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	365741	a. building _____ b. wing _____	02/25/2026

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ASHTABULA COUNTY NURSING HOME	5740 DIBBLE ROAD KINGSVILLE OH, 44048

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F 0000	INITIAL COMMENTS iQIES EVENT ID: 1E4252-H1 COMPLAINT INVESTIGATION COMPLAINT NUMBER 2730416 ADMINISTRATOR: George Dubic, #6179-2 CERTIFIED BED CAPACITY: 133 CENSUS IN HOUSE: 115 The following deficiency is based on the complaint investigation completed on 02/25/26.	F 0000		
F 0689 SS=G	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This STANDARD is not met as evidenced by: THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST	F 0689	Past noncompliance: no plan of correction required.	

laboratory director's or provider/supplier representative's signature | title | (x6) date

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F 0689	Continued From page 1 NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, medical record review, review of a facility investigation, hospital records, facility policy, manufacturer's instructions, and interview, the facility failed to identify and implement comprehensive, individualized and adequate fall interventions to prevent a fall with injury during resident care. This affected one resident (#77) of three residents reviewed for accidents/incidents who required use of a shower gurney. The facility identified 32 residents (#3, #5, #11, #12, #21, #25, #27, #28, #29, #30, #33, #37, #41, #42, #43, #58, #59, #61, #62, #67, #77, #79, #81, #87, #89, #93, #94, #101, #103, #104, #112 and #114) who required a shower gurney for bathing. The facility census was 115. Actual Harm occurred on 01/11/26 at 3:00 P.M. when Resident #77, who was dependent on staff for showers and transfers and required substantial to maximum assistance with rolling left and right, fell from a shower gurney (a shower bed on wheels) onto the floor after Agency Certified Nursing Assistant (ACNA) #719 (only staff present in the shower room) rolled the resident away from her on the shower gurney to remove an incontinence brief and mechanical lift sling (a device used to transfer residents by use of a sling from surface to surface). As a result of the fall, Resident #77 experienced pain,	F 0689		

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F 0689	Continued From page 2 an abrasion/hematoma (swelling of clotted blood within the tissues) to the right eyebrow, skin tears and/or abrasions to the top left hand, the left great toe, the right second, third, fourth and fifth toes, the right shoulder, and discoloration of the right hand and leg. Subsequently, Resident #77 was transferred and admitted to the hospital with septic shock (a life-threatening condition caused by dangerously low blood pressure and organ failure) and bilateral subdural hematomas (bleeding in the brain). The resident was hospitalized from 01/11/26 to 01/20/26 (nine days). Findings include: Review of the medical record for Resident #77 revealed an admission date of 07/25/25. Resident #77 had diagnoses including traumatic subdural hemorrhage (bleeding in the brain) without loss of consciousness (dated 01/12/26), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic obstructive pulmonary disease (COPD), and heart failure. Review of quarterly Minimum Data Set (MDS) dated 10/31/25 revealed Resident #77 had moderate cognitive impairment and impairment to his bilateral upper and lower extremities. The resident was dependent on staff for toileting, hygiene, showers, transfers and dressing, and	F 0689		

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F 0689	Continued From page 3 required substantial to maximum (staff) assistance with rolling left and right. Review of quarterly Fall Risk Assessment dated 11/03/25 completed by Unit Manager Licensed Practical Nurse (LPN) #680 revealed Resident #77 was not at risk for falls. The assessment revealed the resident was forgetful and dependent on toileting needs including checks and changes and had no history of falls. Review of nursing note dated 01/11/26 at 7:20 P.M. completed by LPN #692 revealed the shower room call light was going off when the aide alerted LPN #692 that Resident #77 fell. LPN #692 entered the shower room and saw the resident on the floor lying on his right side with his right arm tucked beneath him, and head facing towards the sink. A pillow was placed under the resident's head for comfort and vital signs were obtained. Resident #77 complained of pain in his left leg and due to the pain he was not moved. LPN #692 was unable to assess the resident's pupils due to his grimacing in pain; the resident did not lose consciousness. The shower gurney was noted to have all the rails up, but one wheel was off the gurney. The aide reported the wheel had come off which caused Resident #77 to roll off the gurney and fall. Emergency Medical Services (EMS) transported the resident to the hospital by rolling him onto a sheet then assisted him onto a gurney. Resident #77 had an abrasion/hematoma to the right	F 0689		

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F 0689	Continued From page 4 eyebrow, a skin tear to the top left hand, skin tears to the left great toe and right second, third, fourth and fifth toes, a large skin tear to the right shoulder with abrasion, and discoloration of the right hand and leg. Resident #77's granddaughter was notified of the fall and being sent to the hospital. Primary Care Physician (PCP)/Medical Director (MD) #723 was also notified. Review of a nursing follow-up form dated 01/11/26 completed by LPN #692 in addition to the above nursing note revealed the incident occurred on 01/11/26 at 3:00 P.M. Resident #77 stated, "I hit my face." He had pain in the left lower extremity at an unidentified pain level. Intervention to prevent re-occurrence was to have maintenance check all shower gurneys for safety. The nursing follow-up form included a witness statement dated 01/11/26 by Registered Nurse (RN) Supervisor #603 who reported being alerted to come to the B-wing shower room and upon entrance observed Resident #77 lying on his right side with the shower gurney next to the resident. The wheel was off a leg of the shower gurney, and the side rails were in the up position. Agency CNA #719 reported she had removed the mechanical lift sling and brief that was under Resident #77, and when she went to discard the brief, the shower gurney wheel fell off, tipping the shower gurney to its side and Resident #77 rolled off the shower gurney onto the floor. Resident	F 0689		

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F 0689	Continued From page 5 #77 complained of pain and had a small hematoma and abrasion to the right eyebrow. He also had visible skin tears and abrasions including a large skin tear to his right forearm, abrasion to the right shoulder, and small skin tears to the right toes. Resident #77 was transported to the hospital by EMS and maintenance was to check all shower gurneys. Review of witness statement dated 01/11/26 completed by Agency CNA #719 revealed Resident #77 was in his bed and it was his shower day (01/11/26). The nurse (LPN #692) and she transferred Resident #77 to the shower gurney and then she took him to the shower room with the side rails up. She locked all the wheels so that she could remove his brief and sling from underneath him. She turned around to discard the brief in the trash can and put the sling down, and when she turned back around to start his shower, she saw Resident #77 falling off the shower gurney due to the wheel coming off the shower bed. She notified the nurse immediately. Review of witness statement dated 01/11/26 completed by Agency CNA #720 revealed she walked into the shower room and witnessed Resident #77 lying on his right side on the floor and the nurse was checking his vitals. The shower gurney was missing a wheel as it was off the bottom of gurney lying next to it on the floor.	F 0689		

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F 0689	Continued From page 6 Review of nursing note dated 01/11/26 at 8:04 P.M. completed by LPN #684 revealed she contacted the hospital who reported Resident #77 was being transferred to the hospital main campus because he had a “brain bleed”. Review of the hospital Intensive Care Unit (ICU) History and Physical dated 01/12/26 completed by Critical Care Medicine Physician #726 revealed Resident #77 arrived at the local hospital after sustaining a mechanical fall off the wash table at the facility. Per EMS one of the wheels fell off and thus the resident fell. The Emergency Department (ED) completed a Computed Tomography (CT) scan that showed subacute/chronic subdural collection along the right cerebral convexity (outer surface of the brain) measuring seven millimeters (mm) and along the left cerebral convexity measuring six mm. He was treated to reverse his previous anticoagulant (blood thinning medication) regimen and was transported to the main campus ICU for further management including a neurosurgery evaluation. While awaiting transport Resident #77 became hypotensive (low blood pressure), so a central venous catheter (CVC) (a long flexible tube inserted into a large vein typically near the heart to provide access to medications and fluids) was placed, and he was started on medication to increase his blood pressure. The resident was a high probability of sudden clinically significant deterioration and required the	F 0689		

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F 0689	Continued From page 7 highest level of physician services due to a mechanical fall, septic shock, and bilateral subdural hematomas. Review of Critical Care Progress Note dated 01/12/26 completed by Neurology Nurse Practitioner (NNP) #725 revealed Resident #77 was transported from the local hospital to the main campus due to need for neurological and trauma services and the reason for consultation was hypotension (low blood pressure). His CT showed a right cerebral convexity subdural hemorrhage. His mean arterial pressure (MAP) (average pressure in a patient's arteries) was low at 60 millimeters of mercury (mmHg) (normal levels were 70 to 110 mmHg). NNP #725 gave orders for phenylephrine (medication to treat low blood pressure) infusion to assist in increasing his MAP. Review of Neurosurgery Initial Consult progress note dated 01/12/26 completed by NNP #727 revealed he was on the wash table when the wheel fell off and Resident #77 fell off the table hitting his head. CT of the brain demonstrated subacute and chronic subdural collection to the right and left cerebral areas. Resident #77 reported a right frontal headache. Review of witness statement completed on 01/13/26 at approximately 3:00 P.M. by the Administrator revealed in person the Administrator and Director of Nursing (DON) met with Resident #77's	F 0689		

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F 0689	Continued From page 8	F 0689		

granddaughter. They showed Resident #77's granddaughter the shower room, pictures of the old gurney, and the investigation conducted. They demonstrated on a different gurney the re-enactments they had conducted and explained that the structural integrity of the gurney was intact and that Agency CNA #719's account of the incident did not make sense. Resident #77's granddaughter reported Resident #77 stated to her in the hospital, "She pushed me too hard and I went over the edge."

Review of an After Visit Summary dated 01/20/26 revealed Resident #77 was discharged from the hospital back to the facility after a lengthy hospital stay from 01/11/26 to 01/20/26 due to subdural hematoma as well as treatment for pneumonia.

Review of Admit/Re-admit Screener dated 01/20/26 and completed by Unit Manager LPN #680 revealed Resident #77 was readmitted back to the facility due to post fall. The resident was dependent on staff for most of his activities of daily living including bed mobility. He had slight edema to his left upper extremity/hand, scattered bruising to his left hand and forearm, bruising to his right shoulder with scabbed abrasion measuring six centimeters (cm) in length by 2.5 cm in width, and bruising to the right elbow, forearm and hand. He had two open skin tears to his right upper forearm and two scabbed skin tears to his right elbow. The

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F 0689	Continued From page 9 resident had bruising to his right side, right hip, and bilateral knees. Also, he had bruising to the right side of his face, cheek, and above the eye with a small abrasion to his right eyebrow measuring 0.6 cm in length by 0.2 cm in width. The resident complained of pain as he stated it was a four on a pain scale (zero to ten), but no other information was noted regarding his pain. Review of nursing follow-up form under section of Summary of Investigation/Conclusion dated 01/21/26 completed by the DON revealed the incident was thoroughly reviewed by administration. A re-enactment was conducted on 01/12/26, statements were obtained from all staff involved and a risk management meeting was held to evaluate all possible explanations for how the fall occurred. Based on the findings of the internal investigation, it was determined that the shower gurney was not likely the contributing factor. The investigation revealed the incident was unintentional and the fall most likely resulted from “Human Error” leading to Resident #77’s fall from the gurney to the floor. Interventions included the shower gurney used in the incident was discarded, all shower gurneys were assessed by maintenance, new shower gurneys were ordered, and the staffing agency was notified. Review of quarterly Minimum Data Set (MDS) assessment dated 01/27/26	F 0689		

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F 0689	Continued From page 10	F 0689		

revealed Resident #77 had intact cognition and had impairment to his bilateral upper and lower extremities. He was dependent on staff for rolling left and right, toileting hygiene, showers, transfers and dressing.

Review of an email dated 01/28/26 at 5:38 A.M. from DON to Agency Trust and Safety Department Representative #724 revealed Agency CNA #719 was getting resident (Resident #77) ready for a gurney shower and was in the shower room. Agency CNA #719 was rolling Resident #77 to remove his brief and the mechanical lift sling when he rolled off the gurney. Agency CNA #719 reported one of the gurney's wheels came off; however, when the incident was re-enacted in several different ways/scenarios the wheel did not come off. The only way the wheel came off was when the shower gurney was lifted off the ground. Agency CNA #719's statement made it sound like it was a device error, but it was determined that the gurney was not likely the contributing factor. The email stated while unintentional, the fall most likely resulted from "Human Error" leading to the resident's fall from the gurney to the shower room floor. Resident #77 was sent to the hospital and admitted with two brain bleeds.

Interview on 02/20/26 at 6:57 A.M. with DON and Assisted Director of Nursing (ADON)/Registered Nurse (RN) #601 revealed LPN #692 and Agency CNA

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F 0689	Continued From page 11 #719 had used the mechanical lift to transfer Resident #77 to the shower gurney from either his chair or bed. Agency CNA #719 then transported Resident #77 on the shower gurney to the shower room to provide a shower without any issues. The wheels on the gurney were functioning. Agency CNA #719 stated she had rolled Resident #77 over side to his side to remove the incontinence brief and mechanical lift sling and undress him with the bilateral side rails up on the shower gurney. When she completed preparing him for his shower, he was lying on his back in the center of the gurney with bilateral side rails still in the up position. As she turned around to dispose of his incontinence brief and set down the mechanical lift sling, the lower left wheel on the shower gurney came off and Resident #77 rolled off the shower gurney onto the floor. They investigated the incident including demonstrated simulations and felt Agency CNA #719's account was not accurate as they were not able to get the wheel to come off with an approximate body weight of Resident #77's weight lying on the gurney without lifting the gurney up itself to have the wheel come off. The DON stated she laid on the shower gurney as they moved the shower gurney in all directions in a firm, rough manner and still was unable to get the wheel to come off. They concluded through investigation that the incident most likely was caused by "Human Error" and felt when Agency CNA #719 was undressing the resident	F 0689		

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F 0689	Continued From page 12 and removing his incontinence brief and the mechanical lift sling, she had rolled him over too far causing him to fall off the gurney onto the floor. They also concluded it as the cause as Resident #77 had stated to his granddaughter when he was in the hospital that Agency CNA #77 had rolled him off the shower gurney. They verified Resident #77 was sent immediately to the hospital by EMS as a result and diagnosed with bilateral brain bleed. Observation on 02/20/26 at 7:29 A.M. of Resident #77 revealed he had bruising surrounding his right eye with swelling. Interview at the time of the observation with Resident #77 revealed after being asked about how the incident happened stated, “She rolled me.” The resident was unable to provide any additional facts. When asked if he knew if the wheel fell of the shower gurney, he opened his eyes wide and stated in an increased tone, “No the wheel did not fall off, rolled me off.” Interview on 02/20/26 at 7:38 A.M. and 12:08 P.M. with LPN #692 revealed she was the nurse on duty when Resident #77 fell off the shower gurney. She stated she had previously assisted Agency CNA #719 transfer Resident #77 using the mechanical lift from his bed or chair (could not remember which) to the shower gurney in his room. She stated both bilateral side rails on the shower gurney were up and Agency CNA #719 transported the shower gurney with	F 0689		

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F 0689	Continued From page 13 Resident #77 lying on the gurney down the hallway into the shower room. There were no issues with how the shower gurney functioned including the wheels. She was coming out of the supply room near the shower room when Agency CNA #719 in the doorway of the shower room stated Resident #77 was on the floor. She proceeded to demonstrate in the shower room where he was positioned compared to the position of the shower gurney during the incident. She revealed when she walked into the shower room she noticed the shower gurney in the center of the room upright with bilateral side rails up and the left bottom wheel on the shower gurney was off causing the shower gurney to be slanted to the left in a downward position. The side rail on the left-hand side (the side Resident #77 fell off) was stationary and always in an upright position. When entering the shower room, Resident #77 was lying on the floor on his right side next to the shower gurney facing the shower. The resident was lying in the same position on the floor as the shower gurney was positioned including his head was where the head would be on the shower gurney and feet where the feet would be. He had a hematoma to the left side of his head, bleeding from a skin tear to his arm and was complaining of pain. EMS was immediately notified. She obtained vitals and they did not move him because of the pain he was in. EMS arrived and transported him to the hospital. The LPN revealed Agency CNA #719's account of	F 0689		

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F 0689	Continued From page 14 the incident sounded off (not quite right) in regard to how the wheel came off because the wheel slid into the Polyvinyl Chloride (PVC) pipe which in her opinion was not possible especially with a person's body weight on top of the gurney unless the wheel broke off or the gurney was picked up to cause the wheel to come off. She verified the wheel was not broken as there was still approximately two inches of PVC attached to be able to slide it into the PVC frame of the shower gurney. She also stated that if the wheel at the bottom left of the shower gurney had come off then she believed Resident #77 would have slid out towards the bottom of the bed and be found positioned at the bottom left corner of the shower gurney. LPN #692 revealed when she found the resident it appeared he had gone over the side rail of the gurney landing on the floor horizontally next to the shower gurney. She specified that at the time of the incident, Resident #77 had stated Agency CNA #719 had rolled him off the shower gurney. She revealed in her opinion she felt Agency CNA #719 had rolled him too far off the shower gurney causing him to fall off the gurney. Interview on 02/20/26 at 8:15 A.M. to 9:30 A.M. with Maintenance Director (MD) #676 and Maintenance Assistant (MA) #675 revealed once a month as preventative maintenance they inspected all shower gurneys and chairs including any breaks in the PVC piping, lubricated the wheels as needed and documented it	F 0689		

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F 0689	Continued From page 15 accordingly including any abnormal findings. They had not noticed any concerns regarding the shower gurney Resident #77 used. They stated at the time of the incident the set screw was missing from the bottom left wheel, but they were unsure if it was out prior to the incident or if it came out during the incident. Even without a set screw there was approximately an inch and three fourths section of PVC piping that went inside the PVC piping of the frame. Unless the wheel would break off from the PVC piping, they did not see how the wheel would fall off unless someone lifted the gurney up to slide the wheel out of the PVC piping especially with body weight on the bed. They re-enacted the incident trying to determine if the “story was plausible” by staff laying on the bed, moving the gurney all around in the shower room, and they could not get the wheel to come off even without a set screw. They did the re-enactment in a rough manner, even moving the bed forcefully and still could not get the wheel to come off. They then took the bed outside in the driveway and ran it up and down a hill and over potholes and still could not get the wheel to pop off. Observation at the time of the interview of the shower gurney in the facility garage revealed three wheels were intact and secured and the left bottom wheel was able to be pulled out as it did not have a set screw. Approximately the one inch and three fourths piping remained intact and was able to slide inside the PVC	F 0689		

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F 0689	Continued From page 16 gurney bed frame. They demonstrated in a forceful manner by moving the gurney in all directions and over uneven surfaces that the wheel did not come off. The left side of the shower gurney (the side Resident #77 was reported to have gone over) had a stationary side rail that always remained up. They measured the top of the stationary rail to the top of the shower gurney bed to be six inches. They demonstrated that the only way the wheel came off was when they lifted the gurney up approximately three inches off the ground. When the wheel was off the shower gurney, it was slanted in a downward position towards the bottom left and they confirmed Resident #77 would have slid off towards the bottom left side of the gurney, not found with his head up towards the head portion of the gurney. They stated if the wheel came off he most likely would have slid down towards the direction the wheel came off, not up and over a six-inch stationary side rail. Interview on 02/20/26 at 10:27 A.M. with Resident #77's granddaughter confirmed in the hospital Resident #77 stated the facility staff had rolled the resident too hard and too far, right off the gurney. She revealed Resident #77 had a double brain bleed, was in significant pain, and had to be transported to the main campus ICU due to his unstable condition. The first night his blood pressure had "tanked", and they were unable to stabilize it even with vasopressors (critical care medications used to increase blood	F 0689		

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pressure and improve perfusion in patients with severe hypotension or shock). They thought he was going to die. The family had a meeting with the facility who admitted it was “user error” as an aide had rolled him too far and he fell off the shower gurney. She felt it was what happened especially since Resident #77 had stated that to her while in the hospital, and not because of the wheel coming off the gurney.

Interview on 02/20/26 at 10:35 A.M. with Agency CNA #719 revealed on 01/11/26 she and LPN #692 had transferred Resident #77 out of his bed with a mechanical lift to the shower gurney. She had locked all the wheels on the shower gurney prior to transfer, and she did not notice anything wrong with the wheels to the shower gurney. She pushed the shower gurney from his room to the shower room with him lying on top of the gurney without any issue. She felt the wheels had functioned appropriately. When she was in the shower room, she was the only one there and kept both side rails up and locked all wheels as she prepared him for his shower. She did not notice anything wrong with the wheels when she re-locked them. The side rail on the left side was stationary and unable to come down. She proceeded to tuck the mechanical lift sling and incontinence brief under him on the side she was on and then rolled him “away” from her towards the stationary side rail. She verified she had rolled him “away” from

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F 0689	Continued From page 18 her as she stated, “yes rolled him away from me see you do not understand that is how you have to roll someone to get the stuff out from underneath them”. She stated he was in the center of the gurney the whole time including while rolling him. While he was lying in the center, she turned around to put the incontinence brief in the garbage, set the mechanical lift sling down and as she was turned around, suddenly he fell off the gurney because the wheel fell off the end of the shower gurney. She stated that he then fell over the stationary side rail on the gurney onto the floor as she felt the side rail on that gurney was “too short”. She immediately got the nurse and stated that she never moved the gurney from the position that it was in when he fell. Review of the undated “Operation Instructions” for the shower gurney model used in the incident involving Resident #77 and Agency CNA #719 revealed the shower beds were equipped with four locking casters to be used during transfers and for when wanting to remain stationary. When a mechanical lift to transfer a resident in and out of the shower gurney was used, the manufacturer recommended keeping the side rails up and always locked. The instructions under “precautions” stated to never leave an at-risk user unattended on the bed, and that exaggerated user movement in any direction or rolling to the edge may cause the gurney to tip. The instructions stated, “Do not roll user away	F 0689		

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F 0689	Continued From page 19 from you unless there is a partner caregiver on the other side." The operation instructions indicated to check the pipe and fittings for hairline fractures monthly, check all junctures to make sure the pipe and fittings do not pull apart, and clean and lubricate casters monthly. Interview on 02/20/26 at 11:46 A.M. with the DON verified per the "Operation Instructions" for the shower gurney model used in incident involving Resident #77 and Agency CNA #719, the instructions stated, "Do not roll user away from you unless there is a partner caregiver on the other side." She verified per the investigation, Agency CNA #719 reported she had rolled Resident #77 away from her when taking out the incontinence brief and mechanical lift sling and that she was the only staff member in the shower room. The DON confirmed staff were to not to roll residents on a shower gurney away from them during care unless they had another staff member on the other side. Interview on 02/23/26 at 1:58 P.M. with PCP/MD #723 revealed he was aware of the incident but was unable to know for a fact if it was caused by the wheel coming off the gurney or by the aide rolling the resident too far off the bed. He stated Resident #77 was very rigid requiring dependence of staff for all his care. It depended on the day if Resident #77 was cognitively intact or not as sometimes he was coherent and sometimes he was not. He was unable to provide any other	F 0689		

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F 0689	Continued From page 20 details regarding the incident. Review of facility policy titled, “Accidents and Incidents,” last revised 05/22/24, revealed all accidents or incidents involving residents were investigated and reported to the administrator. The facility was to be in compliance with current rules and regulations governing accidents and/or incidents. Review of facility undated policy titled, “Shower/Tub Bath,” revealed the purpose of the procedure was to promote cleanliness, provide comfort and observe the condition of the residents’ skin. The policy indicated to handle residents as gently as possible and not to rush the procedure. The procedure specified to never leave the resident unattended in the tub or shower and use the emergency call signal to summon assistance. There was nothing in the policy regarding ensuring staff did not roll residents away from them on a gurney unless there was another caregiver on the other side. The deficient practice was corrected on 01/27/26 when the facility implemented the following corrective actions: On 01/11/26, the Administrator and DON halted all gurney showers until MD #676 inspected and evaluated the equipment. There were no abnormal findings. On 01/11/26, the DON notified the staffing agency and requested the agency place	F 0689		

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F 0689	Continued From page 21 Agency CNA #719 on the do not return (DNR) to the facility list. On 01/12/26, MD #676 implemented and conducted an audit of shower equipment that lubricated the wheels if needed, inspected the PVC tubing for hairline cracks and damage, checked all junctures to make sure pipe and fittings did not pull apart and checked tightness of fasteners. This audit was conducted by MD #676 daily for seven days, weekly for five weeks and then returned to the previous shower beds/chairs monthly maintenance and safety checklist. On 01/12/26, the Administrator, DON, ADON/RN #601, and MD #676 completed a re-enactment of the incident for an investigation of the root cause of the incident. On 01/12/26, a risk management meeting was held with Administrator, DON, ADON/RN #601, MD #676, Unit Manager/RN #602, Unit Manager/LPN #680, LPN #681, and MDS/RN #600 to discuss the incident, root cause, and interventions. On 01/12/26, the Administrator and DON met with Resident #77's granddaughter to review the investigation/re-enactment. On 01/13/26, MD #676 ordered new shower gurneys. On 01/15/26, the DON reviewed the	F 0689		

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F 0689	Continued From page 22 facility investigation with PCP/MD #723. On 01/15/26, the Administrator updated Resident #77's daughter on the investigation. On 01/16/26, the Administrator and DON reviewed the facility policies including "Accidents and Incidents" last revised 05/22/24, and "Shower/Tub Bath" undated. On 01/20/26, the Administrator updated Resident #77's daughter to discuss Resident #77's return to the facility and interventions to be implemented. On 01/21/26, a Physical Therapy (PT) evaluation was completed by PT #729 and Occupational Therapy (OT) evaluation was completed by OT #728 for Resident #77. On 01/21/26, Unit Manager/LPN #680 changed Resident #77 to be a two-person gurney shower on weekdays. On 01/21/26, a risk management meeting was held with Administrator, DON, ADON/RN #601, MD #676, Unit Manager/RN #602, Unit Manager/LPN #680, LPN #681, and MDS/RN #600 to discuss the incident, interventions, changing gurney showers to weekdays with some exclusions, and discussed an upcoming staff in-service meeting scheduled 01/27/26.	F 0689		

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F 0689	Continued From page 23 On 01/21/26, the Unit Manager/RN #602, Unit Manager/LPN #680 and LPN #681 updated the facility shower schedule to change all gurney showers with some exclusions to weekdays. On 01/26/26, ADON #601 updated the interview data sheets/incident/accident reports to provide more details to assist in finding the root cause of an incident. On 01/27/26 and on 01/29/26, an in-service with all nurses and CNAs was conducted by DON and ADON/RN #601 to review fall policy, bathing policy, safety including not rolling a resident away from staff only towards staff unless another staff member was on the other side, have a second staff member assist with gurney showers when needed, updated interview data sheets/incident/accident reports, change in shower schedules, and reporting any maintenance issues including on gurneys. On 01/29/26, MD #676 ordered new shower chairs. On 02/13/26, Interdisciplinary Team Meeting was held with Resident #77's daughter and granddaughter to discuss overall care. On 02/17/26, a risk management meeting was held with Administrator, DON, ADON #601, MD #676, Unit Manager/RN #602, Unit Manager/LPN #680, LPN #681, and MDS/RN #600 to discuss any feedback	F 0689		

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F 0689	Continued From page 24 from in-service and review of all current interventions. On 02/20/26, the Administrator updated PCP/MD #723. This deficiency represents non-compliance investigated under Complaint Number 2730416.	F 0689		