 15 which meant the resident was cognitively impaired. Resident 23's admission Record indicated the resident was admitted on [DATE] with diagnoses to include dementia and difficulty walking. Resident 23's MDS assessment dated [DATE], indicated the resident had a BIMS score 4 out of 15 which meant the resident was cognitively impaired. Resident 25's admission Record indicated the resident was admitted on [DATE] with diagnoses to include glaucoma (eye disease which can cause blindness), macular degeneration (eye disease which can cause blindness), and a history of falling Resident 25's MDS assessment dated [DATE], indicated the resident had a BIMS score 6 out of 15 which meant the resident was cognitively impaired. Resident 27's admission Record indicated the resident was admitted on [DATE] with diagnoses to include a leg fracture following a fall, dementia, anxiety, restlessness and agitation. Resident 27's MDS assessment dated [DATE], indicated the resident had a BIMS score 4 out of 15 which meant the resident was cognitively impaired. Resident 29's admission Record indicated the resident was admitted on [DATE] with diagnoses to include Parkinson's Disease (condition affecting body coordination, balance, and muscle movement), (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Alzheimer's Disease (irreversible brain disorder that destroys memory, thinking skills, and ability to carry out daily tasks), dementia, history of falling, and a fall with abrasion to the head. Resident 29's MDS assessment dated [DATE], indicated the resident had a BIMS score 5 out of 15 which meant the resident was cognitively impaired. A review of the facility provided list of residents falls from 1/1/26 through 3/30/26 indicated the following: -Resident 2 had an unwitnessed fall on 1/15/26 at 6

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility failed to post nursing staffing information which reflected the actual hours worked for staff responsible for resident care. In addition, actual hours worked for nursing staff were not available upon request.As a result, staffing information reflecting actual hours worked was not readily available in a readable format to residents and visitors at any given time. In addition, the facility was unaware of actual hours worked by its nursing staff.Findings:On 4/27/26 at 4:18 P.M., a joint interview and record review was conducted with the Director of Staffing Development (DSD). The DSD stated she assisted with scheduling nursing staff while the staffer was on leave. The DSD reviewed the facility's Daily Nurse Staffing Information dated 4/26/26 that was posted in the facility lobby. The DSD stated the nursing hours posted was projected hours and not actual nursing hours worked. The DSD stated she did not know the actual hours worked. The actual nursing hours for 1/14/26 and 1/15/26 were requested from the DSD.On 4/28/26 at 2:20 P.M., a joint interview and record review was conducted with the DSD. The nursing hours on 1/14/26 and 1/15/26 were provided and reviewed. The DSD stated these were projected nursing hours. The DSD stated the facility did not have access to actual nursing hours because a separate outside management company was handling that. The DSD further stated the facility did not know if they were meeting the State required nursing hours.On 4/28/26 at 2:55 P.M., a telephone interview was conducted with the interim director of nursing (DON). The DON stated the facility should have access to actual nursing hours worked and they should be posted as per regulation. The DON stated the facility should also know if they were meeting State required nurse staffing hours. The DON stated actual nursing hours worked should be readily available when requested.On 4/28/26 at 3:52 P.M. an interview was conducted with the administrator (ADM). The unit manager (UM) 1, UM 2, UM 3, and the DSD were also present. The ADM stated the facility should have access to actual nursing hours worked and they should be posted.A review of the facility's undated policy titled, Nursing Department - Staffing, Scheduling & Postings, indicated, .A. The facility will post the following information on a daily basis. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: a. Registered nurse b. Licensed practical nurses or licensed vocational nurses.c. Certified nurse aides.The facility will post the nurse staffing data as specified above, on a daily basis at the beginning of each shift.The facility will, upon oral or written request, make nurse staffing data available to the public.The facility will maintain the posted daily nurse staffing data for a minimum of 18 months.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure its facility assessment (documented assessment of the facility's resident population and resources needed to provide care to residents) addressed and/or clearly described:1. The care required by residents with dementia/cognitive impairment.2. How the facility determined its resident acuity for purposes of sufficient staffing.3. The specific staffing needs on each resident unit to meet the needs of residents requiring increased supervision.As a result, the facility did not provide sufficient nursing staff to meet the supervision needs of residents with dementia/cognitive impairment. Cross reference F689 and F725.Findings:A review of the facility census dated 4/27/26 indicated the facility had 73 residents.A review of the facility document [facility name] Diagnosis Report dated 4/28/26 indicated there were 27 residents with a dementia diagnosis. A review of the facility's Facility Assessment Tool dated 10/15/25 indicated the facility accepted residents with diagnoses of Alzheimer's disease and dementia. The assessment indicated, .Acuity. Consider if it would also be helpful to differentiate between long-stay and short-stay residents or other categorizations (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons living with dementia or using ventilators). The facility assessment's acuity table (pg. 5) listed Behavioral symptoms and cognitive performance; however, the number/average range of residents was blank. The facility assessment, Part 2. Services and Care We Offer Based on our Resident's Needs.list the type of care that your resident population requires and that you provide to your resident population.The intent is to identify and reflect on resources needed. to provide these types of care.Mental health and behavior: Manage medical conditions. identify and implement interventions to help support individuals with issues such as. care of someone with cognitive impairment. The assessment did not identify how the facility would meet the supervision needs of these residents.The facility assessment further indicated, Staffing plan.Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff members to meet the needs of the residents at any given time. The assessment had two tables for the type of staff and plan which indicated, .Licensed nurses providing direct care. RN 1 LVN 9.Nurse Aides.CNA 16 RNA 3 .Plan.1:x LN ratio days and evenings.1:x LN ratio nights.Direct care staff members. 1:x ratio days. 1:x ratio evenings. 1:x nights or x hours per resident days. The assessment did not identify that the facility nursing staff worked 12-hour shifts and it was unclear as to how a sufficient amount of staff was determined. The facility assessment further indicated, .Individual staff assignment.Describe how you determine and review individual staff member assignments for coordination and continuity of care for residents within and across these staff assignments. The assessment did not describe this.On 4/27/26 at 3:24 P.M., a joint interview and record review was conducted with the director of staff development (DSD). The DSD stated she was covering for the facility staffer who was out on leave. The DSD stated, Staffing's a problem. The DSD stated approximately half the facility's resident population had dementia or were cognitively impaired and required more supervision. The DSD stated the facility lacked a sufficient number of nursing staff to meet the supervision needs of the residents and that this was a major issue and residents are getting hurt. The DSD further stated there was no measure of resident acuity being done. The DSD reviewed the facility's Facility assessment dated [DATE]. The DSD stated the facility assessment did not clearly address the needs of the residents with dementia or assess the required supervision and staffing to meet their needs. The DSD stated the staff numbers under Staffing Plan were plugged into the areas for total number needed or average or range, but this was not personalized to the building's needs. The DSD stated numbers that were plugged in on the facility assessment for Staffing Plan were not accurate. The DSD stated she wished the facility had 16 CNAs (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on any given day. The DSD stated she did not understand where the staff numbers came from. The DSD stated the facility assessment did not describe a method for determining resident acuity which affected the facility's ability to adequately staff. The DSD stated the supervision needs of the residents were not included in the facility assessment and it should be included. The DSD stated the facility assessment was unclear.On 4/28/26 at 2:55 P.M., a telephone interview was conducted with the interim director of nursing (DON). The DON stated she was hired about two weeks ago. The DON stated staffing was a problem and had affected the facility's ability to provide the supervision residents needed. The DON stated resident acuity should have been assessed and reviewed to determine staffing needs. The DON stated a method for determining this should have been clear on the facility's facility assessment.On 4/28/26 at 3:52 P.M., an interview was conducted with the facility's administrator (ADM). UM 1, UM 2, UM 3, and the DSD were also present. The ADM stated residents' supervision needs should have been met. The ADM stated staffing was discussed each month during quality assurance meetings, but that he had not been aware that staffing was such an issue. The ADM stated based on the survey findings, the facility assessment should have identified and assessed the resident needs related to supervision. The ADM stated the facility should have had a method to determine resident acuity in order to sufficiently staff according to resident needs.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a licensed nurse/unit manager (UM) 2 accurately documented a fall interdisciplinary team (IDT) note for one of three residents (Resident 1).As a result of this deficient practice, UM 2's falsified documentation misrepresented the facility's investigation into Resident 1's fall and fall aftercare.Findings:A review of Resident 1's Face Sheet indicated the resident was admitted on [DATE] and re-admitted on [DATE] with diagnoses to include unspecified dementia (progressive brain disorder causing cognitive decline, memory loss, confusion, and behavioral changes), impulse disorder (mental health condition characterized by inability to resist urges or impulses that may harm oneself), anxiety disorder, and a history of falling.A review of Resident 1's IDT Progress Note-Falls dated 4/13/26 at 10:48 A.M., indicated the IDT was composed of the director of rehabilitation, social services director, the director of staff development, infection preventionist, quality assurance nurse, and the MDS coordinator. The IDT note further indicated, .Resident experienced an unwitnessed fall in front of the nurse's station.IDT reviewed the incident and contributing factors, including fall risk status, environment and current care plan. The following interventions will be implemented/reinforced: 30-minute rounding and floor mats.On 4/13/26 at 3:23 P.M., a joint interview and record review was conducted with the director of staff development (DSD). The DSD stated that an IDT meeting was supposed to be conducted after a resident fell in the facility. The DSD stated that there was no IDT conducted to investigate Resident 1's fall on 3/26/26. The DSD reviewed Resident 1's IDT Progress Note-Falls dated 4/13/26. The IDT note indicated the DSD had attended and participated in the IDT meeting. The DSD stated she was not aware of this IDT meeting on 4/13/26 and she was not present during the IDT meeting. On 4/27/26 at 7:29 A.M., a joint interview and record review was conducted with UM 2. UM 2 stated the IDT team met after each fall to investigate the fall, determine its cause, to gather as much information as possible, and to make proper care plans with interventions that were relevant to the residents' needs. UM 2 reviewed documentation of the IDT conducted on 4/13/26 to investigate Resident 1's fall that occurred on 3/26/26. UM 2 stated Resident 1's IDT meeting actually did not occur, and his fall was not investigated. UM 2 stated she was the author of Resident 1's fall IDT note dated 4/13/26. UM 2 stated the IDT members were too busy to conduct Resident 1's fall IDT meeting. UM 2 stated she was aware surveyors were looking into Resident 1's fall and that the IDT for the resident's fall needed to be done. UM 2 stated Resident 1's fall IDT never happened and, It's falsified. UM 2 stated documentation of an IDT meeting should be factual and accurate, reflecting what occurred.On 4/28/26 at 2:38 P.M., an interview was conducted with the administrator (ADM). The ADM stated falsifying resident documentation was unacceptable. The ADM stated his main objective as an administrator of the facility was to promote telling the truth. The ADM stated, We don't lie. We take our lumps and learn from them.On 4/28/26 at 2:55 P.M., a telephone interview was conducted with the interim director of nursing (DON). The DON stated IDT notes and other clinical documentation should be true and accurate.The facility's policy titled Alert Charting Documentation revised 1/1/12 did not provide guidance related to documenting accurately and truthfully in resident's clinical records.

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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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, interview, and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify concerns related to lack of supervision and adequate nurse staffing as contributing to some of the facility's resident falls.This failure had the potential for deficiencies to remain uncorrected and placed the facility's residents' safety at risk.Cross reference F689 and F725.Findings:A review of the facility provided list of resident falls from 1/1/26 through 3/30/26 indicated the facility had 46 falls, of which 34 were unwitnessed (staff were not present to see what happened).On 4/28/26 at 12:12 P.M., an interview was conducted with UM 3. UM 1 was also present. UM 3 stated she was the facility's quality assurance (QA) nurse specifically tasked with keeping track of the falls in the facility since January 2026. UM 3 stated since Resident 1's fall was being investigated by the California Department of Public Health Licensing and Certification, she had identified a pattern related to falls happening due to a lack of supervision. UM 3 stated resident falls and lack of supervision should have been identified as the root cause in some of the unwitnessed falls including the falls of Resident 1 and Resident 2. UM 3 stated staffing issues were discussed during the monthly QA meetings, but staffing had not been identified as contributing to the lack of supervision. UM 3 stated staffing was not part of the facility's Quality Assurance and Program Improvement (QAPI) committee and was not an action item or program improvement project. UM 3 stated falls, supervision, and staffing should have been thoroughly looked at by the QA/QAPI committee.On 4/28/26 at 1:52 P.M., a joint interview and record review was conducted with UM 1. UM 1 stated the facility's QA/QAPI Committee met on 4/15/26 for the quarterly QAPI meeting and that staffing had been a part of the QAPI. UM 1 presented an undated document titled QAPI Performance Improvement Plan CNA and LVN [licensed vocational nurse] Staffing Stability. The document indicated, Problem Statement The facility is experiencing staffing instability due to: Increased CNA/LVN call-offs, Employees out on Workers' Compensation, extended hiring process (~ 4 weeks), new hire turnover shortly after hire. Impact: short staffing, increased workload, risk to resident care and regulatory compliance.On 4/28/26 at 2:55 P.M., a telephone interview was conducted with the interim director of nursing (DON). The DON stated the issues with resident falls, supervision, and staffing should have been addressed and a focused part of the facility's QAPI.On 4/28/26 at 3:52 P.M., an interview was conducted with the facility's administrator (ADM). UM 1, UM 2, UM 3, and the DSD were also present. The ADM stated residents' supervision needs should have been met. The ADM stated there were many residents out in front of the nurses' stations as observed on 4/27/26 and he acknowledged staff had been performing other tasks which made it difficult for them to provide supervision. The ADM stated he had not been aware that staffing was such an issue. The ADM reviewed the facility's undated document titled QAPI Performance Improvement Plan CNA and LVN Staffing Stability. The ADM stated this issue with staffing was discussed during every QA/QAPI meeting, but it was not actively being worked on by the QAPI committee. The ADM stated it should have been an action item actively being worked on to gain the attention and support of the governing body. The ADM stated falls were a QA/QAPI action item, but that supervision and staffing had not been identified as a contributing factor. The ADM stated this should have been identified.A review of the facility's policy titled QAPI01 Quality Assurance and Performance Improvement (QAPI) Program revised 3/28/24, indicated, .The facility implements and maintains an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) Program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality of care, and resolve identified issues.Purpose to implement a process that identifies opportunities for improvement and leads to optimal achievement in clinical and operational outcomes, and overall quality of care.8. The QAPI Committee evaluates.define issues, plan and implement action, and ensure monitoring and follow up.