Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER: Wesley Woods Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 Woodgate Drive Waco, TX 76712	

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interviews and record review, the facility failed to ensure the residents had the right to be free from abuse for one (Resident #1) out of seven reviewed for abuse. The facility failed to prevent abuse by failing to ensure Resident #1 was not pushed by CNA A resulting in a fall in his room on 5/27/2024. This failure placed residents at risk for abuse with potential for injuries, pain, trauma, and hospitalization . Findings included: Review of Resident #1's face sheet dated 6/12/2024 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: Osteoarthritis left knee (arthritis of the knee), Alzheimer's Disease (progressive brain disorder that destroys memory and thinking skills), Age-related Macular Degeneration (degenerative condition of the eye affecting sight), Psychophysical visual disturbances (auditory/visual hallucinations/delusions), Hearing loss, Hypertension (high blood pressure), and Cerebrovascular Disease (problem with blood flow in the brain). Review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 3 suggesting severe cognitive impairment. Section D for mood indicated no mood problems at that time. Section E for behavior indicated Resident #1 had delusions, verbal behaviors/symptoms directed toward others and had refusal of care behaviors 1 to 3 days in the last week. Review of Resident #1's care plan dated 6/12/2024 reflected Resident #1 had a witnessed fall and aggressive/combative behaviors on 5/27/2024 with an intervention of Resident had a witnessed fall related to aggressive and combative behaviors. Resident was assessed for injury and was found to have no injury at this time. Resident refused vitals and all other interventions. Redirection was ineffective. Resident was assisted back to bed. Fall and safety precautions maintained. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's progress notes dated 5/27/2024 at 10:00 AM by RN B reflected: Resident was being assisted to his room by this nurse and aides while showing combative behavior with staff and housekeeping. This nurse and aide walked resident to room and let go of resident when resident tried to swing again at this nurse and lost balance and fell on his bottom against his bed. This nurse and aides attempted to help resident up and resident continued with combative and aggressive behavior, but we were able to get resident backup and resident still attempted to swing at this nurse and aides when on his feet. This nurse and aides exited residents room to prevent resident from injuring staff or himself. Resident refused any VS check. Further review of progress notes on 5/28/2024 at 7:29 PM skin assessment completed and noted healing scratch to left lower back and left side of neck, no open areas noted, no s/s pain noted to areas. Review of neurological flow sheet dated 5/27/2024 for Resident #1 indicated an initial assessment was completed at 10:03 AM on 5/27/2024 by RN B with a note refused by resident. Review of PA progress note dated 5/27/2024 reflected 5/27 More agitation recently will add hydroxyzine to 75mg QID, was on this at home. Has been swinging at staff. Has done this before at home. Was able to speak to [FM]. Doing well with therapy. Family concerned about oral intake, seems good to me, but will follow up with BMP. PA progress notes further revealed that Resident #1's vital signs were taken at 10:27 AM on 5/27/2024. Under Assessment and Plan: 5/27 Increase hydroxyzine [anti-anxiety medications] to 75 mg QID. During an interview on 6/12/2024 at 11:34 AM, Resident #1 stated he was doing good and felt safe at the facility. He stated he remembered falling a while back and got some scratches, but it wasn't too bad. Resident #1 denied having any issues with staff or other residents but appeared confused at times and was not able to answer a question posed, but paused and shrugged his shoulders. During an interview on 6/12/2024 at 1:16 PM, the FM stated they were contacted by the facility on 5/27/2024 and informed that Resident #1 had fallen but had no injuries. The FM stated they went up to the facility on [DATE] and arrived about 30 minutes after the facility called. Resident #1 was in his room in bed. The FM stated about 5 to 10 minutes later the facility PA came in and spoke to Resident #1 and assessed him for increased agitation and stated he would increase his anxiety medication. The FM stated they later reviewed video footage of the incident and could see Resident #1 being pushed by CNA A and fell in his room, then staff left him alone. The FM stated no one ever asked Resident #1 if he was okay or attempted to check him out to see if he was hurt. The FM stated they did not see anyone enter his room again until they arrived approximately 30 minutes later. The FM stated she was very upset and was crying by what they had witnessed being done to Resident #1 in the video. The FM stated they had a care plan meeting the next day, 5/28/2024, at the facility to discuss Resident #1's behaviors and aggressiveness towards staff. The FM stated at the meeting they showed the video footage of the fall incident from 5/27/2024 to the AD. The FM stated the AD watched the video several times and immediately took action. The FM stated a head-to-toe skin assessment was completed for Resident #1. Resident #1 was noted to have a scratch on his left lower back and an abrasion to the left collar bone area. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/12/2024 at 2:24 PM the AD stated the facility had a care plan meeting with Resident #1's FM on 5/28/2024 about 3:00 PM. After the meeting the FM showed her and the DON the video footage from the fall incident on 5/27/2024 in Resident #1's room. The AD stated, in the video I see her [CNA B] push the resident to the ground; the nurse tries to jump in front of him to catch him, but she does not. The AD stated she could see the resident being combative with staff as they tried to help him up but Resident #1 was not assessed immediately due to aggressiveness. She stated in the video she could see staff assist Resident #1 to his feet, assist him to the bed where he sat down, and then staff left the room and closed the door behind them. The AD stated they immediately suspended the CNA and RN involved and notified the police, and the MD. The AD stated the DON had an immediate head to toe skin assessment completed on Resident #1 where a scratch on his lower back and an abrasion on his collar bone area were discovered. The AD stated the police arrived the next morning, 5/29/2024, and Resident #1 was interviewed by her with the police present. Resident #1 was able to recall that he fell and that someone pushed him from behind causing him to fall. Resident #1 showed his injuries to the police officer. During an interview on 6/12/2024 at 2:24 PM, the DON stated on 5/27/2024 she had received a call from RN B that Resident #1 had fallen. RN B had assessed him and had no injuries. She stated she was told the facility PA was on the unit at that time and saw the resident and also assessed him. She stated this was what RN B stated in the statement that she had given about the incident. She stated she was not aware Resident #1 had not been assessed until 5/28/2024 when the FM showed them the video. She stated on 5/28/2024, she watched the video of the fall incident provided by the FM and it showed CNA A pushing Resident #1 from the back. He fell hitting his bed on the way down and landed on his bottom. She stated she could not see RN B assess Resident #1 in the video nor hear her ask if he was okay or if she could take his vital signs. She stated CNA A was terminated after the incident and on 5/30/2024, RN B was provided 1:1 education on proper transfers, had to take a test, and complete a return demonstration before she was cleared to return to work on 5/31/2024. The DON stated Resident #1 was not assessed immediately because of his aggressive behavior. She stated the facility PA was on the unit and about 30 minutes after the fall the AP went to see Resident # 1. There were no new orders, no injuries noted, and no complaints from Resident #1 at that time. The DON stated on 5/30/24 Resident #1 indicated he had pain to his knees and ankles and was observed guarding his left shoulder. Xray images were ordered and ruled out any fractures. During an interview on 6/13/2024 at 10:37 AM, RN B stated she was with Resident #1 and CNA A on 5/27/2024 when Resident #1 fell . RN B stated she did not see CNA A push the resident. She stated she did see him fall and tried to catch him but was not able to and he hit the bed and then landed on the floor on his bottom. She stated they immediately tried to help Resident #1 back up, but he was fighting with them and trying to hit them. She stated she thought she asked him if he was okay and if she could do vitals on him right after he fell . She stated she watched the video and could not hear herself ask if he was ok over CNA A talking. She stated she did not hear herself ask him if she could do vital signs and did not hear Resident #1 say no. She stated she has been trained on falls and stated they were supposed to assess residents after the fall to see if there were any injuries. She stated they left the room because Resident #1 was so agitated, and they wanted to give him time to calm down. She stated the next staff that went in Resident #1's room was the facility PA and that was about 30 minutes or so later and the FM was already in the room. (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

During an interview on 6/13/2024 at 11:42 AM, the Medical Director (MD) stated he was aware of the fall incident with Resident #1 on 5/27/2024 where he was pushed by CNA A. He stated his expectations after a fall was for the resident to be assessed to see if there were any injuries. If there were any major injuries needing emergency care, these should be taken care of and address any reasons for the fall to prevent a recurrence. The MD stated he would have concerns about waiting 30 minutes or more to assess a resident, That is concerning if nobody asks him if he is okay or looks at him for 30 minutes. He stated his understanding was that Resident #1 had been assessed and had no injuries. He stated Resident #1 has been a very challenging resident that they had managed as well as they could until he started becoming more violent.

Review of video provided by the FM revealed on 5/27/2024 at 9:38 am Resident #1 was being assisted to his room by CNA A and RN B. Resident #1 was seen walking through the doorway with both staff and was struggling with staff. RN B lets go of his left hand and then CNA A lets go of his right hand and was seen taking her left hand and pushing it against Resident #1's back causing him to fall to the ground, striking the bed, and landing on the floor on his bottom. Staff was then seen trying to assist Resident #1 up and he was resisting. The staff gets Resident #1 to his feet and assisted him to the bed where he sat down. Staff then left the room and closed the door. Audio review does not indicate if any staff asked him if he was okay after the fall or if any staff asked him if they could check his vitals and Resident said 'no'.

Review of statement dated 5/29/2024 at 10:05 AM, CNA A revealed she denied doing anything to Resident #1 and that he had been forcefully pulling away. In an attempt not to hurt [Resident #1[due to his pulling from us, [RN B] and I let him go, at which time I began to fall and was able to break my fall. I attempted to brace [Resident #1] from falling but it was too late.

Review of statement dated 5/29/2024 at 8:52 AM, RN B stated CNA A had come to help her get Resident #1 to his room and we both help him to his room while he is still trying to hit us, we let go of his arms when we enter the room and at that point [Resident #1] attempts to hit us again and tumbles over his feet and falls to the ground with his back on the bed I ask him is he okay and can I take his vitals. {Resident #1] replies to me no and begins to cuss at us again. We finally were able to get him up and he tells us get the *** out so we leave the room.

Review of facility self-report dated 5/29/2024 that included Plan of Correction and steps taken reflected:

o Reviewed footage from the family multiple times and then reviewed footage from the facility cameras and it Is almost definite that the resident was pushed by CNA [CNA A] resulting in him becoming unsteady and falling. He fell on to his left side brushing against the bed frame and the overbed table.

o Interview with resident with officer [name omitted] present-resident able to recall that he fell . He was not able to recall the day, but he recalls someone pushing him from behind causing him to lose his balance and he fell . He pulled up his sweater and showed the officer the area on his left clavicle and the scratch on his left lower back.

Review of CNA A onboarding folder reflected she had received training on ANE on 9/16/2002 and the form was signed by CNA A. Further review reflected a document Senate [NAME] 9. Legislation on curbing abuse was signed on 9/16/2020 by CNA A indicating CNA A had been made aware of how to curb abuse.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of background check information provided by facility on 6/13/2024 reflected appropriate background checks (employability, criminal and license checks) were performed prior to hire and yearly as required for CNA A and RN B. Review of facility in-service training sheet dated 5/21/2024 with topics Abuse and Neglect, who to report allegations of abuse to, Resident Rights, Customer Service reflected the printed name and signature of CNA A. The in-service sheet had a copy of the facility Abuse and Neglect Policy attached, copy of the Resident Rights hand out attached, as well as hand out with the Abuse Coordinator's information and phone number. Review of undated facility Policy Prevention and Reporting of Suspected Abuse and Neglect reflected This facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. This facility has implemented the following processes in an effort to provide residents and staff a comfortable and safe environment. The Administrator and Director of Nursing are responsible for the implementation and ongoing monitoring of abuse policies and procedures. Implementation and ongoing monitoring consist of the following policies: Screening, Training, Prevention, Identification, Protection, Investigation, and Reporting.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interviews and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one of three residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1 was assessed by RN B for injuries after his fall on 5/27/2024. This failure placed residents at risk for potential injuries, pain, and hospitalization . Findings included: Review of Resident #1's face sheet dated 6/12/2024 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: Osteoarthritis left knee (arthritis of the knee), Alzheimer's Disease (progressive brain disorder that destroys memory and thinking skills), Age -related Macular Degeneration (degenerative condition of the eye affecting sight), Psychophysical visual disturbances (auditory/visual hallucinations/delusions) , Hearing loss, Hypertension (high blood pressure), and Cerebrovascular Disease (problem with blood flow in the brain). Review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 3 suggesting severe cognitive impairment. Section D for Mood indicated no mood problems at that time. Section E for Behavior indicated Resident #1 had delusions, verbal behaviors symptoms directed toward others and had refusal of care behaviors 1 to 3 days in the last week. Review of Resident #1's care plan dated 6/12/2024 reflected Resident #1 had a witnessed fall and aggressive/combative behaviors on 5/27/2024 with an intervention of Resident had a witnessed fall related to aggressive and combative behaviors. Resident was assessed for injury and was found to have no injury at this time. Resident refused vitals and all other interventions. Redirection was ineffective. Resident was assisted back to bed. Fall and safety precautions maintained. Review of Resident #1's progress notes dated 5/27/2024 at 10:00 AM by RN B reflected: Resident was being assisted to his room by this nurse and aides while showing combative behavior with staff and housekeeping. This nurse and aide walked resident room and let go of resident when resident tried to swing again at this nurse and lost balance and fell on his bottom against his bed. This nurse and aides attempted to help resident up and resident continued with combative and aggressive behavior, but we were able to get resident backup and resident still attempted to swing at this nurse and aides when on his feet. This nurse and aides exited residents room to prevent resident from injuring staff or himself. Resident refused any VS check. Further review of progress notes on 5/28/2024 at 7:29 PM skin assessment completed and noted healing scratch to left lower back and left side of neck, no open areas noted, no s/s pain noted to areas. Review of neurological flow sheet dated 5/27/2024 for Resident #1 indicated an initial assessment was completed at 10:03 AM on 5/27/2024 by RN B with note refused by resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of PA progress note dated 5/27/2024 reflected 5/27 More agitation recently will hydroxyzine to 75mg QID, was on this at home. Has been swinging at staff. Has done this before at home. Was able to speak to daughter, Crystal. Doing well with therapy. Family concerned about oral intake, seems good to me, but will follow up with BMP. PA progress notes further revealed that Resident #1's vital signs were taken at 10-:27 AM on 5/27/2024. Under Assessment and Plan: 5/27 Increase hydroxyzine [anti-anxiety medications] to 75 mg QID. During an interview on 6/12/2024 at 11:34 AM, Resident #1 stated he was doing good and felt safe at the facility. He stated he remembered falling a while back and got some scratches, but it wasn't too bad. Resident #1 denied having any issues with staff or other residents but appeared confused at times and had trouble answering questions. During an interview on 6/12/2024 at 1:16 PM, FM stated they were contacted by the facility on 5/27/2024 and informed that Resident #1 had fallen but had no injuries. FM stated they went up to the facility on [DATE] and arrived about 30 minutes after the facility called. Resident #1 was in his room in bed. FM stated about 5 to 10 minutes later the facility PA came in and spoke to Resident #1 an assessed him for increased agitation and stated he would increase his anxiety medication. FM stated they later reviewed video footage of the incident and could see Resident #1 being pushed by CNA A and fell in his room, then staff left him alone. FM stated no one ever asked Resident #1 if he was okay or attempted to check him out to see if he was hurt. FM stated they did not see anyone enter his room again until they arrived approximately 30 minutes later. FM stated she was very upset and was crying by what they had witnessed being done to Resident #1 in the video. FM stated they had a care plan meeting the next day, 5/28/2024, at the facility to discuss Resident #1's behaviors and aggressiveness towards staff. FM stated at the meeting they showed the video footage of the fall incident from 5/27/2024 to the AD. FM stated the AD watched the video several times and immediately took action. FM stated a head-to-toe skin assessment was completed for Resident #1. Resident #1 was noted to have a scratch on his left lower back and an abrasion to the left collar bone area. During an interview on 6/12/2024 at 2:24 PM the AD stated the facility had a care plan meeting with Resident #1's FM on 5/28/2024 about 3:00 PM. After the meeting the FM showed her and the DON the video footage from the fall incident on 5/27/2024 in Resident #1's room. AD stated, in the video I see her [CNA B] push the resident to the ground; the nurse tries to jump in front of him to catch him, but she does not. Ad stated she could see resident being combative with staff as they tried to help him up but Resident #1 was not assessed immediately due to aggressiveness. She stated in the video she could see staff assist Resident #1 to his feet, assist him to the bed where he sat down and then staff left the room and closed the door behind them. AD stated they immediately suspended the CNA and RN involved and notified the police and MD. AD stated the DON had an immediate head to toe skin assessment completed on Resident #1 where a scratch on his lower back an abrasion on his collar bone area were discovered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/2024 at 2:24 PM, DON stated on 5/27/2024 she had received a call from LVN B that Resident #1 had fallen, RN B had assessed him, and had no injuries. She stated she was told the facility PA was on the unit at that time and saw the resident and also assessed him. She stated this is what RN B stated in the statement that she had given about the incident. She stated she was not aware Resident #1 had not been assessed until 5/28/2024 when FM showed them the video. She stated on 5/28/2024, she watched the video of the fall incident provided by the FM and it showed CNA A pushing Resident #1 from the back and he fell hitting his bed on the way down and landed on his bottom. She stated she could not see RN B assess Resident #1 in the video nor hear her ask if he was okay or if she could take his vital signs. She stated CNA A was terminated after the incident and on 5/30/2024, RN B was provided 1:1 education on proper transfers, had to take a test and complete a return demonstration before she was cleared to return to work on 5/31/2024. DON stated Resident #1 was not assessed immediately because of his aggressive behavior. She stated the facility PA was on the unit and about 30 minutes after the fall the AP went to see Resident # 1 - there were no new orders, no injuries noted and no complaints from Resident #1 at that time. DON stated on 5/30/24 Resident #1 resident indicated he had pain to his knees and ankles and was observed guarding his left shoulder. Xray images were ordered and ruled out any fractures. DON stated her expectation was that residents would be assessed immediately after a fall for any injuries and documented in the medical record She stated after Resident #1's fall it would have been the nurse's responsibility to assess the resident. She stated when the RN called her to tell her about the fall, the RN told her she has assessed him and that is what she put in her statement. DON stated she was informed that after the fall, Resident #1 was being combative and aggressive so his assessment could have only made him more upset, but the RN should have attempted or give him time to calm down and then go back a little while later - maybe 10-15 minutes. She stated if residents were not assessed after falls there could be injuries that are not addressed. During an interview on 6/13/2024 at 10:37 AM, RN B stated she was with Resident #1 and CNA A on 5/27/2024 when Resident #1 fell . RN B stated she did not see CNA A push the resident, but she did see him fall and tried to catch him but was not able to and hit the bed and then landed on the floor on his bottom. She stated they immediately tried to help Resident #1 back up, but he was fighting with them and trying to hit them. She stated she thought she asked him if he was okay and if she could do vitals on him right after he fell . She stated she watched the video and could not hear herself ask if he was ok over CNA A talking. She stated she did not hear herself ask him if she could do vital signs and did not hear Resident #1 say no. She stated she has been trained on falls and stated they are supposed to assess residents immediately after the fall to see if there are any injuries and that she had not followed facility policy and assessed Resident #1 after his fall She stated they left the room because Resident #1 was so agitated, and they wanted to give him time to calm down. She stated the next staff that went in Resident #1's room was the facility PA and that was about 30 minutes or so later and FM was already in the room. She stated when an assessment is completed it should be documented in the progress notes. She stated she knows she documented his neurological assessment but wasn't sure about his fall assessment. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/2024 at 11:42 AM, the Medical Director (MD) stated he was aware of the fall incident with Resident #1 on 5/27/2024 where he was pushed by CNA A. He stated his expectations after a fall is for the resident to be assessed immediately to see if there are any emergent injuries. If there are any major injuries needing emergency care, these should be taken care of and address any reasons for the fall to prevent a recurrence. MD stated he would have concerns about waiting 30 minutes or more to assess a resident, That is concerning if nobody asks him if he is okay or looks at him for 30 minutes. He stated his understanding was that Resident #1 had been assessed and had no injuries. He stated Resident #1 has been a very challenging resident that they had managed as well as they could until he started becoming more violent. Review of video provided by FM revealed on 5/27/2024 at 9:38 am Resident #1 was being assisted to his room by CNA A and RN B. Resident #1 is seen walking through the doorway with both staff and is struggling with staff. RN B lets go of his left hand and then CNA A lets go of his right hand and is seen taking her left hand and pushing it against Resident #1's back causing him to fall to the ground, striking the bed and landing on the floor on his bottom. Staff is then seen trying to assist Resident #1 up and he is resisting. The staff gets Resident #1 to his feet and assists him to the bed where he sits down. Staff then leaves the room and closes the door. Audio review does not indicate any staff asked him if he was okay after the fall or if any staff asked him they could check his vitals and Resident said 'no'. Review of statement dated 5/29/2024 at 8:52 AM, RN B stated CNA A had come to help her get Resident #1 to his room and we both help him to his room while he is still trying to hit us, we let go of his arms when we enter the room and at that point [Resident #1] attempts to his us again and tumbles over his fee and falls to the ground with his back on the bed I ask him is he okay and can I take his vitals. {Resident #1] replies to me no and begins to cuss at us again. We finally were able to get him up and he tells us get the *** out so we leave the room. Review of facility self-report dated 5/29/2024 that included Plan of Correction and steps taken reflected: o Reviewed footage from the family multiple times and then reviewed footage from the facility cameras and it Is almost definite that the resident was pushed by CNA [CNA A] resulting in him becoming unsteady and falling. He fell on to his left side brushing against the bed frame and the overbed table. o Interview with resident with officer [name omitted] present-resident able to recall that he fell . He was not able to recall the day but he recalls someone pushing him from behind causing him to loose his balance and he fell . He pulled up his sweater and showed the officer the area on his left clavicle and the scratch on his left lower back. Review of undated facility Policy Fall and Post-Fall management under heading Post-Fall Procedure: 1. Document in the resident's medical record information about the fall to including pain assessment, neurological assessments (if applicable), assessment for injury, witnesses (if any), and any other pertinent information.