

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Atrium of Bellmead		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Development Blvd Bellmead, TX 76705	
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 - Some	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** Based on observation, interview, and record review, the facility failed to consult with the resident's physician when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention for 1 (R#1) of 5 residents. The facility failed to ensure staff notified R#1's Physician, Hospice Physician and NP when R#1 fell during a 1-person transfer without a gait belt on 7/14/26, 7/19/26, and 7/20/26. R#1 cried, said her buttocks was hurting, and complained of right hip pain after the fall on 7/19/26. R#1 also cried and said her right hand was hurting and she hit her leg after the fall on 7/20/26. This failure could place residents at risk of falls and injuries. Findings include: Review of R#1's admission Record, dated 7/21/26, reflected she was admitted to the facility on [DATE]. R#1 also had medical diagnoses that included late onset Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), dementia (a decline in mental ability severe enough to interfere with daily life), muscle wasting and atrophy, muscle weakness, lack of coordination, psychotic disorder with hallucinations, and bone density and structure disorders. Review of R#1's Quarterly MDS Assessment, dated 6/25/26, reflected staff were unable to interview her for BIMS. R#1 also had no falls since admission. R#1 was dependent on staff assistance with transfers. Review of R#1's Care Plan, revised 4/23/26, reflected she was at risk for falls. Staff were required to use 1-person assistance with R#1's transfers. Review of R#1's Fall Risk Assessment, dated 4/20/26, reflected she was a high fall risk. Review of R#1's Fall Event Nurses' Note, created by RN A on 7/14/26 at 11:13 p.m., reflected, CNA notifies this charge nurse that resident is on the floor. Patient was sitting on the floor with her back against her recliner. CNA stated, 'I attempted to move patient from her recliner to the bed, but she didn't stand up as well as she normally does. She sat back down at the edge of the recliner. When she attempted to scoot back in the chair, the chair moved, and she fell on her buttocks.' R#1 didn't receive an injury from the fall and didn't appear or state to be in pain. There were no interventions in place prior to this fall. Interventions that were initiated in response to the fall included a floor mat and walker. R#1's Hospice Nurse was notified. Review of R#1's Fall Event Nurse's Note, created by RN B on 7/19/26 at 1:06 p.m., reflected, CNA attempted to transfer resident into her recliner using a walker. Her legs gave out and resident was assisted to the floor. Denies hitting her head. Denies pain. No swelling noted. R#1 didn't receive an injury from the fall and didn't appear or state to be in pain. R#1's statement reflected she fell. There were no interventions in place prior to this fall. Interventions that were initiated in response to the fall included educating the CNA on transferring R#1 with 2-person assistance. R#1's Physician and Hospice Nurse was notified. Review of R#1's Fall Event Nurse's Note, created by LVN C on 7/20/26 at 2:20 p.m., reflected, Resident transferring with CNA from wheelchair to recliner when her knee (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676289
		If continuation sheet Page 1 of 24

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	started to hurt so resident went to sit down and missed seat of recliner, resident then slide to bottom on the floor in front of the recliner. R#1 didn't receive an injury from the fall. R#1 appeared and stated to be in pain to her right knee. There were no interventions in place prior to this fall and no new interventions initiated in response to this fall. R#1's Hospice Nurse was notified. Review of R#1's POC for July 2026 reflected staff documented they provided 1-person assistance with transfers on 7/14/26 at 1:59 p.m. and 3:18 p.m. and 7/19/26 at 1:44 p.m. Review of Video Footage, dated 7/19/26 at 1:02 p.m., reflected R#1 was sitting in her wheelchair. CNA D entered the room and explained to R#1 that she was going to put her in her recliner so she could put her feet up. CNA D took off the foot pedals from R#1's wheelchair, pushed the wheelchair in front of the recliner, locked the wheelchair wheels, held R#1's left hand with her left hand, held onto R#1's left Tricep with her right arm as she tried to pull R#1 forward and towards the recliner. R#1 didn't move in her wheelchair, CNA D backed the wheelchair from the recliner, placed R#1's walker in front of R#1, and the gait belt hung on the walker. CNA D placed both R#1's hands on the walker, held onto R#1's left arm using her left arm, pulled on R#1's gown up and lifted R#1 with her left arm. R#1 fell forward and over her walker, and her knees landed on the floor as she tried to hold onto the recliner with her upper body. R#1 also cried and told staff to look at her buttocks because it was hurting a little bit when they asked her if she was hurting anywhere. Review of Video Footage, dated 7/20/26 at 2:16 p.m., reflected R#1 was sitting in her wheelchair. CNA E held onto R#1's left arm using her right arm, pulled R#1 up and towards the walker in front of her, pushed the wheelchair away from R#1, pivoted R#1 and the walker as R#1 held onto it until R#1's back faced the recliner. R#1 fell backwards, hit her right arm on the window sill and her back on the wall, slid down, landed on her buttocks on the floor, started to cry, and said, Ow my leg. There was no gait belt. R#1 also told staff her right hand was hurting and she hit her leg when they asked her if she was hurting. Review of the facility's Incident Log, from 6/1/26 through 7/21/26, reflected R#1 had a fall on 7/14/26 at 9:45 p.m. There were no other falls for R#1 documented on the log. Review of the facility's In-Services, from 7/1/26 through 7/21/26, reflected the ADON presented the in-service regarding R#1's to 22 staff on 7/20/26. Staff were taught to use two CNAs at all times, gait belt, walker, and talk to R#1 through the process when transferring her. CNA D did not sign the in-service. LVN C, CNA E, CNA F, CNA G, CNA H and LVN I signed the in-service. During a telephone interview with R#1's RP on 7/21/26 at 10:53 a.m., she said R#1 had no falls before her admission to the facility. She also said R#1 had dementia. She said RN A called and notified her on 7/14/26 that R#1 fell and CNA F was involved. She did not know and was not explained how R#1 fell on 7/14/26. She also said she notified the ADON, who told her that she would investigate the fall. She said she attended care plan meetings and asked staff to ensure R#1 had her walker and used 2-person assistance and a gait belt when transferring her. She said her family notified her on 7/19/26 that R#1 fell again. She also said she spoke with the ADON and RN B, who confirmed R#1 fell on 7/19/26. She said RN B told her that she did not know what happened on 7/19/26 and did not know what R#1's transfer protocols were. She also said R#1 complained of right hip pain after the fall on 7/19/26. She said she observed R#1 fall on 7/20/26 and went to the facility. She also said the ADON was not aware R#1 fell on 7/20/26 and she notified the DON on unknown date. During an interview with R#2 on 7/21/26 at 12:03 p.m., she said R#1 fell when CNA E did not properly sit R#1 down on 7/20/26. She said staff were required to transfer R#1 using 2-person assistance and a gait belt. During an observation and interview of R#1 on 7/21/26 at 12:04 p.m., R#1 was sitting in her wheelchair in front of the nurse's station. The surveyor attempted to interview R#1, but R#1 was unable to recall the falls and provide additional information. During an interview with CNA G on 7/21/26 at 1:10 p.m., she said she was not in-serviced on transfers prior to 7/21/26. She also said she read and signed an (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in-service regarding R#1 on 7/21/26 around 7:00 a.m. She said CNAs and the ADON transferred residents. She said her and CNA H transferred R#1 all the time. She said she also transferred R#1 by herself. She said R#1's family and other CNAs also transferred R#1 without a gait belt. She said LVN I asked her and CNA H to transfer R#1 on 7/21/26 because CNA F refused to go into R#1's room. She explained that her and CNA H transferred R#1 without a gait belt. She said R#1's family told her and CNA H that she told the staff and management about the issue with staff not using a gait belt when transferring R#1. She said she was aware that she did not transfer R#1 with a gait belt. She said she did not transfer R#1 with a gait belt because she did not think anything of it and never did before. She explained she was not told before 7/21/26 that a gait belt was required when transferring R#1 and was placed as an intervention on 7/21/26. She said she knew it was important to accommodate by transferring the resident with a gait belt and said, Proper transferring is going to ensure fall risk residents did not fall and that they did not lose balance. During an interview with CNA H on 7/21/26 at 1:37 p.m., he said he was not in-serviced on transfers before 7/20/26. He said the ADON had him read and sign an in-service regarding R#1 on 7/20/26. He said he did not read the in-service. He said CNAs, nurses and therapy staff transferred residents. He said he never had to transfer R#1. He explained CNA G asked him to help her transfer R#1 on 7/21/26. He said he and CNA H were on each side of R#1, stood R#1 up, and placed her in the chair. He also said he and CNA H did not use a gait belt when they transferred R#1. He said R#1's family walked in and informed him and CNA H that they informed RN J that anyone who transferred R#1 needed to use 2-person assistance with the gait belt. He explained he did not know anything about the interventions until after he and CNA H transferred R#1 without the gait belt. He said he knew it was important to accommodate by transferring the resident with a gait belt and said, For safety of resident and staff. Residents could be at risk of falling and could sustain injuries depending on how staff were grabbing the resident. During an interview with the ADON on 7/21/26 at 1:53 p.m., she said the nurse managers in-serviced staff. She said she provided staff with the in-service to read and sign on paydays and case by case. She couldn't remember when she most recently in-serviced staff on falls. She said CNAs and nurses transferred residents. She explained CNAs primarily transferred residents. She said R#1 needed more assistance with transfers in the last couple of days because R#1 had weakness and her legs would buckle. She said R#1 required 2-person assistance with a gait belt for transfers. She said she was working when R#1 fell on 7/14/26 and could not remember how R#1 fell. She said RN B notified her on 7/19/26 that R#1 had a witnessed fall, did not complain of pain, and did not sustain any injuries. She explained CNA D tried to transfer R#1 without a gait belt and by herself. She put R#1's walker in front of her, tried to assist her up but R#1's knees buckled, and she fell on 7/19/26. She said R#1's family provided her with the video footage. She said the IDT met on 7/20/26 and decided to in-service the staff. She said she put out an in-service about talking to R#1 through and using the gait belt and walker on 7/20/26 because of the fall R#1 had the night of 7/19/26. She said R#1's family notified her that CNA E tried to stand R#1 up by herself, tried to transfer R#1 into the recliner, R#1's legs buckled, and R#1 fell on 7/20/26. She said she investigated the incident. She said CNA E told her that she reviewed and signed the in-service. She said the IDT did not meet after R#1's 7/20/26 fall because the ADM and DON were not at the facility on 7/21/26, RN B was working as a floor nurse until 2:00 p.m. and her and RN B did not do clinical review. She said she was aware CNA G and CNA H transferred R#1 without a gait belt on 7/21/26. She said she knew it was important to accommodate by transferring the resident with a gait belt and said, To protect the resident and yourself. Residents could be at risk of injury. During an interview with LVN I on 7/21/26 at 2:18 p.m., she said she was in-serviced on gait belt safety use with 2-person assistance either on 7/20/26 or earlier on 7/21/26. CNAs and nurses transferred (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. She said R#1 used to require 1-person assistance and a gait belt with transfers. She said R#1's family recently expressed wanting staff to transfer R#1 using 2-person assistance and a gait belt. She said R#1 fell over the weekend. She said CNA E told her that she tried to transfer R#1 by herself on 7/20/26. She did not know whether or not CNA E used a gait belt when she tried to transfer R#1 by herself on 7/20/26. She said R#1's family told her that CNA G and CNA H transferred R#1 without a gait belt on 7/21/26. She said she knew it was important to accommodate by transferring the resident with a gait belt and said, for their safety. That's number one. Safety always come first. Residents could be at risk of getting hurt from the fall, hurt their arms, and we must use what is recommended for that person as well for us. During a telephone interview with the Physician on 7/21/26 at 3:22 p.m., he said he expected staff to use a Hoyer lift when transferring R#1, but R#1's family did not want them to use the device. He said a gait belt could be used to transfer R#1. He said he was aware that R#1 fell a couple times. He said staff did not notify him about R#1's fall on 7/14/26. He said RN B notified him that R#1 fell on 7/19/26. He also said staff did not notify him that R#1 fell on 7/20/26. He advised to call the NP for additional information. The surveyor attempted to call and interview the Hospice Physician on 7/21/26 3:42 p.m. A voicemail and call back number was left. R#1's Hospice Physician did not return the call before exit on 7/22/26. During a telephone interview with the NP on 7/21/26 at 4:05 p.m., she said she was not notified of R#1's falls on 7/14/26, 7/19/26 and 7/20/26. During an interview with CNA F on 7/22/26 at 11:21 a.m., she said she was recently in-serviced on transfers this past week. She explained she received, reviewed and signed the in-service. She said she could not remember if she worked with R#1 on 7/14/26, 7/19/26, and 7/20/26. She said she was notified that R#1 fell within this past week or two weeks. She said she knew it was important to accommodate by transferring the resident with a gait belt and said, We do not want residents falling. It's important to have a gait belt to be used and behind them because residents could have moments of losing balance and need to have something to hold onto. During a telephone interview with LVN C on 7/22/26 at 12:26 p.m., she said CNAs, nurses, and therapy staff transferred residents. She said she knew how to use a gait belt when a resident was a fall risk, required 1-2 person assistance, and was an increased fall risk. She said R#1 required 2-person assistance with a gait belt for transfers. She said R#1's family told her in the past on unknown date how they wanted R#1 properly transferred. She said CNA E told her on 7/20/26 that she moved R#1 towards the seat, R#1 missed the seat and fell. She said she did not know whether or not CNA E transferred R#1 by herself. She said she was in-serviced on transfers for R#1 on 7/21/26. She said she learned to use the gait belt, verbally guide R#1, and ensure R#1 held onto her walker when transferring her. She said she knew it was important to accommodate by transferring the resident with a gait belt and said, To prevent injuries, falls and trauma to the resident and staff. Residents could be at risk of getting hurt when assistive devices and appropriate number of staff weren't used during transfers. During a telephone interview with CNA E on 7/22/26 at 12:48 p.m., she said she could not remember when she was most recently in-serviced on transfers. She also said CNAs must use a gait belt during transfers and did not have to when a resident could stand up. She said she did not read the entire in-service on 7/20/26 because she was assisting another resident when staff handed the in-service to her. She said she did not use 2-person assistance and a gait belt when she tried to transfer R#1 because R#1 was doing good without the gait belt. She said she did not know R#1 required 2-person assistance with transfers and, It's my fault. She explained R#1 slipped from her walker that was placed in front of her recliner, fell on her knees, then turned over and fell on her buttocks, did not hit her head, did not complain of pain, and she notified LVN C and another nurse. She said she knew it was important to accommodate by transferring the resident with a gait belt and said, (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	To guarantee safety of residents. Residents could be at risk of safety and falls when appropriate number of staff and assistive devices aren't used during a transfer. During a telephone interview with CNA D on 7/22/26 at 1:08 p.m., she said she could not remember when she was most recently in-serviced on falls and transfers. She said CNAs transferred residents. She said R#1 required 1-person assistance with transfers, could pivot, and was independent. She said she worked with R#1 when R#1 fell on 7/19/26. She explained R#1 tried to stand up with the walker in front of her, she could not turn and her knees gave out. She lowered R#1 to the ground because she could not lift R#1, and notified RN B. She said R#1 told RN B that her buttocks hurt. During a telephone interview with RN K on 7/22/26 at 1:24 p.m., she said the ADON in-serviced her on transferring R#1 with 1-2 person assistance and a gait belt before 7/20/26. She said CNA E notified her that R#1 fell and did not explain how on 7/20/26. She said CNA E told LVN C that she was trying to transfer R#1 and her legs gave out. R#1 slid onto her buttocks, and did not hit her head. She said she knew it was important to accommodate by transferring the resident with a gait belt and said, So residents didn't fall and get hurt. Residents could have a fracture or break something when not using appropriate number of people and assistive devices. During an interview with RN A on 7/22/26 at 2:17 p.m., he said he could not remember when he was most recently in-serviced on transfers. He said R#1 required a gait belt when transferring her. He said CNA F notified him that R#1 fell on 7/14/26. He explained CNA F told him that she was transferring R#1 from the recliner and R#1 fell. He said CNA F was by herself when he entered R#1's room. He said CNA F did not tell him whether or not there were two people in the room when she transferred R#1. He said he knew it was important to accommodate by transferring the resident with a gait belt and said, It's safe to use gait belt during transfers. It's for safety and to follow procedure and for your own safety. Residents could be at risk of falling and sustaining injuries. During a telephone interview with RN B on 7/22/26 at 5:00 p.m., she said she was not in-serviced after R#1's fall on 7/19/26 because she did not return to the facility after the incident. She said R#1 required 1-person assistance with transfers at the time on 7/19/26. She said CNA D notified her that R#1 fell on 7/19/26. She said CNA D told her that she tried to transfer R#1 to the walker by herself and R#1's legs became weak, and R#1 fell. She said she did not know whether or not CNA D used a gait belt when she tried to transfer R#1 by herself. She said she knew it was important to accommodate by transferring the resident with a gait belt and said, To prevent fractures, injuries and death. During a telephone interview with the ADM on 7/22/26 at 5:13 p.m., she said nurse managers in-serviced staff on transfers routinely and annually. She said she could not remember when staff were most recently in-serviced on transfers. She said she expected CNAs to transfer residents according to their transfer status in their EHR. She said she could not remember exact details for R#1's falls on 7/14/26, 7/19/26 and 7/20/26. She also said she was unaware that staff did not use a gait belt when they transferred R#1 on those dates. She said the ADON notified her that CNA G and CNA H did not use a gait belt when they transferred R#1 on 7/21/26. During a telephone interview with the DON on 7/22/26 at 6:04 p.m., she said she expected staff to transfer residents according to their transfer status in the EHR. She said R#1 required a gait belt when being transferred. She said she expected staff to use 2-person assistance with transfers. She said she was notified R#1 fell during a transfer on 7/14/26. She said RN B notified her on 7/19/26 that R#1 fell during a transfer and recommended 2-person assistance. She said she could not remember whether or not a gait belt was used when R#1 fell during a transfer on 7/19/26. She said she had staff initiate in-services on falls. She said the ADON notified her on 7/20/26 that CNA E attempted to transfer R#1 by herself, did not use a gait belt and did not ask for help. Review of the facility's Notifying the Physician of Change in Status, 2003, reflected, The nurse should not hesitate to contact the physician at any time when an (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to review and revise 1 (R#1) of 5 residents' care plans. The facility failed to review and revise R#1's care plan to reflect she required a gait belt and 2-person assistance with transfers after she fell during a 1-person transfer without a gait belt on 7/14/26, 7/19/26, and 7/20/26. This failure could place residents at risk of not having their care and service needs met. Findings include: Review of R#1's admission Record, dated 7/21/26, reflected she was admitted to the facility on [DATE]. R#1 also had medical diagnoses that included late onset Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), dementia (a decline in mental ability severe enough to interfere with daily life), muscle wasting and atrophy, muscle weakness, lack of coordination, psychotic disorder with hallucinations, and bone density and structure disorders. Review of R#1's Quarterly MDS Assessment, dated 6/25/26, reflected staff were unable to interview her for BIMS. R#1 also had no falls since admission. R#1 was dependent on staff assistance with transfers. Review of R#1's Care Plan, revised 4/23/26, reflected she was at risk for falls. Staff were required to use 1-person assistance with R#1's transfers. There were no revised interventions regarding staff being required to use 2-person assistance and a gait belt when transferring R#1 prior to 7/21/26. Review of R#1's Fall Event Nurses' Note, created by RN A on 7/14/26 at 11:13 p.m., reflected, CNA notifies this charge nurse that resident is on the floor. Patient was sitting on the floor with her back against her recliner. CNA stated, ?I attempted to move patient from her recliner to the bed, but she didn't stand up as well as she normally does. She sat back down at the edge of the recliner. When she attempted to scoot back in the chair, the chair moved, and she fell on her buttocks.' R#1 didn't receive an injury from the fall and didn't appear or state to be in pain. There were no interventions in place prior to this fall. Interventions that were initiated in response to the fall included a floor mat and walker. Review of R#1's Fall Event Nurse's Note, created by RN B on 7/19/26 at 1:06 p.m., reflected, CNA attempted to transfer resident into her recliner using a walker. Her legs gave out and resident was assisted to the floor. Denies hitting her head. Denies pain. No swelling noted. R#1 didn't receive an injury from the fall and didn't appear or state to be in pain. R#1's statement reflected she fell. There were no interventions in place prior to this fall. Interventions that were initiated in response to the fall included educating the CNA on transferring R#1 with 2-person assistance. Review of R#1's Fall Event Nurse's Note, created by LVN C on 7/20/26 at 2:20 p.m., reflected, Resident transferring with CNA from wheelchair to recliner when her knee started to hurt so resident went to sit down and missed seat of recliner, resident then slide to bottom on the floor in front of the recliner. R#1 didn't receive an injury from the fall. R#1 appeared and stated to be in pain to her right knee. There were no interventions in place prior to this fall and no new interventions initiated in response to this fall. Review of R#1's POC for July 2026 reflected staff documented they provided 1-person assistance with transfers on 7/14/26 at 1:59 p.m. and 3:18 p.m. and 7/19/26 at 1:44 p.m. Review of Video Footage, dated 7/19/26 at 1:02 p.m., reflected R#1 was sitting in her wheelchair. CNA D entered the room and explained to R#1 that she was going to put her in her recliner so she could put her feet up. CNA D took off the foot pedals from R#1's wheelchair, pushed the wheelchair in front of the recliner, locked the wheelchair wheels, held R#1's left hand with her left hand, held onto R#1's left Tricep with her right arm as she tried to pull R#1 forward and towards the recliner, R#1 didn't move in her wheelchair, backed the wheelchair from the recliner, placed R#1's walker in front of (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R#1, the gait belt hung on the walker, placed both R#1's hands on the walker, held onto R#1's left arm using her left arm, pulled on R#1's gown up and she lifted R#1 with her left arm and R#1 fell forward and over her walker, and her knees landed on the floor as she tried to hold onto the recliner with her upper body. R#1 also cried and told staff to look at her buttocks because it was hurting a little bit when they asked her if she was hurting anywhere. Review of Video Footage, dated 7/20/26 at 2:16 p.m., reflected R#1 was sitting in her wheelchair. CNA E held onto R#1's left arm using her right arm, pulled R#1 up and towards the walker in front of her, pushed the wheelchair away from R#1, pivoted R#1 and the walker as R#1 held onto it until R#1's back faced the recliner, R#1 fell backwards, hit her right arm on the window sill and her back on the wall, slid down, landed on her buttocks on the floor, started to cry, and said, Ow my leg. There was no gait belt. R#1 also told staff her right hand was hurting and she hit her leg when they asked her if she was hurting. During a telephone interview with R#1's RP on 7/21/26 at 10:53 a.m., she said R#1 had no falls before her admission to the facility. She also said R#1 had dementia. She said RN A called and notified her on 7/14/26 that R#1 fell and CNA F was involved. She did not know and was not explained how R#1 fell on 7/14/26. She also said she notified the ADON, who told her that she would investigate the fall. She said she attended care plan meetings and asked staff to ensure R#1 had her walker and used 2-person assistance and a gait belt when transferring her. She said her family notified her on 7/19/26 that R#1 fell again. She also said she spoke with the ADON and RN B, who confirmed R#1 fell on 7/19/26. She said RN B told her that she did not know what happened on 7/19/26 and did not know what R#1's transfer protocols were. She also said R#1 complained of right hip pain after the fall on 7/19/26. She said she observed R#1 fall on 7/20/26 and went to the facility. She also said the ADON was not aware R#1 fell on 7/20/26 and she notified the DON on unknown date. During an interview with R#2 on 7/21/26 at 12:03 p.m., she said R#1 fell when CNA E did not properly sit R#1 down on 7/20/26. She also said staff were required to transfer R#1 using 2-person assistance and a gait belt. During an observation and interview of R#1 on 7/21/26 at 12:04 p.m., R#1 was sitting in her wheelchair in front of the nurse's station. The surveyor attempted to interview R#1, but R#1 was unable to recall the falls and provide additional information. During an interview with CNA G on 7/21/26 at 1:10 p.m., she said CNAs and the ADON transferred residents. She also said her and CNA H transferred R#1 all the time. She said she also transferred R#1 by herself. She also said R#1's family and other CNAs also transferred R#1 without a gait belt. She said LVN I asked her and CNA H to transfer R#1 on 7/21/26 because CNA F refused to go into R#1's room. She explained that her and CNA H transferred R#1 without a gait belt. She said R#1's family told her and CNA H that she told the staff and management about the issue with staff not using a gait belt when transferring R#1. She also said she was aware that she did not transfer R#1 with a gait belt. She said she did not transfer R#1 with a gait belt because she did not think anything of it and never did before. She explained she was not told before 7/21/26 that a gait belt was required when transferring R#1 and was placed as an intervention on 7/21/26. During an interview with CNA H on 7/21/26 at 1:37 p.m., he said CNAs, nurses and therapy staff transferred residents. He said he never had to transfer R#1. He explained CNA G asked him to help her transfer R#1 on 7/21/26. He said he and CNA H were on each side of R#1, stood R#1 up, and placed her in the chair. He also said he and CNA H did not use a gait belt when they transferred R#1. He said R#1's family walked in and informed him and CNA H that they informed RN J that anyone who transferred R#1 needed to use 2-person assistance with the gait belt. He explained he did not know anything about the interventions until after he and CNA H transferred R#1 without the gait belt. During an interview with the ADON on 7/21/26 at 1:53 p.m., she said CNAs and nurses transferred residents. She explained CNAs primarily transferred residents. She said R#1 needed more assistance with transfers in the last couple of days (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because R#1 had weakness and her legs would buckle. She also said R#1 required 2-person assistance with a gait belt for transfers. She said she was working when R#1 fell on 7/14/26 and could not remember how R#1 fell. She also said RN B notified her on 7/19/26 that R#1 had a witnessed fall, did not complain of pain, and did not sustain any injuries. She explained CNA D tried to transfer R#1 without a gait belt and by herself, put R#1's walker in front of her, tried to assist her up, R#1's knees buckled, and she fell on 7/19/26. She said R#1's family provided her with the video footage. She said R#1's family notified her that CNA E tried to stand R#1 up by herself, tried to transfer R#1 into the recliner, R#1's legs buckled, and R#1 fell on 7/20/26. She said she investigated the incident. She said the IDT did not meet after R#1's 7/20/26 fall because the ADM and DON were not at the facility on 7/21/26, RN B was working as a floor nurse until 2:00 p.m. and her and RN B did not do clinical review. She said she was aware CNA G and CNA H transferred R#1 without a gait belt on 7/21/26. During an interview with LVN I on 7/21/26 at 2:18 p.m., she said CNAs and nurses transferred residents. She said R#1 used to require 1-person assistance and a gait belt with transfers. She also said R#1's family recently expressed wanting staff to transfer R#1 using 2-person assistance and a gait belt. She said R#1 fell over the weekend. She said CNA E told her that she tried to transfer R#1 by herself on 7/20/26. She did not know whether or not CNA E used a gait belt when she tried to transfer R#1 by herself on 7/20/26. She said R#1's family told her that CNA G and CNA H transferred R#1 without a gait belt on 7/21/26. During a telephone interview with the Physician on 7/21/26 at 3:22 p.m., he said he expected staff to use a Hoyer lift when transferring R#1, but R#1's family did not want them to use the device. He said a gait belt could be used to transfer R#1. He said he was aware that R#1 fell a couple times. He said staff did not notify him about R#1's fall on 7/14/26 and 7/20/26. He said RN B notified him that R#1 fell on 7/19/26. He advised to call the NP for additional information. The surveyor attempted to call and interview the Hospice Physician on 7/21/26 3:42 p.m. A voicemail and call back number was left. R#1's Hospice Physician did not return the call before exit on 7/22/26. During an interview with the MDS Coordinator on 7/22/26 at 10:48 a.m., she said she reviewed and revised residents' care plans after morning meeting and falls and when reviewing residents' medications. She said she usually revised residents' care plans the morning of the fall. She explained she was not at the facility on 7/20/26 and 7/21/26. She said the DON and ADM were designated to review and revise residents' care plans whenever she was unavailable and staff needed care plans revised. She said her and the DON were absent on 7/21/26. She said she was notified the morning of 7/22/26 that R#1's care plan was not revised in a timely manner. She said gait belt did not need to be documented in R#1's care plan because it was part of uniform. She said it was important to review and revise residents' care plans timely and said, To provide the best quality of care and to provide safety to the resident. Residents could be at risk if care plans were not accurate and revised in a timely manner. During an interview with CNA F on 7/22/26 at 11:21 a.m., she said she revised residents' EHR to determine what their transfer status was. She said she could not remember if she worked with R#1 on 7/14/26, 7/19/26, and 7/20/26. She said she was notified that R#1 fell within this past week or two weeks. During a telephone interview with LVN C on 7/22/26 at 12:26 p.m., she said CNAs, nurses, and therapy staff transferred residents. She said she had access to residents' care plans and EHR to determine transfer status. She said she did not know who reviewed and revised residents' care plans after falls. She said R#1 required 2-person assistance with a gait belt for transfers. She said R#1's family told her in the past on unknown date how they wanted R#1 properly transferred. She said CNA E told her on 7/20/26 that she moved R#1 towards the seat, R#1 missed the seat and fell. She said she did not know whether or not CNA E transferred R#1 by herself. During a telephone interview with CNA E on 7/22/26 at 12:48 (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m., she said she had access to residents' EHR to determine their transfer status. She said CNAs must use a gait belt during transfers and did not have to when a resident could stand up. She said she did not use 2-person assistance and a gait belt when she tried to transfer R#1 because R#1 was doing good without the gait belt. She said she did not know R#1 required 2-person assistance with transfers and, It's my fault. She explained R#1 slipped from her walker in front of her recliner, fell on her knees, fell on her buttocks, did not hit her head, did not complain of pain, and she notified LVN C and another nurse. During a telephone interview with CNA D on 7/22/26 at 1:08 p.m., she said CNAs transferred residents. She said she had access to residents' EHR and care plan to determine transfer status. She said R#1 required 1-person assistance with transfers, could pivot, and was independent. She said she worked with R#1 when R#1 fell on 7/19/26. She explained R#1 tried to stand up with the walker in front of her, could not turn, knees gave out, she lowered R#1 to the ground because she could not lift R#1, and notified RN B. She said R#1 told RN B that her buttocks hurt. During a telephone interview with RN K on 7/22/26 at 1:24 p.m., she said she had access to residents' EHR and care plans to determine their transfer status. She said CNA E notified her that R#1 fell and did not explain how on 7/20/26. She said CNA E told LVN C that she was trying to transfer R#1, R#1's legs gave out, R#1 slid onto her buttocks, and did not hit her head. During an interview with RN A on 7/22/26 at 2:17 p.m., he said he had access to residents' care plans and EHR to determine their transfer status. He said R#1 required a gait belt when transferring her. He said CNA F notified him that R#1 fell on 7/14/26. He explained CNA F told him that she was transferring R#1 from the recliner and R#1 fell. He said CNA F was by herself when he entered R#1's room. He also said CNA F did not tell him whether or not there were two people in the room when she transferred R#1. He said he did not know who reviewed and revised residents' care plans after a fall. During a telephone interview with RN B on 7/22/26 at 5:00 p.m., she said she had access to residents' care plans to determine their transfer status. She said R#1 required 1-person assistance with transfers at the time on 7/19/26. She said CNA D notified her that R#1 fell on 7/19/26. She said CNA D told her that she tried to transfer R#1 to the walker by herself, R#1's legs became weak, and R#1 fell. She said she did not know whether or not CNA D used a gait belt when she tried to transfer R#1 by herself. She said the MDS Coordinator and DON reviewed and revised residents' care plans after a fall. During a telephone interview with the ADM on 7/22/26 at 5:13 p.m., she said she expected CNAs to transfer residents according to their transfer status in their EHR. She said she expected staff to identify residents' transfer status using their EHR. She said the DON reviews residents' fall incident reports, assessed the need for new interventions, and determines whether current interventions were effective or ineffective. She also said the DON reviewed and revised residents' care plans. She said she could not remember exact details for R#1's falls on 7/14/26, 7/19/26 and 7/20/26. She also said she was unaware that staff did not use a gait belt when they transferred R#1 on those dates. She said the ADON notified her that CNA G and CNA H did not use a gait belt when they transferred R#1 on 7/21/26. During a telephone interview with the DON on 7/22/26 at 6:04 p.m., she said she expected staff to transfer residents according to their transfer status in the care plan and EHR and said, For safety of resident and staff. Residents could be at risk of injury. She said her, the MDS Coordinator, and ADON reviewed and revised residents' care plans. She said R#1 required a gait belt when being transferred. She said she expected staff to use 2-person assistance with transfers. She said she was notified R#1 fell during a transfer on 7/14/26. She said she could not remember whether or not R#1's care plan was reviewed and revised after the 7/14/26 fall. She also said RN B notified her on 7/19/26 that R#1 fell during a transfer and recommended 2-person assistance. She said she could not remember whether or not a gait belt was used when R#1 fell during a transfer on 7/19/26. She said the ADON notified her on (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/20/26 that CNA E attempted to transfer R#1 by herself, did not use a gait belt and did not ask for help. Review of the facility's Comprehensive Care Planning policy, undated, reflected, In situations where a resident's choice to decline care or treatment poses a risk to the resident's health or safety, the comprehensive care plan will identify the care or service being declined, the risk the declination poses to the resident, and efforts by the IDT to educate the resident and the representative as appropriate. The facility's attempts to find alternative means to address the identify risk/need should be documents in the care plan.Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.The resident's care plan will be reviewed after each admission, quarterly, annual and/or significant change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 1 (R#1) of 5 residents received adequate supervision and assistance devices to prevent accidents.1. The facility failed to ensure staff used a gait belt and 2-person assistance when transferring R#1 on 7/14/26, 7/19/26 and 7/20/26. R#1 fell on 7/14/26, 7/19/26, and 7/20/26. R#1 cried, said her buttocks was hurting, and complained of right hip pain after the fall on 7/19/26. R#1 also cried and said her right hand was hurting and she hit her leg after the fall on 7/20/26. 2. The facility failed to ensure staff used a gait belt when transferring R#1 on 7/21/26.This failure could place residents at risk of falls, injuries, and change in condition.Findings include:Review of R#1's admission Record, dated 7/21/26, reflected she was admitted to the facility on [DATE]. R#1 also had medical diagnoses that included late onset Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), dementia (a decline in mental ability severe enough to interfere with daily life), muscle wasting and atrophy, muscle weakness, lack of coordination, psychotic disorder with hallucinations, and bone density and structure disorders.Review of R#1's Quarterly MDS Assessment, dated 6/25/26, reflected staff were unable to interview her for BIMS. R#1 also had no falls since admission. R#1 was dependent on staff assistance with transfers.Review of R#1's Care Plan, revised 4/23/26, reflected she was at risk for falls. Staff were required to use 1-person assistance with R#1's transfers. There were no revised interventions regarding staff being required to use 2-person assistance and a gait belt when transferring R#1 prior to 7/21/26.Review of R#1's Fall Risk Assessment, dated 4/20/26, reflected she was a high fall risk.Review of R#1's Fall Event Nurses' Note, created by RN A on 7/14/26 at 11:13 p.m., reflected, CNA notifies this charge nurse that resident is on the floor. Patient was sitting on the floor with her back against her recliner. CNA stated, 'I attempted to move patient from her recliner to the bed, but she didn't stand up as well as she normally does. She sat back down at the edge of the recliner. When she attempted to scoot back in the chair, the chair moved, and she fell on her buttocks.' R#1 didn't receive an injury from the fall and didn't appear or state to be in pain. There were no interventions in place prior to this fall. Interventions that were initiated in response to the fall included a floor mat and walker.Review of R#1's Fall Event Nurse's Note, created by RN B on 7/19/26 at 1:06 p.m., reflected, CNA attempted to transfer resident into her recliner using a walker. Her legs gave out and resident was assisted to the floor. Denies hitting her head. Denies pain. No swelling noted. R#1 didn't receive an injury from the fall and didn't appear or state to be in pain. R#1's statement reflected she fell. There were no interventions in place prior to this fall. Interventions that were initiated in response to the fall included educating the CNA on transferring R#1 with 2-person assistance.Review of R#1's Fall Event Nurse's Note, created by LVN C on 7/20/26 at 2:20 p.m., reflected, Resident transferring with CNA from wheelchair to recliner when her knee started to hurt so resident went to sit down and missed seat of recliner, resident then slide to bottom on the floor in front of the recliner. R#1 didn't receive an injury from the fall. R#1 appeared and stated to be in pain to her right knee. There were no interventions in place prior to this fall and no new interventions initiated in response to this fall. Review of R#1's POC for July 2026 reflected staff documented they provided 1-person assistance with transfers on 7/14/26 at 1:59 p.m. and 3:18 p.m. and 7/19/26 at 1:44 p.m.Review of Video Footage, dated 7/19/26 at 1:02 p.m., reflected R#1 was sitting in her wheelchair. CNA D entered the room and explained to R#1 that she was going to put her in her recliner so she could put her feet up. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA D took off the foot pedals from R#1's wheelchair, pushed the wheelchair in front of the recliner, locked the wheelchair wheels, held R#1's left hand with her left hand, held onto R#1's left Tricep with her right arm as she tried to pull R#1 forward and towards the recliner, R#1 didn't move in her wheelchair, backed the wheelchair from the recliner, placed R#1's walker in front of R#1, the gait belt hung on the walker, placed both R#1's hands on the walker, held onto R#1's left arm using her left arm, pulled on R#1's gown up and she lifted R#1 with her left arm and R#1 fell forward and over her walker, and her knees landed on the floor as she tried to hold onto the recliner with her upper body. R#1 also cried and told staff to look at her buttocks because it was hurting a little bit when they asked her if she was hurting anywhere. Review of Video Footage, dated 7/20/26 at 2:16 p.m., reflected R#1 was sitting in her wheelchair. CNA E held onto R#1's left arm using her right arm, pulled R#1 up and towards the walker in front of her, pushed the wheelchair away from R#1, pivoted R#1 and the walker as R#1 held onto it until R#1's back faced the recliner, R#1 fell backwards, hit her right arm on the window sill and her back on the wall, slid down, landed on her buttocks on the floor, started to cry, and said, Ow my leg. There was no gait belt. R#1 also told staff her right hand was hurting and she hit her leg when they asked her if she was hurting. Review of the facility's Incident Log, from 6/1/26 through 7/21/26, reflected R#1 had a fall on 7/14/26 at 9:45 p.m. There were no other falls for R#1 documented on the log. Review of the facility's In-Services, from 7/1/26 through 7/21/26, reflected the ADON presented the in-service regarding R#1's to 22 staff on 7/20/26. Staff were taught to use two CNAs at all times, gait belt, walker, and talk to R#1 through the process when transferring her. CNA D did not sign the in-service. LVN C, CNA E, CNA F, CNA G, CNA H and LVN I signed the in-service. During a telephone interview with R#1's RP on 7/21/26 at 10:53 a.m., she said R#1 had no falls before her admission to the facility. She also said R#1 had dementia. She said RN A called and notified her on 7/14/26 that R#1 fell and CNA F was involved. She did not know and was not explained how R#1 fell on 7/14/26. She also said she notified the ADON, who told her that she would investigate the fall. She said she attended care plan meetings and asked staff to ensure R#1 had her walker and used 2-person assistance and a gait belt when transferring her. She said her family notified her before staff on 7/19/26 that R#1 fell again. She also said she spoke with the ADON and RN B, who confirmed R#1 fell on 7/19/26. She said RN B told her that she did not know what happened on 7/19/26 and did not know what R#1's transfer protocols were. She also said R#1 complained of right hip pain after the fall on 7/19/26. She said she observed R#1 fall on 7/20/26 and went to the facility. She also said the ADON was not aware R#1 fell on 7/20/26 and she notified the DON on unknown date. During an interview with R#2 on 7/21/26 at 12:03 p.m., she said R#1 fell when CNA E did not properly sit R#1 down on 7/20/26. She also said staff were required to transfer R#1 using 2-person assistance and a gait belt. She said R#1 went to the hospital on 7/20/26 and returned. During an observation and interview of R#1 on 7/21/26 at 12:04 p.m., R#1 was sitting in her wheelchair in front of the nurse's station. The surveyor attempted to interview R#1, but R#1 was unable to recall the falls and provide additional information. During an interview with CNA G on 7/21/26 at 1:10 p.m., she said she was not in-serviced on transfers prior to 7/21/26. She also said she read and signed an in-service regarding R#1 on 7/21/26 around 7:00 a.m. She said CNAs and the ADON transferred residents. She said some residents could be transferred with a gait belt using one or two person assistance. She also said her and CNA H transferred R#1 all the time. She said she also transferred R#1 by herself. She also said R#1's family and other CNAs also transferred R#1 without a gait belt. She said LVN I asked her and CNA H to transfer R#1 on 7/21/26 because CNA F refused to go into R#1's room. She explained that her and CNA H transferred R#1 without a gait belt. She said R#1's family told her and CNA H that she told the staff and management about the issue with staff not (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	using a gait belt when transferring R#1. She also said she was aware that she did not transfer R#1 with a gait belt. She said she did not transfer R#1 with a gait belt because she did not think anything of it and never did before. She explained she was not told before 7/21/26 that a gait belt was required when transferring R#1 and was placed as an intervention on 7/21/26. She said she knew it was important to transfer the resident with a gait belt and said, Proper transferring is going to ensure fall risk residents did not fall and that they did not lose balance. During an interview with CNA H on 7/21/26 at 1:37 p.m., he said he was not in-serviced on transfers before 7/20/26. He said the ADON had him read and sign an in-service regarding R#1 on 7/20/26. He also said he did not read the in-service. He said CNAs, nurses and therapy staff transferred residents. He said he was expected to transfer residents with 2-person assistance and a gait bely. He said he never had to transfer R#1. He explained CNA G asked him to help her transfer R#1 on 7/21/26. He said he and CNA H were on each side of R#1, stood R#1 up, and placed her in the chair. He also said he and CNA H did not use a gait belt when they transferred R#1. He said R#1's family walked in and informed him and CNA H that they informed RN J that anyone who transferred R#1 needed to use 2-person assistance with the gait belt. He explained he did not know anything about the interventions until after he and CNA H transferred R#1 without the gait belt and because he did not really transfer residents. He said he knew it was important to transfer residents with a gait belt and said, For safety of resident and staff. Residents could be at risk of falling and could sustain injuries depending on how staff were grabbing the resident. During an interview with the ADON on 7/21/26 at 1:53 p.m., she said the nurse managers in-serviced staff. She also said she provided staff with the in-service to read and sign on paydays and case by case. She couldn't remember when she most recently in-serviced staff on falls. She said CNAs and nurses transferred residents. She explained CNAs primarily transferred residents. She said R#1 needed more assistance with transfers in the last couple of days because R#1 had weakness and her legs would buckle. She also said R#1 required 2-person assistance with a gait belt for transfers. She said she was working when R#1 fell on 7/14/26 and could not remember how R#1 fell. She also said RN B notified her on 7/19/26 that R#1 had a witnessed fall, did not complain of pain, and did not sustain any injuries. She explained CNA D tried to transfer R#1 without a gait belt and by herself, put R#1's walker in front of her, tried to assist her up, R#1's knees buckled, and she fell on 7/19/26. She said R#1's family provided her with the video footage. She said the IDT met on 7/20/26 and decided to in-service the staff. She said she put out an in-service about talking to R#1 through and using the gait belt and walker on 7/20/26 because of the fall R#1 had the night of 7/19/26. She said R#1's family notified her that CNA E tried to stand R#1 up by herself, tried to transfer R#1 into the recliner, R#1's legs buckled, and R#1 fell on 7/20/26. She said she investigated the incident. She said CNA E told her that she reviewed and signed the in-service. She said the IDT did not meet after R#1's 7/20/26 fall because the ADM and DON were not at the facility on 7/21/26, RN B was working as a floor nurse until 2:00 p.m. and her and RN B did not do clinical review. She said she was aware CNA G and CNA H transferred R#1 without a gait belt on 7/21/26. She said she knew it was important to transfer residents with a gait belt and said, To protect the resident and yourself. Residents could be at risk of injury. During an interview with LVN I on 7/21/26 at 2:18 p.m., she said she was in-serviced on gait belt safety use with 2-person assistance either on 7/20/26 or earlier on 7/21/26. CNAs and nurses transferred residents. She said R#1 used to require 1-person assistance and a gait belt with transfers. She also said R#1's family recently expressed wanting staff to transfer R#1 using 2-person assistance and a gait belt. She said R#1 fell over the weekend. She said CNA E told her that she tried to transfer R#1 by herself on 7/20/26. She did not know whether or not CNA E used a gait belt when she tried to transfer R#1 by herself on 7/20/26. She said R#1's family told her that CNA G and CNA H (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transferred R#1 without a gait belt on 7/21/26. She said she knew it was important to transfer residents with a gait belt and said, For their safety. That's number one. Safety always come first. Residents could be at risk of getting hurt from the fall, hurt their arms, and we must use what is recommended for that person as well for us. During a telephone interview with the Physician on 7/21/26 at 3:22 p.m., he said he expected staff to use a Hoyer lift when transferring R#1, but R#1's family did not want them to use the assistive device. He said a gait belt could be used to transfer R#1. He said he was aware that R#1 fell a couple times. He said staff did not notify him about R#1's fall on 7/14/26 and he expected staff to notify him whenever there was a fall. He said he did not attend or was notified about any IDT meeting after R#1's fall on 7/14/26 and was usually involved if the staff determined he needed to be. He said RN B notified him that R#1 fell on 7/19/26. He also said staff did not notify him that R#1 fell on 7/20/26. He advised to call the NP for additional information. The surveyor attempted to call and interview the Hospice Physician on 7/21/26 3:42 p.m. A voicemail and call back number was left. R#1's Hospice Physician did not return the call before exit on 7/22/26. During a telephone interview with the NP on 7/21/26 at 4:05 p.m., she said she was not notified of R#1's falls on 7/14/26, 7/19/26 and 7/20/26 and expected staff to notify residents' physician team. During an interview with the MDS Coordinator on 7/22/26 at 10:48 a.m., she said she reviewed and revised residents' care plans after morning meeting report, falls, and when reviewing residents' medications. She said she usually revised residents' care plans the morning of the fall. She said she was not at the facility on 7/20/26 and 7/21/26. She said the DON and ADM were her designees in the event she was absent and residents' care plans needed to be revised. She said her and the DON were absent on 7/21/26. She said she was notified the morning of 7/22/26 that R#1's care plan was not revised timely. She said the gait belt did not need to be in R#1's care plan because it was part of the uniform. She also said she was unaware staff did not use the gait belt when transferring R#1 on 7/14/26, 7/19/26, 7/20/26, and 7/21/26. She said the staff were required to comply with residents' transfer requirements. During an interview with CNA F on 7/22/26 at 11:21 a.m., she said she was recently in-serviced on transfers this past week. She explained she received, reviewed and signed the in-service. She said she had access to the residents' EHR to determine their transfer status. She said she could not remember if she worked with R#1 on 7/14/26, 7/19/26, and 7/20/26. She said she was notified that R#1 fell within this past week or two weeks. She said she knew it was important to transfer residents with a gait belt and said, We do not want residents falling. It's important to have a gait belt to be used and behind them because residents could have moments of losing balance and need to have something to hold onto. During a telephone interview with LVN C on 7/22/26 at 12:26 p.m., she said CNAs, nurses, and therapy staff transferred residents. She said she knew how to use a gait belt when a resident was a fall risk, required 1-2 person assistance, and was an increased fall risk. She said there were no instances in which staff could not use the gait belt when transferring a resident. She said she had access to residents' care plan and EHR to determine transfer status. She said R#1 required 2-person assistance with a gait belt for transfers. She said R#1's family told her in the past on unknown date how they wanted R#1 properly transferred. She said CNA E told her on 7/20/26 that she moved R#1 towards the seat, R#1 missed the seat and fell. She said she did not know whether or not CNA E transferred R#1 by herself. She said she was in-serviced on transfers for R#1 on 7/21/26. She said she learned to use the gait belt, verbally guide R#1, and ensure R#1 held onto her walker when transferring her. She said the DON investigated falls and identified contributing factors and said, To help prevent future falls and to figure out what was causing the falls. She said she knew it was important to transfer residents with a gait belt and said, To prevent injuries, falls and trauma to the resident and staff. Residents could be at risk of getting (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hurt when assistive devices and appropriate number of staff weren't used during transfers. During a telephone interview with CNA E on 7/22/26 at 12:48 p.m., she said she could not remember when she was most recently in-serviced on transfers. She also said CNAs must use a gait belt during transfers and did not have to when a resident could stand up. She said she did not read the entire in-service on 7/20/26 because she was assisting another residents when staff handed the in-service to her. She also said she did not use 2-person assistance and a gait belt when she tried to transfer R#1 because R#1 was doing good without the gait belt. She said she did not know R#1 required 2-person assistance with transfers and said, It's my fault. She explained R#1 slipped from her walker in front of her recliner, fell on her knees, fell on her buttocks, did not hit her head, did not complain of pain, and she notified LVN C and another nurse. She said she knew it was important to transfer residents with a gait belt and said, To guarantee safety of residents. Residents could be at risk of safety and falls when appropriate number of staff and assistive devices aren't used during a transfer. During a telephone interview with CNA D on 7/22/26 at 1:08 p.m., she said she could not remember when she was most recently in-serviced on falls and transfers. She also said CNAs transferred residents. She said she had access to residents' EHR to determine transfer status. She said R#1 required 1-person assistance with transfers, could pivot, and was independent. She said she worked with R#1 when R#1 fell on 7/19/26. She explained R#1 tried to stand up with the walker in front of her, could not turn, knees gave out, she lowered R#1 to the ground because she could not lift R#1, and notified RN B. She said R#1 told RN B that her buttocks hurt. During a telephone interview with RN K on 7/22/26 at 1:24 p.m., she said the ADON in-serviced her on transferring R#1 with 1-2 person assistance and a gait belt before 7/20/26. She said she had access to residents' care plan and EHR to determine transfer status. She said the ADON reviewed and revised residents' care plans after a fall. She said CNA E notified her that R#1 fell and did not explain how on 7/20/26. She said CNA E told LVN C that she was trying to transfer R#1, R#1's legs gave out, R#1 slid onto her buttocks, and did not hit her head. She said she knew it was important to transfer residents with a gait belt and said, So residents didn't fall and get hurt. Residents could have a fracture or break something when not using appropriate number of people and assistive devices. During an interview with RN A on 7/22/26 at 2:17 p.m., he said he could not remember when he was most recently in-serviced on transfers. He said all staff were responsible for resident care and he had access to residents' assessments and EHR to determine transfer status. He said he did not know who reviewed and revised residents' care plans after a fall. He said R#1 required a gait belt when transferring her. He said CNA F notified him that R#1 fell on 7/14/26. He explained CNA F told him that she was transferring R#1 from the recliner and R#1 fell. He said CNA F was by herself when he entered R#1's room. He also said CNA F did not tell him whether or not there were two people in the room when she transferred R#1. He said he knew it was important to transfer residents with a gait belt and said, It's safe to use gait belt during transfers. It's for safety and to follow procedure and for your own safety. Residents could be at risk of falling and sustaining injuries. During a telephone interview with RN B on 7/22/26 at 5:00 p.m., she said she was not in-serviced after R#1's fall on 7/19/26 because she did not return to the facility after the incident. She said R#1 required 1-person assistance with transfers at the time on 7/19/26. She said she did not know whether R#1 require a gait belt for transfers at the time of her fall on 7/19/26. She said CNA D notified her that R#1 fell on 7/19/26. She said CNA D told her that she tried to transfer R#1 to the walker by herself, R#1's legs became weak, and R#1 fell. She said she did not know whether or not CNA D used a gait belt when she tried to transfer R#1 by herself. She said the DON and IDT investigated falls and reviewed and revised residents' care plans after a fall. She said she knew it was important to transfer residents with a gait belt and said, To prevent fractures, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	injuries and death.During a telephone interview with the ADM on 7/22/26 at 5:13 p.m., she said she reviewed falls during clinical meetings. She said nurse managers in-serviced staff on transfers routinely and annually. She said she could not remember when staff were most recently in-serviced on transfers. She said her staff in-serviced the staff to her understanding. She said she expected CNAs to transfer residents according to their transfer status in their EHR. She also expected staff to notify the charge nurse whenever residents' level of assistance changed and said, For the safety of residents and staff. She said she could not remember exact details for R#1's falls on 7/14/26, 7/19/26 and 7/20/26. She also said she was unaware that staff did not use a gait belt when they transferred R#1 on those dates. She said the ADON notified her that CNA G and CNA H did not use a gait belt when they transferred R#1 on 7/21/26. She said she discussed interventions with staff. She said the DON reviewed incident reports from falls, assessed the need for new interventions, and determined whether current interventions were effective or ineffective. She said the DON also reviewed and revised residents' care plans after a fall.During a telephone interview with the DON on 7/22/26 at 6:04 p.m., she said she expected staff to transfer residents according to their transfer status in the care plan and EHR and said, For the safety of the resident and staff. Residents could be at risk of injury. She said R#1 required a gait belt when being transferred. She said she expected staff to use 2-person assistance with transfers. She said she was notified R#1 fell during a transfer on 7/14/26. She said she expected staff to assess residents' fall risk assessments and fall event notes at the time the fall occurred. She said her, the ADON and therapy reviewed falls during morning meetings and identified contributing factors for falls and said, To prevent falls from reoccurring. She said she investigated R#1's 7/14/26 fall and determined the incident occurred during a transfer. She said she implemented new interventions after the fall. She said her, the MDS Coordinator or the ADON reviewed and revised residents' care plans after a fall. She said she could not remember whether or not R#1's care plan was reviewed and revised after 7/14/26. She said she knew it was important to review and revise residents' care plans after a fall and said, To help prevent injuries to the resident. She also said RN B notified her on 7/19/26 that R#1 fell during a transfer and recommended 2-person assistance. She said she could not remember whether or not a gait belt was used when R#1 fell during a transfer on 7/19/26. She said she had staff initiate in-services on falls. She said the ADON notified her on 7/20/26 that CNA E attempted to transfer R#1 by herself, did not use a gait belt and did not ask for help.Review of the facility's Moving a Resident, Bed to Chair/Chair to Bed policy, 2023, reflected, The purpose of this are to allow the resident to be out of his or her bed as much as possible and to provide for safe transferring of the resident.This procedure may require two (2) persons.h. Position a gait belt around the resident's waist and clasp it.i. If the resident requires, two persons (one on each side) should grasp the gait belt and gently stand and turn the resident and sit him or her in the chair.Review of the facility's Preventive Strategies to Reduce Fall Risk policy, revised 10/5/16, reflected, The goal of fall prevention strategies is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining and improving residents' mobility.5. Incident Reporting: Reported falls will be thoroughly investigated to assess fall risk factors and contributing factors in order to provide a safe environment for the resident(s).Review of the facility's Event Reporting: Completion of policy, undated, reflected, Investigation: The investigation should be completed by the DON/Administrator or designee. The investigation report documents a thorough investigation of the events of the reported Event including persons, equipment, and materials that were involved. The investigation report must include what actions were taken to prevent subsequent events and signatures of the individuals as indicated on the form.Interventions: Include and care plan any required interventions or supervision to help prevent further occurrence of the event.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 (R#1) of 5 residents were provided with pain management. The facility failed to accurately assess R#1's pain after her falls on 7/19/26 and 7/20/26. R#1 cried, said her buttocks was hurting, and complained of right hip pain after the fall on 7/19/26. R#1 also cried and said her right hand was hurting and she hit her leg after the fall on 7/20/26. This failure could place residents at risk of not having pain treated and change in condition. Findings include: Review of R#1's admission Record, dated 7/21/26, reflected she was admitted to the facility on [DATE]. R#1 also had medical diagnoses that included late onset Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), dementia (a decline in mental ability severe enough to interfere with daily life), muscle wasting and atrophy, muscle weakness, lack of coordination, psychotic disorder with hallucinations, and bone density and structure disorders. Review of R#1's Quarterly MDS Assessment, dated 6/25/26, reflected staff were unable to interview her for BIMS. R#1 also had no falls since admission. R#1 was dependent on staff assistance with transfers. Review of R#1's Care Plan, revised 4/23/26, reflected she was at risk for falls. Staff were required to use 1-person assistance with R#1's transfers. There were no revised interventions regarding staff being required to use 2-person assistance and a gait belt when transferring R#1 prior to 7/21/26. Review of R#1's Fall Event Nurse's Note, created by RN B on 7/19/26 at 1:06 p.m., reflected, CNA attempted to transfer resident into her recliner using a walker. Her legs gave out and resident was assisted to the floor. Denies hitting her head. Denies pain. No swelling noted. R#1 didn't receive an injury from the fall and didn't appear or state to be in pain. R#1's statement reflected she fell. There were no interventions in place prior to this fall. Interventions that were initiated in response to the fall included educating the CNA on transferring R#1 with 2-person assistance. Review of R#1's Fall Event Nurse's Note, created by LVN C on 7/20/26 at 2:20 p.m., reflected, Resident transferring with CNA from wheelchair to recliner when her knee started to hurt so resident went to sit down and missed seat of recliner, resident then slide to bottom on the floor in front of the recliner. R#1 didn't receive an injury from the fall. R#1 appeared and stated to be in pain to her right knee. There were no interventions in place prior to this fall and no new interventions initiated in response to this fall. Review of Video Footage, dated 7/19/26 at 1:02 p.m., reflected R#1 was sitting in her wheelchair. CNA D entered the room and explained to R#1 that she was going to put her in her recliner so she could put her feet up. CNA D took off the foot pedals from R#1's wheelchair, pushed the wheelchair in front of the recliner, locked the wheelchair wheels, held R#1's left hand with her left hand, held onto R#1's left Tricep with her right arm as she tried to pull R#1 forward and towards the recliner, R#1 didn't move in her wheelchair, backed the wheelchair from the recliner, placed R#1's walker in front of R#1, the gait belt hung on the walker, placed both R#1's hands on the walker, held onto R#1's left arm using her left arm, pulled on R#1's gown up and she lifted R#1 with her left arm and R#1 fell forward and over her walker, and her knees landed on the floor as she tried to hold onto the recliner with her upper body. R#1 also cried and told staff to look at her buttocks because it was hurting a little bit when they asked her if she was hurting anywhere. Review of Video Footage, dated 7/20/26 at 2:16 p.m., reflected R#1 was sitting in her wheelchair. CNA E held onto R#1's left arm using her right arm, pulled R#1 up and towards the walker in front of her, pushed the wheelchair away from R#1, pivoted R#1 and the walker as R#1 held onto it until R#1's back faced the recliner, R#1 fell backwards, hit her right arm on the window sill and her back on the wall, slid down, landed on her (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	buttocks on the floor, started to cry, and said, Ow my leg. There was no gait belt. R#1 also told staff her right hand was hurting and she hit her leg when they asked her if she was hurting. Review of R#1's Pain Level Summary, as of 7/21/26, reflected staff previously used a Pain Ad (non-verbal) to assess R#1 for pain until 3/12/26. Staff started to use a pain numerical scale to assess R#1's pain from 4/3/26 through 5/14/26, which was the most recent documented entry. There were no other entries. During a telephone interview with R#1's RP on 7/21/26 at 10:53 a.m., she said R#1 had no falls before her admission to the facility. She also said R#1 had dementia. She said she attended care plan meetings and asked staff to ensure R#1 had her walker and used 2-person assistance and a gait belt when transferring her. She said her family notified her before the staff on 7/19/26 that R#1 fell again. She also said she spoke with the ADON and RN B, who confirmed R#1 fell on 7/19/26. She said RN B told her that she did not know what happened on 7/19/26 and did not know what R#1's transfer protocols were. She said staff did not mention anything about sending R#1 to the hospital for further evaluation after the fall. She also said R#1 complained of right hip pain after the fall on 7/19/26. She said she did not report R#1's c/o pain to the staff. She said she observed R#1 fall on 7/20/26 on the electronic monitoring system and went to the facility. She also said the ADON was not aware R#1 fell on 7/20/26. She said she had staff send R#1 to the hospital after the fall. She said R#1 returned from the hospital the night of 7/20/26 and had negative results for any injuries. She said she notified the DON on unknown date of the results and the DON did not respond back to her. During an interview with R#2 on 7/21/26 at 12:03 p.m., she said R#1 fell when CNA E did not properly sit R#1 down on 7/20/26. She said R#1 did not complain of pain, but the staff also did not come and evaluate her or help CNA E after the fall. She said R#1 went to the hospital on 7/20/26, came back and was fine. She also said staff were required to transfer R#1 using 2-person assistance and a gait belt. During an observation and interview of R#1 on 7/21/26 at 12:04 p.m., R#1 was sitting in her wheelchair in front of the nurse's station. R#1 wore a hospital band around on of her wrists. The surveyor attempted to interview R#1, but R#1 was unable to recall the falls and provide additional information. During an interview with CNA G on 7/21/26 at 1:10 p.m., she said R#1 could not verbalize her pain levels. She explained nurses would need to use a Pain Ad scale to determine whether or not R#1 was in pain. During an interview with the ADON on 7/21/26 at 1:53 p.m., she said she taught staff to assess residents after a fall and determine whether or not they needed to be sent to the hospital. She said she expected the nurses to assess the resident after a fall. R#1 needed more assistance with transfers in the last couple of days because R#1 had weakness and her legs would buckle. She said R#1 required 2-person assistance with a gait belt for transfers. She said RN B notified her on 7/19/26 that R#1 had a witnessed fall, did not complain of pain, and did not sustain any injuries. She explained CNA D tried to transfer R#1 without a gait belt and by herself, put R#1's walker in front of her, tried to assist her up, R#1's knees buckled, and she fell on 7/19/26. She said R#1's family provided her with the video footage. She said the IDT met on 7/20/26 and decided to in-service the staff. She said she put out an in-service about talking to R#1 through and using the gait belt and walker on 7/20/26 because of the fall R#1 had the night of 7/19/26. She said R#1's family notified her that CNA E tried to stand R#1 up by herself, tried to transfer R#1 into the recliner, R#1's legs buckled, and R#1 fell on 7/20/26. She said she investigated the incident. She said CNA E told her that she reviewed and signed the in-service. She said the IDT did not meet after R#1's 7/20/26 fall because the ADM and DON were not at the facility on 7/21/26, RN B was working as a floor nurse until 2:00 p.m. and her and RN B did not do clinical review. She said R#1's family wanted her to go out to the hospital, R#1 was sent out, and returned with no injuries. She said R#1 could let staff know when she was in pain. She said she used a Pain Ad scale when assessing R#1's pain. She explained she would look for signs (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and symptoms, such as hollering and facial grimacing, to determine whether or not R#1 was in pain. During a telephone interview with the Physician on 7/21/26 at 3:22 p.m., he said a gait belt could be used to transfer R#1. He said he was aware that R#1 fell a couple times. He said RN B notified him that R#1 fell on 7/19/26. He also said staff did not notify him that R#1 fell on 7/20/26. He said he would not have expected staff to send R#1 out to the emergency room unless she experienced pain. He expected staff to notify him if there was a fall and injury, if the resident complained of pain, and ensure resident was checked on and there were no complaints of pain. He advised to call the NP for additional information. The surveyor attempted to call and interview the Hospice Physician on 7/21/26 3:42 p.m. A voicemail and call back number was left. R#1's Hospice Physician did not return the call before exit on 7/22/26. During a telephone interview with the NP on 7/21/26 at 4:05 p.m., she said she was not notified of R#1's falls on 7/19/26 and 7/20/26 and expected staff to notify the resident's primary care staff. During an interview with the MDS Coordinator on 7/22/26 at 10:48 a.m., she said staff must take residents pain at the cognitive status of where they are at right now. She explained staff used a numerical scale if they can when assessing a resident's pain. She went on to explain that staff used a Pain Ad scale if they cannot assess a resident's pain with the pain numerical scale. She said she knew it was important to accurately assess residents' pain and said, Because pain is a big deal and we want to make sure we help with their pain because it impacts their (residents') behaviors, moods, and eating and we notify the physician of any changes. During an interview with CNA F on 7/22/26 at 11:21 a.m., she said she revised residents' EHR to determine what their transfer status was. She said she could not remember if she worked with R#1 on 7/14/26, 7/19/26, and 7/20/26. She said she was notified that R#1 fell within this past week or two weeks. She said charge nurses evaluated residents' pain. She said she would determine R#1 was in pain based on R#1's nonverbal cues, signs and symptoms of pain, and after evaluating her skin. She explained staff could not use a pain numerical scale to assess R#1's pain levels because she could not provide a response. During a telephone interview with LVN C on 7/22/26 at 12:26 p.m., she said R#1 required 2-person assistance with a gait belt for transfers. She said R#1's family told her in the past on unknown date how they wanted R#1 properly transferred. She said she was coming over for shift change when CNA E notified her that R#1 fell. She said CNA E told her on 7/20/26 that she moved R#1 towards the seat, R#1 missed the seat and fell. She said she did not know whether or not CNA E transferred R#1 by herself. She said she asked R#1 if she had any pain. She said RN K took R#1's vitals and she returned to the hallway she was assigned to. She said R#1 had periods of lucidity (clarity of thought, clearness of expression, or a temporary state of mental sanity), but the staff were required to use a Paid Ad scale to evaluate her pain because she was nonverbal. She said she did not know a pain numerical scale was used to assess R#1 and believed a Pain Ad nonverbal scale should be used. She said she knew it was important to accurately assess residents' pain levels and said, It helps gives symptoms to physician to make better judgement and help with treatment plan and adequately monitor resident. During a telephone interview with CNA E on 7/22/26 at 12:48 p.m., she said she did not use 2-person assistance and a gait belt when she tried to transfer R#1 because R#1 was doing good without the gait belt. She said she did not know R#1 required 2-person assistance with transfers and said, It's my fault. She explained R#1 slipped from her walker in front of her recliner, fell on her knees, fell on her buttocks, did not hit her head, did not complain of pain, and she notified LVN C and another nurse. She said RN K asked R#1 if she was hurt and R#1 expressed her knee was hurting. She said nurses were expected to ask R#1 what parts of her body were hurt and observe for nonverbal cues. She said she knew it was important to accurately assess residents' pain levels and said, To get an accurate pain assessment of what's going on with the resident. Residents (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could be at risk of not having their pain treated.During a telephone interview with CNA D on 7/22/26 at 1:08 p.m., she said R#1 required 1-person assistance with transfers, could pivot, and was independent. She said she worked with R#1 when R#1 fell on 7/19/26. She explained R#1 tried to stand up with the walker in front of her, could not turn, knees gave out, she lowered R#1 to the ground because she could not lift R#1, and notified RN B. She said R#1 told RN B that her buttocks hurt. She said the nurses evaluated resident post-fall for pain and injuries. She said RN B was aware R#1 could not articulate the severity of her pain. She said the RN B asked R#1 open ended questions about her pain and R#1 told her that her buttocks hurt. She said staff were expected to look for nonverbal cues for pain. She said she knew it was important to accurately assess residents' pain levels and said, Because the nonverbal resident isn't capable of speaking for themselves. Residents could be at risk of not having pain evaluated properly. During a telephone interview with RN K on 7/22/26 at 1:24 p.m., she said CNA E notified her that R#1 fell and did not explain how on 7/20/26. She said CNA E told LVN C that she was trying to transfer R#1, R#1's legs gave out, R#1 slid onto her buttocks, and did not hit her head. She said she observed R#1 was leaning up against the recliner. She said LVN C assessed R#1. She said nurses assessed residents after fall. She said LVN C used pain numerical scale when assessing R#1's pain. She said she did not know what the facility's guideline was for evaluating nonverbal residents' pain because she only worked for the facility since 7/9/26. She said staff could ask where R#1 was hurting, but R#1 could not give a numerical pain value. She said she knew it was important to accurately assess residents' pain levels and said, Because we need to know if the resident needed pain medication and to keep them comfortable. Residents could be at risk of not having pain treated and comforted.During an interview with RN A on 7/22/26 at 2:17 p.m., he said R#1 required a gait belt when transferring her. He said all staff were responsible for resident care. He said R#1 could tell staff where she was hurting at times. He said nurses were expected to evaluate pain. He said staff were expected to use a Pain Ad scale when R#1 could not tell staff where she was hurting. He said R#1 would not be able to tell staff how severe her pain level was. He said it was important to accurately assess residents' pain levels and said, Its important because we must use observation of nonverbal cues because resident is not that alert. It's also a greater impact on getting pain identified and treated.During a telephone interview with RN B on 7/22/26 at 5:00 p.m., she said R#1 required 1-person assistance with transfers at the time on 7/19/26. She said CNA D notified her that R#1 fell on 7/19/26. She said CNA D told her that she tried to transfer R#1 to the walker by herself, R#1's legs became weak, and R#1 fell. She said she did not know whether or not CNA D used a gait belt when she tried to transfer R#1 by herself. She said the DON and IDT investigated falls and reviewed and revised residents' care plans after a fall. She said R#1 did not complain of pain. She said she touched R#1 all over the body and asked her if she had any pain and R#1 told her no. She said she normally assessed residents' pain this way. She said staff were supposed to use a Pain Ad scale and look for non-verbal cues for pain. She said R#1 would not have been able to tell her the severity of her pain. She said it was important to accurately assess residents' pain levels and said, It's important to make sure resident didn't have any injuries and obvious injuries. Residents could be at risk of pain not being treated.During a telephone interview with the ADM on 7/22/26 at 5:13 p.m., she said she reviewed falls during clinical meetings. She said her staff in-serviced the staff to her understanding. She said she expected CNAs to transfer residents according to their transfer status in their EHR. She also expected staff to notify the charge nurse whenever residents' level of assistance changed and said, For the safety of residents and staff. She said she could not remember exact details for R#1's falls on 7/19/26 and 7/20/26. She also said she was unaware that staff did not use a gait belt when they transferred R#1 on those dates. She said she discussed interventions with staff. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said she expected nurses to use their scope of practice to assess residents' pain. She said she did not know how staff were required to assess R#1's pain. She said R#1 had dementia and she expected staff to document how they evaluated R#1's pain. She said it was important to accurately assess residents' pain levels and said, Because we want resident's pain to be addressed. During a telephone interview with the DON on 7/22/26 at 6:04 p.m., she said she expected staff to transfer residents according to their transfer status in the care plan and EHR and said, For the safety of the resident and staff. Residents could be at risk of injury. She said R#1 required a gait belt when being transferred. She said she expected staff to use 2-person assistance with R#1's transfers. She said RN B notified her on 7/19/26 that R#1 fell during a transfer and recommended 2-person assistance. She said she could not remember whether or not a gait belt was used when R#1 fell during a transfer on 7/19/26. She said she had staff initiate in-services on falls. She said the ADON notified her on 7/20/26 that CNA E attempted to transfer R#1 by herself, did not use a gait belt and did not ask for help. She said she expected staff to use a pain assessment that was appropriate for the resident at the time. She said it was important to accurately assess residents' pain levels and said, To get the correct pain level for them. Review of the facility's Pain Management Assessment Scale policy, undated, reflected, Procedure: If a resident is verbal, the new questions will be identical to the questions asked on the MDS. If a resident is non-verbal, the questions will be a PAINAD assessment. Have the resident to rate pain on a scale of one to ten with one being the least pain and ten being the worst pain experienced. The nurse may use the pain rating scale when assessing effectiveness of medications and assessing for pain intensity. Utilize the Pain Assessment Tool in documenting the resident's complaint of pain.		

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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** Based on observation, interview, and record review, the facility failed to ensure 1 (R#3) of 5 residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility failed to follow hospital discharge orders and ensure R#3's physician followed up with her within a week after she returned from the hospital with an acute kidney injury on 7/10/26. This failure could place residents at risk of falls, injuries, and change in condition. Findings include: Review of R#3's admission Record, dated 7/22/26, reflected she was admitted to the facility on [DATE] and readmitted on [DATE]. She had medical diagnoses that included Parkinson's disease (a progressive neurological disorder that primarily affects movement), age-related cognitive decline, and chronic congestive heart failure (a chronic, progressive condition where the heart's muscle weakens or stiffens). Review of R#3's Quarterly MDS, dated [DATE], reflected she had a 13/15 BIMS score, which indicated she was cognitively intact. Review of R#3's Care Plan, revised 7/22/26, reflected she had potential fluid deficit. Staff were required to obtain and monitor lab/diagnostic work as ordered, report results to the MD and follow-up as indicated. Review of R#3's Progress Notes, from 7/1/26 through 7/22/26, reflected: -LVN L created a note on 7/7/26 at 7:57 p.m., Resident returned to the facility from OOP with [family member] and [family member's] reports noticing a change in mental status last night and requested this nurse to reach out to have a UA run. Received orders to have a UA done. -RN M created a note on 7/8/26 at 9:36 a.m., This nurse contacted NP to notify resident was having SOB and received new order for chest x-ray. -LVN N created a note on 7/9/26 at 12:17 p.m., While awaiting arrival of EMS resident admitted that she had c/p a couple of times yesterday and that she did not tell anyone. She also said that when she has laid down in the evenings and became SOB that she did not report this to anyone. -LVN N created a note on 7/10/26 at 6:37 a.m., Resident admitted to [hospital] with AKI. -LVN O created a note on 7/10/26 at 10:51 p.m., Resident returned from the hospital. -LVN N created a note on 7/12/26 at 2:39 p.m., Noted that hospital instructions and f/u appts. There were no progress notes from the physician after R#3 returned from the hospital on 7/10/26. Review of R#3's Hospital After Visit Summary Discharge Orders, dated 7/10/26, reflected, Follow-up with [Physician] in 1 week. Review of the facility's admission and Discharge Report, from 7/1/26 through 7/21/26, reflected R#3 was discharged to the hospital on 7/9/26 and returned 7/10/26. During a telephone interview with the Physician on 7/21/26 at 3:22 p.m., he said he had not seen R#3 in a couple of months. He said the NP visited residents once or twice a week. He said he visited residents who were new admissions and who went out to the emergency room. He reviewed the physician progress notes and said the most recent note he sees was from 6/18/26. During a telephone interview with the NP on 7/21/26 at 4:05 p.m., she said she had not seen R#3 since June 2026. She said she visited residents once a month and as needed. She said she could not remember whether or not she visited and followed-up with R#3 after she returned from the hospital on 7/10/26. During an interview with the MDS Coordinator on 7/22/26 at 10:48 a.m., she said R#3 was not feeling well, started to exhibit signs and symptoms of a change in condition, had respiratory issues and shortness of breath, was sent to the hospital on 7/9/26, and diagnosed with pneumonia and dehydration. She said the physician visited residents weekly, monthly, annually and as requested. During a telephone interview with R#3's RP on 7/22/26 at 1:39 p.m., she said staff notified her on 7/9/26 that R#3 was being sent out to the hospital. She said R#3 returned from the hospital on 7/10/26. She said the Physician and MP did not follow-up with R#3 after she returned from the hospital. She said she emailed the DON and, asked who R#3's Physician (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was and never received a response. She said the NP told her that she saw R#3 and did not. Record review of an email from the ADM on 7/22/26 at 2:45 p.m., and read, Physician notes for [R#3] for July should be in the progress notes, but the NP notes may be in medical records. I sent messages to both [Physician] and [NP] to see if either have seen her [R#3] in July. [Physician] just messaged me in response to my call, ?She was on [NP's] list in 7/20, but [R#3] was not in facility. She is in my list for tomorrow [7/23/26]. During an interview with R#3 on 7/22/26 at 3:51 p.m., she said the Physician did not visit her and never saw her after she returned from the hospital on 7/10/26. During a telephone interview with LVN L on 7/22/26 at 4:01 p.m., she said she was expected to review residents' discharge orders and enter them into the EHR. She said she also had to reach out to the Physician/NP about any appointments. She knew it was important to follow orders and said, It's health. There's a change for the reason. Must enter physician orders. Residents could be at risk of anything when discharge orders not followed. During a telephone interview with RN P on 7/22/26 at 4:13 p.m., she said the readmission nurses were expected to notify the physician that the resident was back from the hospital and to review the orders. She knew it was important to follow orders and said, You have to communicate with the physician because medications could be stopped from the hospital. Residents could be at risk of not being looked at or followed-up on. There might be medications on hold that need to be restarted. Labs could also not end up being entered. Residents could face a decline. During a telephone interview with LVN N on 7/22/26 at 4:33 p.m., she said R#3 returned from the hospital on 7/10/26. She said nurse managers were expected to enter discharge orders. She said she knew it was important to follow orders and said, To prevent delay in care. Residents could be at risk of unfavorable outcomes and encounter delay in treatments. During a telephone interview with the ADM on 7/22/26 at 5:13 p.m., she said R#3 was sent out to the hospital on 7/9/26. She said she expected nurse managers to review residents' discharge orders. She also said the charge nurse would enter orders. She said she expected charge nurses to enter the orders by the end of their shift. She said R#3's hospital discharge summary including Physician follow-up within one week was, Discharge stuff with the hospital that is generic. They are not instructions. Just orders. During a telephone interview with the DON on 7/22/26 at 6:04 p.m., she said she was notified that R#3 was sent out to the hospital on 7/9/26. She said staff were expected to enter orders in EHR. She said the readmission nurse also relays notifications to the physician at the time. She said she knew it was important to follow orders and said, That way they (Physicians) can do it. Review of the facility's Physician Progress Notes policy, 2023, reflected, Regulation states that a resident must be seen by a physician on a specific timeline after admission. After admission, a resident must be seen within the first 30 days, then every 30 days there after to complete the first 90 days of the stay. After the 90-day time frame the resident must then be seen every 60 days. A. The physician does have the option to delegate these visits to the physician assistance or the nurse practitioner. However, within the first 90 days after an admission the attending physician themselves must at least alternate visits with the NP during any Medicare admission. 2. It is our responsibility to notify the physician when a physician's progress note is due. Routine clinical chart audits alert you which physician needs to be notified. Physician visits must confirm to the following scheduled: (B) A physician visit is considered timely if it occurs not later than ten days after the date the visit is required.		