STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675272	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbend Nursing and Rehabilitation Center	2231 Highway 80 E Mesquite, TX 75150

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interview and record review, the facility failed to include pertinent information when notifying the resident's emergency contact and failed to immediately notify the responsible party when there was a change in condition for one (Resident #13) of four residents reviewed for notification of changes. The facility failed to ensure Resident #13's responsible party was notified on 2/24/2025 that Resident #13 was transferred to the hospital for dehydration and acute renal failure. The facility failed to ensure Resident #13's emergency contacts were notified what hospital Resident #13 was transferred to on 2/24/2025. These failures could place residents' responsible parties at risk of not being informed of changes in the residents' conditions and of not knowing where residents were located. Findings included: Record review of Resident #13's Admission MDS assessment dated [DATE] revealed Resident #13 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of dehydration, cognitive communication deficit (difficulty communicating needs), malnutrition, and renal insufficiency or end stage renal disease (kidney failure). Section C of the MDS assessment revealed Resident #13 had a BIMS score of 12 (indicated moderate cognitive impairment). Record review of Resident #13's care plan with a closed date of 2/27/2025 revealed Resident #13's contact information would be updated with Power of Attorney or legally authorized representative information. Resident #13's care plan also revealed the resident was at risk for impaired cognitive function or impaired thought processes. Record review of Resident #13's face sheet dated 3/21/2025 revealed Resident #13's POA was listed as emergency contact number one with his name and phone number. Resident #13's friend was listed as emergency contact number two. Record review of Resident #13's progress notes on 2/24/25 at 9:22 p.m. entered by RN A revealed an order was received from the doctor to send Resident #13 to the hospital for dehydration and acute renal failure. This note revealed the resident and responsible party were notified. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #13's progress notes on 2/24/2025 at 10:03 p.m. entered by RN A revealed the name of Resident #13's representative that was notified was the friend who was emergency contact number two. In an interview on 3/21/2025 at 10:18 a.m., Resident #13's friend (emergency contact two) reported he received a message from the facility indicating Resident #13 was being sent to the hospital for dehydration. The friend stated the facility did not tell him what hospital Resident #13 was sent to. The friend stated they had to find Resident #13 because the facility did not know where Resident #13 was. The friend reported they went to the facility, and Resident #13 was not there. The friend stated they had to call the police because the facility could not find Resident #13. The friend reported the facility made several phone calls and determined Resident #13 was transferred from one hospital to another hospital. Record review of Resident #13's friend's (emergency contact number two) voicemail dated 2/24/2025 at 9:26 p.m. revealed a message was left indicating the call was from the facility, and Resident #13 was being sent to the hospital for dehydration. The voicemail did not indicate to what hospital. In an interview on 3/21/2025 at 3:46 p.m., RN A reported she received an order from the doctor to send Resident #13 to the hospital because Resident #13 had acute renal failure. RN A stated Resident #13 asked her to call his friend (the second emergency contact) and let the friend know he was being transferred to the hospital. RN A stated she called the friend (the second emergency contact) twice, but no one answered. RN A stated she left a voicemail for the friend (the second emergency contact). RN A stated she did not attempt to call the POA because there was not a name next to the number on the face sheet. RN A stated the family and emergency contact should always be contacted if there was a change in condition. RN A did not state what could happen if the POA was not notified of a change in condition. In an interview on 3/24/25 at 8:55 a.m., Resident #13's POA stated he was not notified on 2/24/2025 that Resident #13 was transferred to the hospital, and he did not know where the resident was at that time. The POA stated he wanted to be notified and was unable to find the resident. The POA reported Resident #13's friend (the second emergency contact) had received a message but had not spoke with anyone at the facility. The POA stated after Resident #13's friend (the second emergency contact) notified him that Resident #13 was sent to the hospital that he had to call the hospital which told him the resident was not there. The POA reported they did not know what hospital Resident #13 was at. The POA stated the police had to be called by Resident #13's friend (the second emergency contact) to the facility to determine Resident #13 was transferred from the initial hospital to another hospital. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 3/25/2025 at 9:42 a.m., the DON reported the nurses are expected to notify the first contact for transfers or changes in condition. The DON stated the POA should always be notified unless the resident requested someone else to be notified. The DON reported that the day after Resident #13 was sent to the hospital that Resident #13's friend (second emergency contact) went to the facility to find Resident #13. The DON stated the friend had gone to the hospital, but Resident #13 was not there. The DON reported the friend's husband went outside and called the police while the facility staff were making calls to determine where Resident #13 was. The facility staff were able to contact the hospital and determined Resident #13 was sent to another hospital. The DON reported the initial hospital did not notify the facility of the transfer to another hospital. The DON opened her laptop and confirmed Resident #13's face sheet had a name and number listed for Resident #13's POA. The DON stated she expected that the POA would be notified first for any changes in condition, and the risk would be that the POA would not be able to make decisions pertaining to the resident. The DON reported the ADONs and herself were responsible for monitoring who was notified of changes in condition. Record review of the facility's policy titled Change of Condition, with a revision date of 07/2015, revealed the Licensed nurse will inform family/responsible party of change of condition and document notification. Record review of Resident Rights from the CMS website accessed on 3/26/2025 at https://downloads.cms.gov/medicare/your_resident_rights_and_protections_section.pdf revealed, The nursing home must notify your doctor and, if known, your legal representative or an interested family member when the following occurs . the nursing home decides to transfer or discharge you from the nursing home.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and treatment consistent with professional standards of practice to promote healing and to prevent further development of skin breakdown or pressure ulcers for three (Resident #22, Resident #30, and Resident #87) of five residents reviewed for pressure ulcers. 1. The facility failed to ensure Resident #22's and Resident #87's wounds were measured on the weekly skin assessment per facility policy. 2. The facility failed to ensure Resident #22, Resident #30, and Resident #87 were repositioned or turned to prevent skin breakdown and promote healing of pressure sores per facility policy, care plans, and physician orders. These failures could place residents at risk for worsening pressure ulcers, new pressure ulcers, or discomfort. Findings included: Record review of Resident #22's Admission MDS assessment dated [DATE] revealed Resident #22 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of diabetes, a fracture of the upper end of the humerus (arm bone near the shoulder), malnutrition, muscle weakness, and obesity with a BMI of 50-59.9. Section C of the MDS assessment revealed Resident #22 had a BIMs score of 12 (indicated moderate cognitive impairment). Section GG of the MDS assessment revealed Resident #22 was dependent on staff and required staff to provide all effort to roll to either side. Section M of the MDS assessment revealed Resident #22 had two pressure ulcers upon admission. Record review of Resident #22's care plan with a revision date of 3/25/2025 revealed Resident #22 had pressure ulcers or potential to develop pressure ulcers related to decreased mobility. The care plan listed an intervention to complete a weekly head to toe skin assessment. Record review of Resident #22's weekly skin assessment dated [DATE] revealed Resident #22 admitted with two pressure ulcers: 1. Stage two (partial thickness loss of the skin and an open wound) on the right buttock that measured 0.5x0.5x0.1cm 2. Stage two (partial thickness loss of the skin and an open wound) on the left buttock that measured 0.8x0.7x0.1cm Record review of Resident #22's weekly skin assessment dated [DATE] revealed no measurements were taken of pressure ulcers. Record review of Resident #22's weekly skin assessment dated [DATE] revealed no measurements were taken of pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 3/21/2025 at 9:11 a.m., CNA D and CNA E provided incontinent care to Resident #22. While Resident #22 was turned on her right side a quarter sized open wound on the left buttocks was observed. After incontinent care was completed, CNA D and CNA E positioned Resident #22 flat on her back and buttocks in the bed. Pillows were placed under Resident #22's right arm. In an interview on 3/21/2025 at 9:36 a.m., Resident #22 stated the staff never turned her on her side or used pillows to reposition her. Resident #22 stated she would allow the staff to place pillows under her because her back did sink into the bed. Resident #22 was not aware she had a pressure ulcer or how long it had been there. In an interview on 3/21/2025 at 9:40 a.m., CNA D stated they turned residents every two hours, so residents would not develop pressure ulcers. CNA D stated Resident #22 did not like to turn, so they just used the air mattress. In an interview and observation on 3/21/2025 at 10:59 a.m., Resident #22 was lying flat in the bed with no pillows under her back or buttocks. Resident #22 stated the staff had not put a pillow under her yet, but they might be busy. In an observation on 3/21/2025 at 11:34 a.m., Resident #22 was observed lying flat in bed with no pillows under her back or buttocks. In an observation on 3/21/2025 at 2:35 p.m., Resident #22 was observed lying flat in bed with no pillows under her back or buttocks. In an observation on 3/21/2025 at 4:20 p.m., Resident #22 was observed lying flat in bed with no pillows under her back or buttocks. - Record review of Resident #30's Quarterly MDS assessment dated [DATE] revealed Resident #30 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of diabetes, stroke, malnutrition, and hemiplegia or hemiparesis (weakness or paralysis of one side of the body). Section B of the MDS assessment indicated Resident #30 was in a persistent vegetative state or had no discernible consciousness (loss of cognitive function or awareness). Section GG of the MDS assessment revealed Resident #30 had an impairment of all extremities (legs and arms). Section M of the MDS assessment revealed Resident #30 was at risk for developing pressure ulcers and had zero pressure ulcers at that time. Record review of Resident #30's care plan with a revision date of 3/06/2025 revealed Resident #30 had potential for pressure ulcers and should be repositioned as tolerated. On 3/06/2025 the care plan was updated to include Resident #30 had developed a stage three (full thickness tissue loss) pressure ulcer to the upper right back and should be repositioned as tolerated. Record review of Resident #30's weekly skin assessment dated [DATE] revealed Resident #30 developed a stage three (full thickness tissue loss) pressure ulcer to the upper right back on 3/05/2025. Measurements on 3/12/2025 were 2.4x5.0x1.0cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #30's weekly skin assessment dated [DATE] revealed the stage three pressure ulcer to Resident #30's upper right back measurements were 1x3.6x0.4cm. Record review of Resident #30's physician order dated 3/06/2025 revealed an order to turn and reposition Resident #30 every two hours and as needed. In an observation on 3/21/2025 at 12:29 p.m., Resident #30 was lying in bed flat on his buttocks with his right shoulder slightly elevated. A pink foam wedge was under the right shoulder. No other pillows or wedges were observed. In an observation on 3/21/2025 at 2:40 p.m., Resident #30 was lying in bed flat on his buttocks with his right shoulder slightly elevated. A pink foam wedge was under the right shoulder. No other pillows or wedges were observed. In an observation on 3/21/2025 at 4:27 p.m., Resident #30 was lying in bed flat on his buttocks with his right shoulder slightly elevated. A pink foam wedge was under the right shoulder. No other pillows or wedges were observed. - Record review of Resident #87's Quarterly MDS dated [DATE] revealed Resident #87 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of hip fracture, dementia, and lack of coordination. Section C of the MDS assessment revealed Resident #87 had a BIMs score of 09 (indicated moderate cognitive impairment). Section GG of the MDS assessment revealed Resident #87 had impairment of range of motion in both arms. Section M of the MDS assessment revealed Resident #87 was at risk for developing pressure ulcers but had zero pressure ulcers at that time. Record review of Resident #87's care plan with a revision date of 2/01/2025 revealed Resident #87 had developed a stage four (full thickness tissue loss with exposed bone, tendon, or muscle) and interventions included to turn and reposition the resident as tolerated. The care plan also revealed Resident #87 was on hospice services for heart disease. Record review of Resident #87's weekly skin assessment dated [DATE] revealed Resident #87 had five wounds develop while in the facility: 1. Site 1 was an unstageable (wound bed was not visible due to dead tissue) pressure ulcer on the left heel that developed on 12/11/2024 with measurements of 3.8x2.8x0cm on 2/19/2025 2. Site 2 was an unstageable (wound bed was not visible due to dead tissue) pressure ulcer on the right heel that developed on 1/08/2025 with measurements of 5.8x2.3x0cm on 2/19/2025 3. Site 3 was a suspected deep tissue injury (discolored intact skin or blister caused by pressure or skin shearing) on the left lateral (side away from the middle) lower leg that developed on 1/08/2025 with measurements of 2.1x1.1x0cm on 2/19/2025 4. Site 4 was a suspected deep tissue injury (discolored intact skin or blister caused by pressure or skin shearing) on the left dorsal foot (upper surface of foot) that developed on 1/08/2025 with measurements of 1.5x1.7x0cm on 2/19/2025 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Site 5 was an unstageable (wound bed was not visible due to dead tissue) wound on the sacrum that developed on 1/10/2025 with measurements of 6.3x8.7x2.5cm on 2/19/2025 Interventions listed on this skin assessment included to turn or reposition the patient every two hours. Record review of Resident #87's weekly skin assessment dated [DATE] revealed Resident #87 had five wounds: 1. Site 1 was an unstageable (wound bed was not visible due to dead tissue) pressure ulcer on the left heel that developed on 12/11/2024 was not measured on 3/19/2025 2. Site 2 was an unstageable (wound bed was not visible due to dead tissue) wound on the right heel that developed on 1/08/2025 with measurements of 4.1x4.1x0cm on 3/19/2025 3. Site 3 was a suspected deep tissue injury (discolored intact skin or blister caused by pressure or skin shearing) on the left lateral (side away from the middle) lower leg that developed on 1/08/2025 with measurements of 1.8x1.2x0cm on 3/19/2025 4. Site 4 was a suspected deep tissue injury (discolored intact skin or blister caused by pressure or skin shearing) on the left dorsal foot (upper surface of foot) that developed on 1/08/2025 with measurements of 0.7x1x0cm on 3/19/2025 5. Site 5 was an unstageable (wound bed was not visible due to dead tissue) on the sacrum that developed on 1/10/2025 with measurements of 5.8x6.7x2.2cm on 3/19/2025 In an interview and observation on 3/21/2025 at 11:18 a.m., Resident #87 was lying flat in bed. One pillow was located under Resident #87's lower legs. Resident #87 stated sometimes the staff turned her, and she did not mind if they did. Resident #87 had difficulty answering questions due to cognitive impairment but was pleasant. In an observation on 3/21/2025 at 2:38 p.m., Resident #87 was lying flat in bed. One pillow was located under Resident #87's lower legs. In an observation on 3/21/2025 at 4:25 p.m., Resident #87 was lying flat in bed. One pillow was located under Resident #87's lower legs. - In an interview on 3/25/2025 at 10:29 a.m., LVN G stated she was the wound care nurse for the facility. LVN G stated if a resident was not turned every two hours, then bed sores could occur. LVN G stated nurses and CNAs on the floor monitored to ensure residents were turned. LVN G stated she also checked if residents were turned when she does wound care. LVN G reported if she had concerns about residents not being turned then she would tell the floor nurses or ADONs. LVN G stated she did not provide wound care for Resident #22 and was not familiar with that resident. LVN G stated Resident #87 and Resident #30 should have been repositioned. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/25/2025 at 11:28 a.m., ADON F stated skin assessments were completed weekly and nurses measured the wounds. ADON F stated the DON and nurses should monitor and ensure wounds were measured weekly. ADON F stated if there were no wound measurements she would know if wounds were getting larger, but a new nurse would not know. ADON F stated to prevent wounds, resident needed to be repositioned every two hours or more often. ADON F stated if residents were not repositioned then they could be in pain. ADON F stated there was no reason Resident #30 would not be repositioned every two hours. ADON F stated Resident #30 had developed new wounds recently, but they were healing. ADON F stated the charge nurses and ADONs should monitor and ensure residents were turned. ADON F stated her expectation was for residents to be turned every two hours. In an interview on 3/25/2025 at 9:42 a.m., the DON stated pressure sores were prevented by repositioning residents every two hours, providing skin care, and by monitoring the residents' nutritional status. The DON stated if a resident was not turned every two hours, then it could lead to pressure injuries. The DON reported the charge nurses monitored to ensure residents were turned every two hours. The DON stated her expectation was that there would not be any skin breakdown if they were doing what they were supposed to do. In an interview and observation on 3/25/2025 at 11:53 a.m., the DON reported Resident #22 admitted with wounds. The DON opened her laptop and confirmed measurements were obtained for wounds on 3/13/2025 but were not obtained again. The DON reported Resident #22 was sent to the hospital on 3/24/2025 and she did not know what the wound measurements were prior to the resident's transfer. The DON stated wounds were measured to determine if they were improving or deteriorating. The DON reported that wounds should have been measured with each weekly skin assessment that was completed. The DON stated the wound care nurse had assigned Resident #22's wound care to the floor nurses because the wounds were small. The DON stated she and the wound care nurse monitored wound measurements weekly. The DON stated she expected wounds to be measured weekly. The DON stated Resident #22 should have been repositioned as tolerated. Record review of facility's policy titled Skin and Wound Monitoring and Management, with a revision date of 01/2022, revealed It is the policy of this facility that: 1. A resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable; and 2. A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. The policy also revealed A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to: 1) Measuring the skin injury. The policy also revealed Prevention: In order to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan: . c. Reposition the patient.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interview and record review the facility failed to ensure residents received adequate supervision and assistance to prevent accidents for one (Resident #99) of five residents reviewed for falls. CNA B failed to reposition Resident #99 safely while in a shower chair in the shower room causing Resident #99 to have a fall on 2/17/2025. This failure could affect the residents by placing them at risk for discomfort, pain, and/or injury. Findings included: Record review of Resident #99's Quarterly MDS assessment dated [DATE] revealed Resident #99 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of dementia, cognitive communication deficit (difficulty communicating needs), and absence of right foot. Section C of the MDS assessment revealed a BIMs score of 03 (indicated severe cognitive impairment). Section GG of the MDS assessment revealed Resident #99 was dependent with showering and required the helper to provide all of the assistance or the assistance of two or more helpers while showering. Record review of Resident #99's care plan with a revision date of 2/19/2025 revealed Resident #99 was totally dependent on staff to provide baths. On 2/19/2025 an intervention was added that stated Resident #99 required two staff members for repositioning in the shower. Record review of Resident #99's progress note dated 2/17/2025 at 6:35 p.m. by LVN C, revealed LVN C was called to the shower room by CNA B. The note revealed LVN C saw Resident #99 sitting on the bathroom floor and leaning halfway on the shower chair with a mechanical sling under her. The note revealed CNA B told LVN C she was adjusting the mechanical lift sling under Resident #99 when the resident slid out of the shower chair. The note revealed CNA B lowered Resident #99 to the floor. The note revealed Resident #99 did not have injuries. In an interview on 3/21/2025 at 3:35 p.m., CNA B stated she was showering Resident #99, and Resident #99 had a mechanical lift sling under her. CNA B reported this was a sling with an opening under the resident's bottom, so the resident's bottom could be cleaned. CNA B stated the sling was covering Resident #99's bottom, and she was unable to clean it properly. CNA B stated she tried to tug on the sling, so she could wipe Resident #99's bottom. CNA B reported a normal person could support themselves, but she had no legs. CNA B reported she was standing in front of the resident when she tugged on the sling, but Resident #99 was covered in soap. CNA B reported Resident #99 was slippery, had no legs, and started sliding out of the front of the chair. CNA B reported she was holding the sling and guided her to the ground. CNA B stated no one else was in the shower room with them, but she called LVN C for assistance after the fall. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/25/2025 at 9:42 a.m., the DON stated if a resident was transferred to a shower chair with a mechanical lift, then staff should get additional help to realign the sling. The DON stated staff should never pull the sling to reposition the resident because that can cause the resident to slide on the shower chair. The DON reported all CNAs were trained and in-serviced on safety transfers. The DON reported the floor nurses were responsible for monitoring the CNAs. The DON stated her expectation was for residents to be safely repositioned in shower chairs and that there were no falls. The DON stated the risks to the resident if not positioned safely was that residents could fall and have an injury. In an interview on 3/25/2025 at 2:20 p.m., LVN C reported he was sitting at the nurse's station facing the shower room when CNA B waved for him to go to the shower room. LVN C stated when he entered the shower room, Resident #99 was sitting in the floor against the shower chair. LVN C stated he assessed Resident #99, and there were no injuries. LVN C reported that CNA B told him she attempted to reposition Resident #99 because she was not sitting up. LVN C reported CNA B told him that she had to lower Resident #99 to the floor. LVN C stated CNA B should have called for help to reposition Resident #99 because the resident was much larger than CNA B. LVN C stated the risk for not calling for help is that there could be an accident. LVN C reported staff completed an in-service after the incident. In an interview on 3/25/2025 at 3:03 p.m., the DON reported an in-service was completed with the morning and day shift for two halls. The DON reported the staff on the other halls were not in-serviced. The DON reported no monitoring documentation was completed, but the nurses were supposed to monitor the CNAs. Record review of in-service dated 2/18/2025, revealed topics were 1. While providing care for residents that required hoyer lift during showers. Please ensure that resident is positioned correctly in the shower chair for fall prevention. 2. Call for assistance when needed. 21 signatures were noted. Record review of the facility's policy titled Fall Management System, with a revision date of 6/2018, revealed This facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices and functional programs as appropriate to prevent accidents.