STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	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 provide adequate supervision and assistance to prevent an avoidable fall accident for one of three sampled residents (Resident 1), who was identified at high risk for falls.This failure resulted in Resident 1 falling, hitting his head and fracturing his right femur (thighbone), causing severe pain, and transfer to the hospital. Resident 1 was placed on comfort care in the hospital and died on [DATE], 3 days after the fall incident.A review of the admission record indicated the facility admitted Resident 1 in November of 2025 with multiple diagnoses which included aftercare following right hip arthroplasty (a surgical procedure to replace the fractured joint and restore mobility) and dementia (when a person has progressive decline in mental abilities and has trouble remembering, learning new things, concentrating or making decisions). Resident 1's medical history indicated he had history of frequent falls.A review of Order Summary Report indicated the following orders dated [DATE], SAFETY DEVICE: Bed Pad Alarm [a pad with sensors that will alarm when a resident stands up unassisted by alerting staff] .every shift.Clip alarm [a device, similar to bed pad] while in wheelchair.A review of the Fall Risk Evaluation dated [DATE] indicated that Resident 1 had a score of 16 (total score of 10 or above represented high risk for falls). The clinical evaluation indicated Resident 1 had decreased muscular coordination and required to use assistive devices, including walker and wheelchair.A review of Resident 1's admission Minimum Data Set (MDS, an assessment tool), dated [DATE] indicated that Resident 1 had severely impaired cognitive status.A review of care plan initiated on [DATE], indicated Resident 1 was at risk for falls. The care plan goal indicated Resident 1's risks for falls and injuries will be reduced. The care plan interventions directed staff to assist resident with ambulation and transfers, utilize devices (bed pad and clip alarms) to ensure safety, evaluate resident's environment to identify factors known to increase fall risks. The care plan did not address Resident 1's poor safety awareness and did not include hourly checking and monitoring.A review of the SBAR (an acronym for Situation, Background, Assessment, Recommendation, a communication tool used between members of the health care team) dated [DATE] at 4:11 p.m., indicated that Resident 1 experienced a change in condition (COC). The SBAR indicated, Staff saw resident walk out from his room and fell on the hallway. Assessed resident and he seems in a lot of pain. Cannot move his lower extremities. The COC note indicated Resident 1 was transferred to emergency department (ED) for evaluation.A review of Post Fall Evaluation Note (PFEN) dated [DATE] at 5:36 p.m., indicated that Resident 1 had a witnessed fall on [DATE] at 4:15 p.m. The PFEN indicated, Resident [1] was found ambulating [walking] in hallway directly outside of his room without device or staff assist. Resident has poor balance and difficulty walking and requires one person for all walking and transfers.Resident was unsteady and was not using.walker [assistive device for standing and walking]. Resident lost his balance and fell to the right landing on his right side and hitting the back of his head. The PFEN indicated that Resident 1 experienced (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	pain is his right hip and back of head from the fall.A review of ED physician's note dated [DATE] at 10:22 p.m., indicated that Resident 1 had severe deformity (body part appear or function differently than how it is supposed to be) of the right femur (thighbone).A review of CT (computed tomography, an imaging procedure) result performed at ED on [DATE], indicated that Resident 1 had displaced fracture of right femur, further away from where he had joint replacement surgery on [DATE]. The CT result indicated that bone fracture resulted in hemorrhage (ruptured blood vessels) into Resident 1's intramuscular (within a muscle) area.A review of ED nursing progress note dated [DATE] at 8:08 p.m., indicated that Resident 1 was airlifted via Emergency Medical Services helicopter for further evaluation and treatment to another hospital.During an interview on [DATE] at 10:20 a.m., the Director of Nursing (DON) stated that Resident 1 was admitted to facility for rehabilitation after joint replacement surgery. The DON stated Resident 1 had unsteady balance, required staff's assistance with transfer and ambulation, and was at high fall risk. The DON stated that on [DATE] Resident 1 was observed by Licensed Nurse (LN 1) ambulating in the hall unsupervised and without walker and fell in the hall hitting his right side. The DON explained that the facility used a bed pad alarm as one of the safety measures. The DON stated that pad alarm was supposed to alert staff when Resident 1 attempted to get up from his bed, but on that day, the alarm did not go off, and staff were not aware that Resident 1 got out of his bed and started ambulating. The DON stated that in addition to utilizing pad alarms, the staff were to round on residents every hour, to assess and assist with their needs, especially on residents identified at high risk for falls. The DON explained that during hourly rounding staff would check on residents visually, but the visual checks were not documented.During a tour of Hall 4 accompanied by DON on [DATE] at 10:35 a.m., another resident (Resident 2) was observed standing in the doorway to her room attempting to walk into the hall. The bed pad alarm in the resident's room was beeping loudly and the call light above room was blinking. A loud beeping sound was coming from the device at the nursing station alerting staff that Resident 2 got out of bed, but no staff were present in the hallway and at the nursing station. The DON stated Resident 2 was identified at high risk for falls and had pad alarm to alert staff when she attempted to get out of bed.During a continued interview on [DATE] at 10:40 a.m., in Resident 2's room, the DON demonstrated how the bed pad alarm sent alerts to staff when resident moved in bed or attempted to get up. The DON stated that the facility was not able to establish why the bed pad alarm in Resident 1's room did not go off and Resident 1 got up and injured himself. The DON explained that the pad alarm was retested after Resident 1's fall and it worked fine without any functional issues.During an interview on [DATE] at 10:45 a.m., LN 1 stated that Resident 1's cognition and safety awareness were impaired, and he was not able to use a call light to call for assistance. LN 1 stated that Resident 1 was at increased risk for falls and required to have staff assistance when getting out of bed and ambulating. LN 1 stated the facility utilized bed pad alarm and chair clip as safety measures to alert staff when Resident 1 attempted to get up from bed.During a continued interview on [DATE] commencing at 10:45 a.m., LN 1 explained that on [DATE] around 4:15 p.m., she was at the nursing station with other staff. LN 1 added, I looked and saw Resident [1] standing in the doorway. Initially I thought somebody was behind him. He did not have a walker. He teetered a few times and by the time I got there, he fell in the hallway on his right side. LN 1 stated Resident 1's room was further away from nursing station. LN 1 stated that Resident 1's bed pad alarm did not go off when Resident 1 got up unassisted from bed.During an interview on [DATE] at 11:10 a.m., with a Certified Nursing Assistant (CNA 1), CNA 1 stated Resident 1 was always confused and sometimes attempted to get out of bed. CNA 1 stated that Resident 1 was not allowed to get up by himself, even with a walker. CNA 1 explained that on [DATE] Resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1 was up in wheelchair for a long time and seemed very tired. CNA 1 stated when she transferred Resident 1 to bed, the bed pad alarm gave two short beeps indicating that it was activated. CNA 1 stated she reported to the nurse when she left for lunch, and another CNA was covering for her residents. CNA 1 stated she started rounding on her assigned residents after her lunch and when left another resident's room, she saw Resident 1 already on the floor in the hallway. CNA 1 added, He was moaning and yelling when we attempted to move him, but unable to verbalize pain. CNA 1 stated that according to LN 1, Resident 1's alarm did not go off. CNA 1 added, Normally it's blaring loud when the resident attempts to get up.During an interview on [DATE] at 11:57 a.m., with Physical Therapist (PT), PT stated Resident 1 had physical therapy every day. The PT stated Resident 1 became stronger after receiving therapy for a few weeks but still required to have staff's assistance with transfers. The PT added, Staff had to keep close eye on him because he had fallen so many times at home. His balance was not good. The PT explained that on [DATE], before Resident 1's fall incident, Resident 1 did not do well [with therapy] .We tried to stand up, and he needed maximum assistance and continued falling backward. The PT added, I don't know how to explain that he walked from his bed which is next to window all the way into hallway.During a follow up interview on [DATE] at 11:25 a.m., pad alarm functionality was discussed with DON with the presence of Quality &Patient Safety. The DON explained that pad alarms did not require checking for functionality and were guaranteed to work for 30 days after which they were to be replaced. The DON added, I don't know what happened that the alarm did not go off and the resident fell and fractured his leg.During a telephone interview on [DATE] at 9:35 am., Resident 1's ‘At risk for falls' care plan dated [DATE] was discussed with DON. The DON was asked if Resident 1's care plan fall prevention interventions were individualized. The DON stated that the care plan was based on Resident 1's MDS assessment and addressed the resident's risk for falls. The DON did not provide answer when asked if care plan interventions should address hourly checks and monitoring related to the resident's poor safety awareness.A review of the facility's policy titled, Fall Risk Assessment/Fall prevention, dated 11/2025, indicated, It is the policy of this facility to assess residents for risk of falls upon admission.in order to identify residents at risk for future falls and prepare a plan of care to reduce the potential for future falls.Prevention interventions will be initiated immediately and documented on the care plan.Residents will be placed in high visibility rooms and may have one or more alarms to alert staff of unassisted attempts to transfer themselves. The policy indicated that fall injury prevention intentions will be customized to each resident.A policy addressing resident's safety, supervision, and accident prevention was requested multiple times but was not provided.