STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676376	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring	1690 N. Treadway Blvd. Abilene, TX 79601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #1) of 8 residents reviewed for pain. Facility failed to ensure Resident #1's pain was recognized, properly assessed and received pain management in accordance with professional standards of practice. Facility nurse aides and occupational therapy assistant moved Resident #1 from the floor to the wheelchair to the bed, after a fall without a nurse assessing the resident for any pain or injuries on 4/8/25 at approximately 6PM. Facility nurse aides failed to relay Resident #1's pain to nurse immediately after a fall on 4/8/25 at approximately 6PM. Facility nurse failed to complete a proper pain assessment on Resident #1 when later notified of a resident leg pain on 04/08/25 at approximately 7:00PM. Resident #1 was transported to the local community hospital and was diagnosed with a femoral fracture. An Immediate Jeopardy (IJ) situation was identified on 6.23.25. The IJ template was provided to the facility on 6.23.25 at 4:20 pm. While the IJ was lowered on 6.25.25 at 4:27 PM, the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm, with a scope of isolated, due to the facility's need to evaluate the effectiveness of their corrective actions. These failures could put residents at pain not being managed by the facility. The findings included: Record review of Resident #1's face sheet dated 6.5.25 revealed Resident #1 was admitted on 4.8.25 and was [AGE] years old. Resident #1 had diagnoses of metabolic encephalopathy (a condition where a systemic health issue or imbalance impairs brain function, causing a range of symptoms from confusion and memory loss to coma), type 2 diabetes, cirrhosis of liver (a condition where healthy liver tissue is replaced by scar tissue, preventing the liver from functioning properly), and sepsis due to Escherichia coli (occurs when an E. coli infection spreads to the bloodstream and triggers a dangerous overreaction of the body's immune system, potentially leading to organ damage and even death). Record review of Resident #1's comprehensive care plan reflected: No Care plan available. Resident #1 was only in building for 6 hours total. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's medical record dated 4.9.25 indicated: Department of Radiology and Nuclear Medicine. Exam: {lain films of the left knee (xray). Findings: On the AP view there is a cortical irregularity in the lateral distal femoral metaphysis consistent with fracture. Record review of Resident #1's progress notes written by LVN W dated 4.8.25 indicated: Late Entry: Note Text: Pt. family member approached this nurse and reported that Pt. is c/o pain to the leg, according to family member the pain was R/T fall. This nurse explained to the family member that no fall, was reported during shift change. This nurse f/u to find out from Pt. when the fall occurred. It was reported that prior to shift change the resident was lowered to floor during toileting due to her legs getting too weak to stand. Pt. stated, I was being cleaned up in the restroom while standing and my legs gave up on me and sat in the floor. Head to toe assessment was completed, Pt. was A&O x2. Pt. was able to move the upper limb but refuse to move the lower limb and complained pain of 12 to the whole of left. Comparing L-leg to right leg, no shortness was noted however, Slight swelling was noted to left knee, but this nurse couldn't confirm if that was R/T fall because it was the 1st time seeing this Pt. Family explained that was not normal for Pt. Acetaminophen 325 mg po x 2 tabs was administered per order. Vital signs: T-97.3, BP-141/94. Day nurse, LVN A was contacted due to Pt. complain of fall, and LVN A said CNA B reported that Pt. had assisted fall. This explained to family that X-ray will be done to find out what was causing the pain but for stat X-ray pt. might has to transfer to the ER for and family said yes. EMT was contacted and at 9:03 pm Pt. together with family members left the facility to the ER. DON notified. During an interview on 6.3.25 at 12:05 pm LVN A stated he does remember Resident #1. He stated that he did do her initial documentation when Resident #1 admitted to the facility. He stated that the hospital never mentioned that Resident #1 needed lift assistance or anything like that. He stated that the resident was seen to transfer with no assistance, but he would say he would recommend Resident #1 at least had two persons to assist her. He stated he must have missed filling out the mobility/safety section in Resident #1 initial assessment. He stated that he should have filled this part of the document out because it indicates to other staff the type of assistance Resident #1 needed. He stated this information could help Resident #1 not sustain any falls. Record review of CNA B witness statement dated 4.8.25 indicated: CNA C then carefully raised Resident #1's leg so CNA D could put a pillow under Resident #1 knee and then CNA C carefully and slowly laid Resident #1 leg down on the pillow. The lady (Resident #1) didn't complain that it hurt until after CNA C had laid Resident #1 knee back down on the pillow. I gave Resident #1 the bed control as CNA D gave her the call light, I walked out of the room. Record review of CNA C witness statement dated 4.8.25 indicated: Me and CNA B held her up as PT E and CNA D tried to put the wheelchair underneath her. When she finally had the bottom in the wheelchair enough to pull her out of the bathroom, PT E told the lady to bend her knees so she can scoot back in the chair. At that time of bending the knee is when she yelled that it hurt. Record review of PT E witness statement dated 4.8.25 indicated: Transitioned resident from EOB to supine with 4 people. Resident complained of pain upon being positioned in supine and notified night shift nurse as day shift nurse was on the phone receiving report for new admission. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 6.22.25 at 10:20 am PT E stated that when she went to report to LVN W that Resident #1 had a fall, she stated that all she told LVN W was that Resident #1 complained of left knee pain. She stated she did not tell the nurse that Resident #1 had a fall because she assumed LVN W already knew because CNA C let LVN A know about the fall. During an interview on 6.20.25 at 6:45 pm LVN W stated that a fall is any change in position from one height to another. She stated this was a fall and the resident should have been assessed. She stated during shift change LVN A was usually good about letting her know about every situation, but he forgot to on the day of the incident. She stated she could not remember at what time, but PT E came to her and said Resident #1 was complaining of left leg pain. She stated she should have asked more questions but did not. She stated she was in the middle of giving out medications, so she took 2 Tylenol to Resident #1. She stated she did not do an assessment of Resident #1 at this time, only that she gave Resident #1 pain medication. She stated later when she was working at the nurse's station and the daughter of Resident #1 came to her and stated that Resident #1 had a fall. She stated to the daughter, when, thinking it just happened. She stated the daughter said no earlier. She stated she went to assess the resident. She stated on doing an assessment you must do a head-to-toe assessment of the resident looking for any abnormalities. She stated, that can include, bruising, swelling, redness, etc. She stated that Resident #1's left knee/leg was a little bit swollen, and the resident did state it was painful. She stated this was the first time she had ever seen the resident since she was a new admit today, so she was not sure if this was the resident's baseline. She stated she went and called LVN A to ask if he knew anything and found out about the incident over the phone. She stated at that point she let the daughter know that there was no portable stat xray available at this time, so the only other option was to send the resident out to the hospital via EMS to go get the residents xray complete. She stated that was what the family wanted and that was why the resident was sent out. She stated she has no idea why anyone would have moved the resident from the floor to the wheelchair without letting a nurse assess the resident first and she has no idea why all this information was not provided to her during shift change. She stated when it comes to a fall and the resident was on the ground they are to stay there until the resident was assessed by a nurse. She stated in this case, if a fall occurs and the resident was assessed and noted to have pain to hip or knee area, she would make the resident comfortable on the floor and call ems because she would not want to move the resident if there was a break to the knee or hip. She stated but this did not happen. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6.20.25 at 7:15 pm CNA D he stated that this was literally his first or second day on the job. He stated that when he came into work, he noticed that the residents call light was on so he was going to answer it. He stated that CNA B joined him because she had assisted the resident to the restroom and the resident had already started to pee and got some on herself. He stated so CNA B wanted to come and help him, so he was not cleaning and doing everything by himself. He stated they went into the resident room they assisted the resident to stand from toilet using gait belt. He stated they were both cleaning the resident up when the resident stated she couldn't do it and began to go down. He stated CNA B was behind the resident at this time in which the resident was lowered down onto CNA B. He stated it was very slow. He stated around the same time CNA C had entered the room. He stated he was not sure but believe CNA C went to let the nurse know about the assessment. He stated CNA C came back to the room and he was not sure how long but maybe 10 mins and PT E came by and asked if they needed assistance. He stated he can't remember if CNA B said anything about no assessment had been done by a nurse or not, but they all assisted the resident back into the wheelchair. He stated the only thing he could remember was that the resident was stating that her knee hurt while they were waiting on the nurse to assess the resident. He stated he was not sure why they didn't wait on the assessment to be completed but they should have waited. He stated this was all new to him. During an interview on 6.5.25 at 11:15 am admin stated that before a resident was accepted into the building the assessment of the resident should be complete. He stated the administration side he may not know everything, but he knows that the information that was needed before accepting the resident was if the resident needs any devices, (walker, wheelchair, etc.), if the resident was ambulatory, needs assistance, what kind of assistance, if the resident needs oxygen or any extra equipment. He stated this should all be known before the resident was accepted into the building. He stated this information is necessary to know that the facility can provide the proper care for the resident and that the resident will have all their needs met. He stated if any of this information was not acquired then it could result in an injury to the resident. During an interview on 6.5.25 at 1:25 pm the DON she stated that the readmit screener documentation should have been filled out completely which was not done. She stated LVN A should have completed that documentation so the staff/facility would have known the assistance required by the resident. She stated overall there were a few misses here in this situation, but she started in-services on the situation to cover documentation. She stated the pain assessment and head-to-toe should have been done while Resident #1 was still on the floor. She stated this did not occur. She stated there were a lot of misses that occurred during this incident. Record review of facility policy dated December 2016 titled: Comprehensive Assessments and the Care Delivery Process indicated: Assessment and information collection includes (WHAT, WHERE and WHEN). The objective of the information collection (assessment) phase is to obtain, organize, and subsequently analyze information about a patient. This was determined to be an Immediate Jeopardy (IJ) on 6.23.25 at 4:20 PM. The Administration was informed of the IJ. The Administrator was provided with the IJ template on 6.23.25 at 4:20 pm. Record review of Plan of Removal accepted on 6.24.25 at 12:10 PM reflected the following: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Impact Statement: On 6/23/2025 an abbreviated survey was initiated on 6/23/25 the facility was provided with notification that the Survey Agency has determined that the conditions at the center constitute Immediate Jeopardy to resident health due to failure for 1 of 87 residents pain being recognized, properly assessed, and receiving pain management. What corrective actions have been implemented for the identified residents? a. The resident involved in the incident on 4/8/25 received immediate pain management and evaluation once identified. The resident was sent to the emergency room on 4/8/25 and diagnosed with a femoral fracture. Resident's pain was managed per physician orders and follow-up care was provided. b. Ambassador rounds were completed by the interdisciplinary team on 4/8/25 and incident reports of falls that occurred in the last 24 hours were reviewed to ensure any resident pain was properly assessed, reported, and addressed by direct care staff and no other discrepancies were identified. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? a. On 6/23/25 the Director of Nursing and/or nurse managers in-serviced direct care staff on recognizing, properly assessing, and receiving pain management. Staff educated on reporting recognized resident pain to the charge nurse, the charge nurse is to immediately assess the resident's pain, and administer pain medication in accordance to the results of the pain assessment completed. All Direct care staff employees will be in-serviced by the Director of Nursing and/or nurse managers on recognizing, properly assessing, and receiving pain management prior to their next scheduled shift. Staff members will recite understanding of the education to the educator and 5 staff interviews will be completed daily for seven days. b. The facility DON or nurse manager will in-service new hires during orientation, on recognizing, properly assessing, and receiving pain management prior to their next scheduled shift. Staff educated on reporting recognized resident pain to the charge nurse, the charge nurse is to immediately assess the resident's pain, and administer pain medication in accordance to the results of the pain assessment completed. Effectiveness of staff educated on recognizing, properly assessing, and receiving pain management will be evaluated with staff reciting information and 5 staff interviews per day for seven days to ensure information is retained. How will the system be monitored to ensure compliance? a. Starting 6/23/25 the DON or nurse manager will complete resident interviews and/or assessments daily for seven days to ensure are pain was recognized, properly assessed and received pain medication in a timely manner. Post the daily monitoring on 6/30/25 the DON/nurse manager will round on residents to ensure pain was recognized, properly assessed and received pain medication in a timely manner effectively 2x week X 6 weeks or until it is determined the metric is met. Any discrepancies identified will be addressed immediately by the nurse manager and further education provided by the DON or designee when necessary. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6.24.25 at 1:35 pm CNA H stated she was in-serviced 3 different times over the past day or so. She stated pain was a big one she can remember. She stated she is not a nuse so assessing the resident for pain was not something required. She stated but inquiring about pain level and maybe how the resident hurt themselves was okay. She stated right when the resident let her know of any pain she would report it to the charge nurse. She stated the next two topics kind of went hand in hand. She stated that if a resident has a fall, assisted or not, it must be reported to the nurse and nothing should be done to the resident until the nuse has completed her assessment of the resident. She stated, essentially, if a resident falls, let charge nurse know, don't move the resident and wait for the nurse to do their assessment of the resident before any moving of the resident was allowed. During an interview on 6.24.25 at 1:45 pm CNA I stated any fall any was any change in residents plane. She stated even if it's a 3 inch movement, different plane means a fall. She stated it also doesn't matter if it was assisted, witnessed or unwitnessed it was still a fall and had to be reported to the nurse. She stated even while waiting on the nurse to get to the residents room, the resident was not to be moved or assisted in any way. She stated once the nurses assessment was complete she would be allowed to, with the help of the nurse, get the resident up. She stated the other in-service covered pain. She stated this could be any pain, in general or associated to a fall. She stated all pain should be immediately reported to the nurse and the nurse would come and do the assessment of the resident. During an interview on 6.24.25 at 2:00 pm RN J stated she has been nurse since 23. She stated she was in-serviced this morning before she was allowed to work. She stated that she went through a few in-services. She stated the first one covered falls. She stated, it covered what constitutes as a fall, with injury or no injury. She stated that the in-service covered what a CNA must do related to a fall and what a nurse must do related to a fall. She stated that a CNA was not to assist or move the resident, but only too report the fall to the nurse and wait for the nurse to come do the nursing assessment. She stated second the nursing assessment covered a head to toe assessment that checked for swelling, bruising, bleeding, how the resident was acting, etc. she stated if there were concerns the resident hit their head the resident would not be moved at all and EMS would be called to come and get the resident. She stated after assessment was completed on resident then the resident could be moved and then monitored. She stated lastly, if any resident complains of any sort of pain, to CNA, the CNA should come report to the nurse immediately, but if the pain was notated directly from resident to nurse, the nurse must do a head to toe assessment and pull meds pending level of pain or reach out to physician if pain was high. During an interview on 6.24.25 at 2:15 pm LVN K stated that this was a refresher, but it was everything that she did consistently. She stated the main topic was about falls and pain associated to falls. She stated the CNA's got a little bit different of an in-service then the nurses did. She stated for the nurses, the requirement was no matter how big of a fall, a nurse must go and assess the resident before they were allowed to be moved by anyone. She stated pain was covered and the overview was that any resident who complains of any sort of pain, associated to a fall or not should be assessed from head to toe and meds could be given associated to the level of pain and what medications were available to the resident. She stated primary focus, no moving of any resident associated to any fall could be done until the nursing assessment was completed. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6.24.25 at 2:25 pm RN L stated that she was in-serviced and it covered 3 parts. She stated two parts went together, any fall occurs in the building a nurse must respond to the resident and do a full body head to toe assessment of the resident before the resident was allowed to be moved by anyone. She stated that CNA's were to either call for help while still being able to see the resident or have another CNA who was with them to go and let the nurse know that they had a fall and a nursing assessment must be done. She stated that all pain in the same process should be notated to the nurse at this time as well. She stated beyond a fall, any pain a resident notates to any CNA, the CNA must immediately come to the nurse and let the nurse know of the pain and the nurse must go and perform a pain assessment on the resident and provide the resident with any medication the resident may have for pain or reach out to the physician. During an interview on 6.24.25 at 2:45 pm ADON stated that he was aware of the situation going on. He stated that he has been helping/part of every in-service provided by the DON to all nursing staff. He stated that the main topic was falls and pain, which went for both CNA's and nurses. He stated that any fall in the facility must be responded to and a nurse must do a nursing assessment before the resident was allowed to be moved at all. He stated that it was imperative that any CNA does not move the resident at all until the resident was assessed by the nurse. He stated it was also imperative that a nurse do a head to toe nursing assessment on all residents who had a fall, checking for swelling, bruising, blood, etc. he stated second topic for both CNA and nurse was to communicate fully to each other when any resident complains of pain anywhere on their body. He stated the CNA just needs to inform the nurse that resident complained of pain and where on the body. He stated it was then the nurses responsibility to go and assess the resident for any pain. During an interview on 6.24.25 at 3:00 pm CNA M stated she was in serviced last night before she came on shift. Phone interview. She stated that she got in-serviced the night before. She stated it was roughly around 5:30pm. She stated there were 3 topics covered, falls, pain, and nursing assessments. She stated the main thing for the CNA's that was covered was falls. She stated the definition of a call, which was anytime a residents body went to the floor. She stated it does not matter if it was assisted or not, it was still considered a fall. She stated second the topic that was associated to the fall was that a CNA's was not to move or get the resident up after the fall unless a nurse had completed the nursing assessment of the resident. She stated lastly was pain, she stated pain does not have to be only associated to a fall but anytime a resident complains of any pain on their body they are to report it to the nurse so the nurse could come and do a pain assessment of the resident. During a phone interview on 6.24.25 at 3:10 pm CNA N stated that there were 3 topics covered. She stated pain, falls, and nursing assessment. She stated that pain can be any complaint made by the resident no matter how big or small of a complaint, the complaint should be reported to the nurse immediately. She stated she was not a nurse so she would not assess the resident for pain but may ask how it happened or level of pain. She stated the other topic that was covered, was falls and reporting falls to the nurse. She stated not only do you have to report the fall to the nurse but stay with the resident, do not move them until the nurse has physically come and done a nursing assessment. She stated that it was drilled into the CNA's that they are not to move the resident for no reason until that nursing assessment was completed. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 6.24.25 at 3:15 pm CNA O stated she works nights and can work both sides. she stated she got in-serviced yesterday 6.23.25 at roughly late afternoon. She stated that there were so many that they molded together, but she knows she did at least 3. She stated one in-service covered falls. She stated that it covered what constitutes as a fall, what to do in case of a fall and who to call. She stated if a fall occurred assisted or not she was not allowed to touch the resident. She stated if there was another CNA with you that CNA can go and let the nurse know but if you were by yourself you need to call out for help because you do not leave the resident. She stated that nothing was to be done to the resident until the nursing assessment had been completed by the nurse. She stated the nursing assessment was to be completed by the nurse, and there was no reason for the resident to ever be moved until it was completed. She stated but if a resident did complain of pain, no associated to a fall or anything witnessed, then the CNA would ask the resident basic questions such as, how bad is the pain, how did you hurt yourself etc. She stated once that information was received she would go directly to the charge nurse to let them know the resident had pain. Record Review of in-service presented by DON titled communication of complaints of pain-CNA's from residents, dated 6.23.25, signature page provided. Inservice covered CAN/CMA's: When a resident reports having pain, specifically after a fall, ask the resident where the pain is coming from on their body. Then tell the resident's charge nurse immediately. DO NOT MOVE RESIDENT AFTER A FALL WITHOUT A NURSE COMPLETING AN ASSESSMENT OF PAIN AND/OR INJURY. All employees interviewed were verified with signatures. During a phone interview on 6.24.25 at 3:20 pm LVN P stated she worked the north side. She stated that she got in-serviced last night. She stated that the main topic covered for the nurses was that an assessment had to be done from head to toe for each resident now matter how minor of a fall occurred. She stated there was no excuse that a resident after a fall was not assessed before the resident was moved off of the ground. She stated the second topic covered was pain in general. She stated pain associated to a fall or not, must be brought to the attention of the nurse even if it was minor. She stated once being reported that a resident complained of pain, the nurse must go to the resident and assess the resident for pain level, location, injury, etc. she stated once the pain was identified, medications could be administered if resident has prn meds or pain meds in general. Record review of in-service presented by DON titled Resident Assessment of Pain-Nurses. Do not move resident after a fall without completing an assessment of pain and/or injury. Assess: onset- Mechanism of injury or etiology of pain, if identifiable. Location/distribution. Duration. Course or temporal pattern. Character and quality of the pain. Aggravating/provoking factors. Alleviating factors. And Associated symptoms. Administer pain medication as ordered by physician. If no pain medication is previously ordered by physician, notify physician immediately of residents pain/pain assessment. Acquire orders as given by physician for pain control and/or additional orders as received. All employees interviewed were verified with signatures. Record Review of Qapi Signature Page. Quapi meeting covering PoR and topic of IJ. Attendees included administrator, Dr A, DON, ADON, RUP, and DRO. (continued on next page)

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	676376	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring	1690 N. Treadway Blvd. Abilene, TX 79601

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 6.24.25 at 3:40 pm RN Q stated that she got in-serviced last night. She stated that the main topic covered for the nurses was that an assessment had to be done from head to toe for each resident now matter how minor of a fall occurred. She stated there was no excuse that a resident after a fall was not assessed before the resident was moved off of the ground. She stated the second topic covered was pain in general. She stated pain associated to a fall or not, must be brought to the attention of the nurse even if it was minor. She stated once being reported that a resident complained of pain, the nurse must go to the resident and assess the resident for pain level, location, injury, etc. she stated once the pain was identified, medications could be administered if resident has prn meds or pain meds in general. During a phone interview on 6.24.25 at 3:50 pm CNA R stated topics covered pain, then falls, wait for assessment before anyone is moved. She stated there were a few in-services. She stated that the topics discussed in the in-services were falls, nursing assessments and pain. She stated a fall is any time a resident ends up on the ground without intending to. She stated it did not matter if it was assisted or witnessed, with injury or no injury, a fall was to be reported to the charge nurse immediately. She stated she should not move the resident, sit the resident up, assist the resident in anyway. She stated the focus at that time was to make sure the resident did not move and stayed on the floor [TRUNCATED]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety anfor 1 of 8 (Resident #1) resident reviewed for staffing, in that: Facility failed to ensure licensed nurses and nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents need. Facility nurse aides failed to relay resident complaint of pain to appropriate nurse after a fall so that resident could be promptly assessed. Facility nurse failed to provide the on-coming nurse with information about the residents assisted fall from earlier in the day in order for resident to be monitored. Facility nurse aides and staff (PT) moved a resident after a fall without a nurse completing an assessment of resident for pain or injury. Facility nurses did not fully assess resident pain before administering pain medication. An Immediate Jeopardy (IJ) situation was identified on 6.23.25. The IJ template was provided to the facility on 6.23.25 at 4:20 pm. While the IJ was removed on 6.25.25 at 4:27 PM, the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm, with a scope of isolated, due to the facility's need to evaluate the effectiveness of their corrective actions. These failures could put residents at risk of not being provided care by nursing staff with sufficient skills/training. Findings included: Record review of Resident #1's face sheet dated 6.5.25 revealed Resident #1 was admitted on 4.8.25 and was [AGE] years old. Resident #1 had diagnoses of metabolic encephalopathy (a condition where a systemic health issue or imbalance impairs brain function, causing a range of symptoms from confusion and memory loss to coma), type 2 diabetes, cirrhosis of liver (a condition where healthy liver tissue is replaced by scar tissue, preventing the liver from functioning properly), and sepsis due to Escherichia coli (occurs when an E. coli infection spreads to the bloodstream and triggers a dangerous overreaction of the body's immune system, potentially leading to organ damage and even death). Record review of Resident #1's comprehensive care plan reflected: No Care plan available. Resident #1 was only in building for 6 hours total. Record review of Resident #1's medical record dated 4.9.25 indicated: Department of Radiology and Nuclear Medicine. Exam: {lain films of the left knee (xray). Findings: On the AP view there is a cortical irregularity in the lateral distal femoral metaphysis consistent with fracture (fracture of femur). (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's admit/readmit form indicated all sections to be completed by LVN A except for section mobility/safety. Record review of Resident #1's progress notes dated 4.8.25 indicated: Late Entry: Note Text: Pt. family member approached this nurse and reported that Pt. is c/o pain to the leg, according to family member the pain was R/T fall. This nurse explained to the family member that no fall, was reported during shift change. This nurse f/u to find out from Pt. when the fall occurred. It was reported that prior to shift change the resident was lowered to floor during toileting due to her legs getting too weak to stand. Pt. stated, I was being cleaned up in the restroom while standing and my legs gave up on me and sat in the floor. Head to toe assessment was completed, Pt. was A&O x2. Pt. was able to move the upper limb but refuse to move the lower limb and complained pain of 12 to the whole of left. Comparing L-leg to right leg, no shortness was noted however, Slight swelling was noted to left knee, but this nurse couldn't confirm if that was R/T fall because it was the 1st time seeing this Pt. Family explained that was not normal for Pt. Acetaminophen 325 mg po x 2 tabs was administered per order. Vital signs: T-97.3, BP-141/94. Day nurse, LVN A was contacted due to Pt. complain of fall, and LVN A said CNA B reported that Pt. had assisted fall. This explained to family that X-ray will be done to find out what was causing the pain but for stat X-ray pt. might has to transfer to the ER for and family said yes. EMT was contacted and at 9:03 pm Pt. together with family members left the facility to the ER. DON notified. During an interview on 6.3.25 at 11:45 am CNA B stated the resident was brand new that day. She stated that when she went to answer the call light the resident was already in her wheelchair. She stated before she went to the restroom, she asked the resident how stable she was and if she needed much help because she was not sure how much assistance the resident needed. She stated that the resident told her that at the hospital she really didn't even need much assistance to transfer from wheelchair to toilet. She stated that she took the resident to the restroom and told the resident to use her call light after she was done, and she would come help her. She stated the resident used to the call light indicating resident was complete. She stated that CNA D and herself went to the resident's room and went to assist the resident off the toilet. She stated the resident stood up and she was standing behind the resident while CNA D was on the front/side of the resident. She stated the resident stood fully up, then stated I can't do this, and went to sit back down. She stated the resident started to sit down and slowly slid down to the ground, basically using her legs as a slide down to the floor landing on her foot. She stated that CNA C let LVN A know of the assisted fall and then was called into Resident #1's room, the entire time the resident was on her foot, the resident was assisted back to the wheelchair and then put back into bed. She stated that roughly 15min later the resident complained of her left knee hurting. She stated this all happened around shift change, the resident was sent out and she is not sure what has happened since then. During an interview on 6.3.25 at 1:55 pm LVN A stated he did not go in and do an assessment of the resident because the way he was told it was like the resident just was assisted and sat on the floor. He stated he should have went and assessed Resident #1 before she was moved from the floor. He stated any resident that sustained a fall, must be assessed by a nurse before the resident was allowed to be moved. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6.5.25 at 11:55 am CNA C stated that the nurse should have come and assessed the resident, but it did not happen. She stated she let him know and he said OK but never came down to assess the resident. She stated the protocol for any fall, assisted or not needs to be assessed by a nurse before moved. She stated blood pressure and vitals everything before the resident was moved, but this did not happen. During interview on 6.22.25 at 10:20 am PT E stated that when she went to report to LVN W that Resident #1 had a fall, she stated that all she told LVN W was that Resident #1 complained of left knee pain. She stated she did not tell the nurse that Resident #1 had a fall because she assumed LVN W already knew because CNA C let LVN A know about the fall. Record review of CNA B witness statement dated 4.8.25 indicated: CNA C then carefully raised Resident #1's leg so CNA D could put a pillow under Resident #1 knee and then CNA C carefully and slowly laid Resident #1 leg down on the pillow. The lady (Resident #1) didn't complain that it hurt until after CNA C had laid Resident #1 knee back down on the pillow. I gave Resident #1 the bed control as CNA D gave her the call light, I walked out of the room. Record review of CNA C witness statement dated 4.8.25 indicated: Me and CNA B held her up as PT E and CNA D tried to put the wheelchair underneath her. When she finally had the bottom in the wheelchair enough to pull her out of the bathroom, PT E told the lady to bend her knees so she can scoot back in the chair. At that time of bending the knee is when she yelled that it hurt. Record review of PT E witness statement dated 4.8.25 indicated: Transitioned resident from EOB to supine with 4 people. Resident complained of pain upon being positioned in supine and notified night shift nurse as day shift nurse was on the phone receiving report for new admission. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6.20.25 at 6:45 pm LVN W stated that a fall is any change in position from one height to another. She stated this was a fall and the resident should have been assessed. She stated that PT E did let her know about Resident #1's knee pain so she went and gave Resident #1 two Tylenol. She stated she did not assess Resident #1 at this time, but only gave her Tylenol. She stated during shift change LVN A was usually good about letting her know about every situation, but he forgot to on the day of the incident. She stated that she was working at the nurse's station and the of the resident came to her and stated that the resident had a fall. She stated to the, when, thinking it just happened. She stated the said no earlier. She stated she went to assess the resident. She stated on doing an assessment you must do a head-to-toe assessment of the resident looking for any abnormalities. She stated, that can include, bruising, swelling, redness, etc. She stated that the resident's left leg/knee was a little bit swollen, and the resident did state it was painful. She stated this was the first time she had ever seen the resident since she was a new admit today, so she was not sure if this was the resident's baseline. She stated she went and called [NAME] to ask if he knew anything and found out about the incident over the phone. She stated at that point she let the daughter know that there was no portable stat xray available at this time, so the only other option was to send the resident out to the hospital via EMS to go get the residents xray complete. She stated that was what the family wanted and that was why the resident was sent out. She stated she has no idea why anyone would have moved the resident from the floor to the wheelchair without letting a nurse assess the resident first and she has no idea why all this information was not provided to her during shift change. She stated when it comes to a fall and the resident was on the ground they are to stay there until the resident was assessed by a nurse. She stated in this case, if a fall occurs and the resident was assessed and noted to have pain to hip or knee area, she would make the resident comfortable on the floor and call EMS because she would not want to move the resident if there was a break to the knee or hip. She stated but this did not happen. During an interview on 6.5.25 at 11:15 am Admin stated that from what he knows, any fall that occurs in the building a nurse must go and assess the resident before the resident is allowed to be moved from the ground. He stated this was protocol and from what he found out; this did not occur. During an interview on 6.5.25 at 1:25 pm DON stated this was absolutely a fall. She stated the first time she heard of the incident was when the night nurse LVN E reached out to her asking her if she was aware of any fall by that resident. She stated she didn't know, she stated she started to reach out to her aids via text and realized this was a fall. She stated that LVN A the nurse on shift during the incident should have gone and assessed the resident. She stated that the way it was described to LVN A it was not a fall, so he didn't assess. She stated it should have been treated as a fall. She stated overall there were a few misses here in this situation, but she started in-services on the situation to cover documentation and what was considered a fall. She stated a change in plane was considered a fall. Record review of facility policy dated September 2012 titled: Falls-Clinical Protocol indicated: 2. In addition, the nurse shall assess and document/report the following: a. vital signs, b. recent injury, especially fracture or head injury, c. musculoskeletal function, observing for changing in normal range of motion, weight bearing etc., d. change in cognition or level of consciousness, e. neurological status, f. pain, g. frequency and number of falls since last physician visit. H. precipitating factors, details on how fall occurred, i. all current medications, especially those associated with dizziness or lethargy, and j. all active diagnosis. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This was determined to be an Immediate Jeopardy (IJ) on 6.23.25 at 4:20 PM. The Administration was informed of the IJ. The Administrator was provided with the IJ template on 6.23.25 at 4:20 pm. And a Pla of Removal was requested. The facility Plan of Removal was accepted on 6.24.25 at 12:10 PM and reflected the following: Impact Statement: On 6/23/2025 an abbreviated survey was initiated on 6/23/25 the facility was provided notification that the Survey Agency has determined that the conditions at the center constitute Immediate Jeopardy to resident health due to failure to protect 1 of 87 residents in ensuring licensed nurses and nurse aides were able to demonstrate competency in skills and techniques necessary to care for resident's needs. What corrective actions have been implemented for the identified residents? a. The resident involved in the incident on 4/8/25 received immediate pain management and evaluation once identified. The resident was sent to the emergency room on 4/8/25 and diagnosed with a femoral fracture. Resident's pain was managed per physician orders and follow-up care was provided. Resident was closely monitored for any complications related to the injury or delayed treatment on 4/8/25. b. On 6/23/25 all current residents who have had an incident in the last two weeks were reviewed to ensure the resident was not moved prior to a nurse assessing the patient and pain was assessed by licensed nurse prior to administering medication. No other discrepancies identified with licensed nurses and nurse aides being able to demonstrate competency in skills and techniques necessary to care for the residents needs. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? a. On 6/23/25 the Director of Nursing and/or nurse managers initiated an in-service direct care staff reporting recognized resident pain to the charge nurse, the charge nurse is to immediately assess the resident's pain, and administer pain medication in accordance to the results of the pain assessment completed. The in-service will be completed by 6/24/25. All Direct care staff employees will be in-serviced by the Director of Nursing and/or nurse managers on recognizing, properly assessing, and receiving pain management and any PRN or weekend staff will be in-serviced by 6/24/2025. If PRN or weekend staff are unable to be reached, they will be removed from the schedule until in-service is completed. Effectiveness of staff educated on reporting recognized resident pain to the charge nurse, the charge nurse is to immediately assess the resident's pain, and administer pain medication in accordance to the results of the pain assessment completed will be evaluated with staff reciting information and 5 staff interviews per day for seven days to ensure information is retained. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. On 6/23/25 an in-service was initiated by the Director of Nursing and nurse managers with nurse aides on relaying resident's complaint of pain to charge nurse when a resident expresses signs of pain and not moving a resident after a fall without a nurse completing an assessment of resident for pain or injury. All nursing assistants will be in-serviced by 6/24/2025 by the Director of Nursing and/or nurse managers on relaying resident's complaint of pain to charge nurse when a resident expresses signs of pain and not moving a resident after a fall without a nurse completing an assessment of resident for pain or injury including PRN and Weekend staff. If staff are unable to be reached to provide in-service by 6/24/25 they will removed from the schedule until in-service is completed. Effectiveness of staff educated on relaying resident's complaint of pain to charge nurse when a resident expresses signs of pain and not moving a resident after a fall without a nurse completing an assessment of resident for pain or injury will be evaluated with staff reciting information and 5 staff interviews per day for seven days to ensure information is retained. c. On 6/23/25 the Director of Nursing and nurse managers initiated an in-service with licensed nurses on completing a full assessment of a residents pain prior to administering pain medication. The in-service will be completed 6/24/25. All licensed nurses will be in-serviced by the Director of Nursing and/or nurse managers initiated an in-service with licensed nurses on completing a full assessment of a residents pain prior to administering pain medication including PRN and weekend staff by 6/24/25 or they will be removed from the schedule until in-service is completed. Effectiveness of staff educated on completing a full assessment of a residents pain prior to administering pain medication will be evaluated with staff reciting information and 5 staff interviews per day for seven days to ensure information is retained. d. The facility DON or nurse manager will in-service new hire nursing assistants and licensed nurses during orientation, relaying resident's complaint of pain to nurse so the resident can be properly assessed, not to move a resident post resident fall without a nurse completing an assessment of resident for pain or injury, and the need to fully assess a resident's pain before administering pain medication. Staff members will recite understanding of the education to the educator. How will the system be monitored to ensure compliance? a. Starting 6/23/25 the DON or nurse manager will complete interviews and/or assessments with residents daily for seven days to ensure pain was recognized, properly assessed and received pain medication in a timely manner. Post the daily monitoring on 6/30/25 the DON/nurse manager will round on residents to ensure pain was recognized, properly assessed and received pain medication in a timely manner effectively 2x week X 6 weeks or until it is determined the metric is met. Any discrepancies identified will be addressed immediately by the nurse manager and further education provided by the DON or designee when necessary. b. Starting 6/23/25 the DON and/or nurse manager will review the 24 hour report in electronic medical record that identifies all nurse documentation, PRN pain administration, resident assessments completed, and progress note documentation daily for 7 days and then 5x week for 3 weeks to ensure any documented pain was recognized, properly assessed, the resident was fully assessed prior to pain medication administration, and received pain medication in a timely manner (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Starting on 6/23/25 the DON and/or nurse manager will review fall incident reports daily in the electronic medical record for seven days and then 3x week for six weeks to ensure resident was assessed for pain and/or injury by a licensed nurse prior to moving the resident post fall and that the resident was fully assessed for pain prior to providing pain medication by the licensed nurse. If it is identified that a resident was not assessed prior to being moved, the resident will immediately be assessed and the employee will receive further education. d. Administrator and/or designee will review the 24 hour report in the electronic medical record and round on residents daily for seven days and then on a weekly for six weeks basis to ensure nurse managers are following the plan of removal of ensuring staff are competent in skills and techniques necessary to care for resident needs or until it is determined the metric is met starting 6/23/25. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 6/23/25 with the Medical Director. The Medical Director has reviewed and agrees with this plan. Monitoring of facilities Plan of Removal through observations, interviews, and record reviews from 06/24/2025 to 06/25/2025 revealed: During an interview on 6.24.25 at 1:10 pm CNA F stated she got in-serviced yesterday 6.23.25 at roughly late afternoon. She stated that there were so many that they molded together, but she knows she did at least 3. She stated one in-service covered falls. She stated that it covered what constitutes as a fall, what to do in case of a fall and who to call. She stated if a fall occurred assisted or not she was not allowed to touch the resident. She stated if there was another CNA with you that CNA can go and let the nurse know but if you were by yourself you need to call out for help because you do not leave the resident. She stated that nothing was to be done to the resident until the nursing assessment had been completed by the nurse. She stated the nursing assessment was to be completed by the nurse, and there was no reason for the resident to ever be moved until it was completed. She stated but if a resident did complain of pain, no associated to a fall or anything witnessed, then the CNA would ask the resident basic questions such as, how bad is the pain, how did you hurt yourself etc. She stated once that information was received she would go directly to the charge nurse to let them know the resident had pain. During an interview on 6.24.25 at 1:25 pm CNA G stated she has been doing this for many years and this was all a refresher for her. She stated that the topics discussed in the in-services were falls, nursing assessments and pain. She stated a fall is any time a resident ends up on the ground without intending to. She stated it did not matter if it was assisted or witnessed, with injury or no injury, a fall was to be reported to the charge nurse immediately. She stated she should not move the resident, sit the resident up, assist the resident in anyway. She stated the focus at that time was to make sure the resident did not move and stayed on the floor and then go and inform the charge nurse. She stated nothing at all was to be done even while waiting on the nurse to come and do the assessment. She stated ever fall in the building must have a nursing assessment completed. She stated lastly pain was discussed. She stated anytime a resident has any sort of pain, major or minor, she would repot to the charge nurse and let them know the resident was complaining of pain. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6.24.25 at 1:35 pm CNA H stated she was in-serviced 3 different times over the past day or so. She stated pain was a big one she can remember. She stated she is not a nuse so assessing the resident for pain was not something required. She stated but inquiring about pain level and maybe how the resident hurt themselves was okay. She stated right when the resident let her know of any pain she would report it to the charge nurse. She stated the next two topics kind of went hand in hand. She stated that if a resident has a fall, assisted or not, it must be reported to the nurse and nothing should be done to the resident until the nuse has completed her assessment of the resident. She stated, essentially, if a resident falls, let charge nurse know, don't move the resident and wait for the nurse to do their assessment of the resident before any moving of the resident was allowed. During an interview on 6.24.25 at 1:45 pm CNA I stated any fall any was any change in residents plane. She stated even if it's a 3 inch movement, different plane means a fall. She stated it also doesn't matter if it was assisted, witnessed or unwitnessed it was still a fall and had to be reported to the nurse. She stated even while waiting on the nurse to get to the residents room, the resident was not to be moved or assisted in any way. She stated once the nurses assessment was complete she would be allowed to, with the help of the nurse, get the resident up. She stated the other in-service covered pain. She stated this could be any pain, in general or associated to a fall. She stated all pain should be immediately reported to the nurse and the nurse would come and do the assessment of the resident. During an interview on 6.24.25 at 2:00 pm RN J stated she has been nurse since 2023. She stated she was in-serviced this morning before she was allowed to work. She stated that she went through a few in-services. She stated the first one covered falls. She stated, it covered what constitutes as a fall, with injury or no injury. She stated that the in-service covered what a CNA must do related to a fall and what a nurse must do related to a fall. She stated that a CNA was not to assist or move the resident, but only too report the fall to the nurse and wait for the nurse to come do the nursing assessment. She stated second the nursing assessment covered a head to toe assessment that checked for swelling, bruising, bleeding, how the resident was acting, etc. she stated if there were concerns the resident hit their head the resident would not be moved at all and EMS would be called to come and get the resident. She stated after assessment was completed on resident then the resident could be moved and then monitored. She stated lastly, if any resident complains of any sort of pain, to CNA, the CNA should come report to the nurse immediately, but if the pain was notated directly from resident to nurse, the nurse must do a head to toe assessment and pull meds pending level of pain or reach out to physician if pain was high. During an interview on 6.24.25 at 2:15 pm LVN K stated that this was a refresher, but it was everything that she did consistently. She stated the main topic was about falls and pain associated to falls. She stated the CNA's got a little bit different of an in-service then the nurses did. She stated for the nurses, the requirement was no matter how big of a fall, a nurse must go and assess the resident before they were allowed to be moved by anyone. She stated pain was covered and the overview was that any resident who complains of any sort of pain, associated to a fall or not should be assessed from head to toe and meds could be given associated to the level of pain and what medications were available to the resident. She stated primary focus, no moving of any resident associated to any fall could be done until the nursing assessment was completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676376	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring	1690 N. Treadway Blvd. Abilene, TX 79601

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6.24.25 at 2:25 pm RN L stated that she was in-serviced and it covered 3 parts. She stated two parts went together, any fall occurs in the building a nurse must respond to the resident and do a full body head to toe assessment of the resident before the resident was allowed to be moved by anyone. She stated that CNA's were to either call for help while still being able to see the resident or have another CNA who was with them to go and let the nurse know that they had a fall and a nursing assessment must be done. She stated that all pain in the same process should be notated to the nurse at this time as well. She stated beyond a fall, any pain a resident notates to any CNA, the CNA must immediately come to the nurse and let the nurse know of the pain and the nurse must go and perform a pain assessment on the resident and provide the resident with any medication the resident may have for pain or reach out to the physician. During an interview on 6.24.25 at 2:45 pm ADON stated that he was aware of the situation going on. He stated that he has been helping/part of every in-service provided by the DON to all nursing staff. He stated that the main topic was falls and pain, which went for both CNA's and nurses. He stated that any fall in the facility must be responded to and a nurse must do a nursing assessment before the resident was allowed to be moved at all. He stated that it was imperative that any CNA does not move the resident at all until the resident was assessed by the nurse. He stated it was also imperative that a nurse do a head to toe nursing assessment on all residents who had a fall, checking for swelling, bruising, blood, etc. he stated second topic for both CNA and nurse was to communicate fully to each other when any resident complains of pain anywhere on their body. He stated the CNA just needs to inform the nurse that resident complained of pain and where on the body. He stated it was then the nurses responsibility to go and assess the resident for any pain. During an interview on 6.24.25 at 3:00 pm CNA M stated she was in serviced last night before she came on shift. Phone interview. She stated that she got in-serviced the night before. She stated it was roughly around 5:30pm. She stated there were 3 topics covered, falls, pain, and nursing assessments. She stated the main thing for the CNA's that was covered was falls. She stated the definition of a call, which was anytime a residents body went to the floor. She stated it does not matter if it was assisted or not, it was still considered a fall. She stated second the topic that was associated to the fall was that a CNA's was not to move or get the resident up after the fall unless a nurse had completed the nursing assessment of the resident. She stated lastly was pain, she stated pain does not have to be only associated to a fall but anytime a resident complains of any pain on their body they are to report it to the nurse so the nurse could come and do a pain assessment of the resident. During a phone interview on 6.24.25 at 3:10 pm CNA N stated that there were 3 topics covered. She stated pain, falls, and nursing assessment. She stated that pain can be any complaint made by the resident no matter how big or small of a complaint, the complaint should be reported to the nurse immediately. She stated she was not a nurse so she would not assess the resident for pain but may ask how it happened or level of pain. She stated the other topic that was covered, was falls and reporting falls to the nurse. She stated not only do you have to report the fall to the nurse but stay with the resident, do not move them until the nurse has physically come and done a nursing assessment. She stated that it was drilled into the CNA's that they are not to move the resident for no reason until that nursing assessment was completed. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 6.24.25 at 3:15 pm CNA O stated she works nights and can work both sides. she stated she got in-serviced yesterday 6.23.25 at roughly late afternoon. She stated that there were so many that they molded together, but she knows she did at least 3. She stated one in-service covered falls. She stated that it covered what constitutes as a fall, what to do in case of a fall and who to call. She stated if a fall occurred assisted or not, she was not allowed to touch the resident. She stated if there was another CNA with you that CNA can go and let the nurse know but if you were by yourself you need to call out for help because you do not leave the resident. She stated that nothing was to be done to the resident until the nursing assessment had been completed by the nurse. She stated the nursing assessment was to be completed by the nurse, and there was no reason for the resident to ever be moved until it was completed. She stated but if a resident did complain of pain, no associated to a fall or anything witnessed, then the CNA would ask the resident basic questions such as, how bad is the pain, how did you hurt yourself etc. She stated once that information was received she would go directly to the charge nurse to let them know the resident had pain. Record Review of in-service presented by DON titled communication of complaints of pain-CNA's from residents, dated 6.23.25, signature page provided. Inservice covered CAN/CMA's: When a resident reports having pain, specifically after a fall, ask the resident where the pain is coming from on their body. Then tell the resident's charge nurse immediately. DO NOT MOVE RESIDENT AFTER A FALL WITHOUT A NURSE COMPLETING AN ASSESSMENT OF PAIN AND/OR INJURY. All employees interviewed were verified with signatures. During a phone interview on 6.24.25 at 3:20 pm LVN P stated she worked the north side. She stated that she got in-serviced last nig[TRUNCATED]