Department of Inspections, Appeals, and Licensing
Health & Safety Division
Citation

Citation Number #11174			**Report Date** June 30, 2026
Facility Name Elm Crest Retirement Comm.		**Survey Dates** June 3, 2026 to June 10, 2026	
Facility Address 2104 12th Street			
City Harlan, Iowa 51537	**LG**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.28(3)e	**481—58.28 (135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) 58.28(3) Resident safety. e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) **DESCRIPTION** Based on clinical record review, facility investigation file review, resident and staff interviews, and policy review the facility staff failed to follow the facility's fall policy and protocol to notify the charge nurse in order to complete an assessment in a timely manner and begin interventions after a resident had a fall for one of three residents reviewed for injuries of unknown origin and nursing supervision (Resident #1). The facility reported a census of 41 residents. Findings include: A facility self-report to the Department of Inspections, Appeals and Licensing (DIAL) submitted on 2/5/26 at 8:52 AM revealed an allegation of abuse between staff to a resident occurred on approximately 2/3/26. The incident summary revealed on 2/4/26, a CNA reported the resident had bruises to her right forehead, right eye and right hip. The resident stated she rolled out of bed. The resident complained of nausea and vomiting and was sent to the Emergency Department (ED) for	**I**	**$5500.00** **Held in Suspension**	**Upon Receipt**

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	evaluation. The facility began an investigation when the resident transferred to the hospital. The Admission Minimum Data Set (MDS) assessment dated 11/4/25 revealed Resident #1 had diagnoses of nontraumatic intracranial hemorrhage (bleeding into the brain tissue not caused by trauma), cerebrovascular accident (CVA) (stroke), hemiplegia (paralysis on one side of the body), aphasia (inability to speak, write or read) and muscle weakness. The MDS indicated the resident had impaired short-term and long-term memory, and severely impaired decision-making skills. The MDS recorded the resident had no falls and no behaviors. The resident had impaired range of motion to her upper extremity on one side and bilateral lower extremities, and had dependence on staff for bed mobility, transfers and toileting. The Care Plan created on 10/31/25 and revised on 2/8/26 revealed Resident #1 had a stroke and had a risk for falls related to right sided paralysis. The resident required assistance with transfers and toileting. The Care Plan directed to use two staff for assistance with transfers and toileting, implement fall prevention/reduction precautions per the facility protocol, and ensure the call light was within reach. The following interventions were added related to a concern for a fall that had occurred: • 2/4/26 - scoop mattress (added to the care plan on 2/8/26). • 2/6/26 - do not leave resident alone on the commode and reinforce the need to call for assistance (added to the care plan 2/8/26).			

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	• 3/18/26- store the commode in the bathroom when not in use. • 5/21/26 -bed at lowest position and place a fall mat at the bedside whenever the resident was in bed. (added to the care plan on 5/22/26) A Fall Risk Assessment dated 10/31/25 and 2/4/26 revealed the resident had a risk for falls. The Progress Notes for Resident #1 revealed the following: a. On 1/23/26 at 7:31 AM, resident required assistance of two with a gait belt for transfers and toileting or a bedside commode. b. On 1/24/26 at 8:20 PM, a Skin Check revealed skin warm and dry, and skin color WNL (within normal limits). c. On 1/31/26 at 8:21 PM, a Skin Check revealed the resident had a bruise to the right front axilla and an abrasion to her left lateral foot. d. On 2/3/26 at 3:03 PM, resident moved to 209A. e. On 2/4/26 at 10:56 AM, Staff A, Registered Nurse (RN), notified by certified nursing assistant (CNA), that the resident had bruising. A bruise found on the right forehead measured 2 centimeter (cm) x 3 cm, under the right eye 1 cm x 2 cm, and right upper hip/thigh 9.5 cm x 10 cm. The resident left the facility to go to the ED. At 3:30 PM, resident returned to the facility. At 4:13 PM, order for Ceftin (an antibiotic) for a UTI (urinary tract infection). After the resident returned to			

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	the facility she had an emesis (vomiting). Order obtained for Zofran (antiemetic used to prevent and treat nausea and vomiting) every 6 hours. f. On 2/5/26 at 4:53 AM, Staff B, Licensed Practical Nurse (LPN), documented the resident had an unwitnessed fall and received bruises to the right side of her body. She had a bump on the left side of her face above the eye and a big bump on the left upper outer thigh. Neuro (checks) at baseline. The resident denied pain. g. On 2/5/26 at 12:44 PM, the IDT (Interdisciplinary Team) met to review the bruising of unknown origin. The resident was assessed by the DON (Director of Nursing) on 2/4/26 at approximately 10:30 AM to verify the location and extent of bruising. The family and provider were notified promptly after the assessment completed. Resident transferred to the ED for an evaluation. An investigation was initiated by the DON and the Administrator. Incident reports reviewed from 1/1/26 to 6/8/26 revealed Resident #1 had a fall incident on 3/18/26 at 2:23 AM and 5/21/26 at 11:34 PM, and an injury of unknown origin on 2/4/26 at 11:00 AM. The injury of unknown origin incident report completed by the DON revealed a CNA reported the resident had bruising to the forehead, right eye and right hip. The nurse notified the DON. Resident reported she rolled out of bed. Resident was sent to the ED for evaluation. A Fax Notice to the Physician's Assistant, on 2/4/26 revealed the resident had an unwitnessed fall. The injuries included the following: Right hip = Length (L) 10 cm x Width (W) 9.5 cm			

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	Right eye = L 2 cm x W 1 cm Left forehead = L 3 cm x W 2 cm An After Visit Summary dated 2/4/26 revealed Resident #1 was seen in the ED for bruising and diagnosed with contusions to her forehead and right hip, a minor head injury, and a UTI. Bruising consistent with some type of a fall but resident had no fracture. Suspect a mild concussion due to vomiting once but otherwise neuro status at baseline. The After Visit Summary indicated that Fall prevention at the nursing home is a must. An x-ray of the right hip and pelvis dated 2/4/26, revealed resident had pain and bruising to her right hip. The resident had a prior stroke and could not communicate what happened. X-ray results revealed no fracture. The facility Census report dated 2/2/26 revealed Resident #1 resided in a private room, and had no roommate at that time. A Notification of Room Change revealed Resident #1 had a room change on 2/3/26 at 12:00 PM and moved from Room 225A to 209A. The Facility Investigation Summary revealed on 2/4/26 at approximately 10:30 AM, Staff E, CNA, reported she saw bruising on Resident #1's right forehead, right eye and right hip while giving Resident #1 a bath. Resident #1 was assessed by Staff A, RN, and the DON. Resident #1 had complained of nausea and had an emesis prior to the assessment. Resident #1 was able to answer yes and no questions and provide short answers. Resident #1 said "No" when asked if she			

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	fell. Resident #1 replied "yes" when asked if she rolled out of bed. Resident #1 was then asked how she got back into bed and she replied, "they picked me up". Resident #1 was sent to the hospital ED for further evaluation. An investigation was initiated by the DON and the facility administrator. Resident #1 returned to the facility with a diagnosis of UTI and suspected mild concussion related to vomiting once, though no testing or imaging was performed to confirm this diagnosis. A scoop mattress was put in place as an intervention. The staff who worked 2/2/26 - 2/4/26 provided written statements. During the interview process it was revealed that on 2/2/26 at approximately 9:00 PM, Staff C, agency CNA, and Staff D, CNA, assisted Resident #1 to the commode. Staff C left the room and Staff D stayed with the resident until she was finished, then Staff D left the room to find a second person for the transfer. When Staff D and Staff C returned to Resident #1's room, she was on the floor between the commode and the bed. Staff C reported he "asked if she was in pain and looked her over for bruising and didn't see any". During the interview with Staff C, he stated that "I should have reported it but she looked ok". Staff D reported that she and Staff C went into Resident #1's room and found Resident #1 on the floor. Staff D asked Staff C what room number they were in so she could walkie for help. Staff C instructed Staff D not to report the incident. Staff D reported she was scared and did not know what to do as she was a new CNA and had not been involved in a fall before. Through the facility's investigation it was revealed that on 2/2/26 that Staff C and Staff D did not follow the facility's Fall Policy and Procedures and failed to report the incident. Per policy, the resident should have been assessed by a nurse prior to being moved. The policy then required a mechanical lift used to assist a resident off the floor.			

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	Resident #1's care plan was updated to include not leaving her alone on the commode as an intervention for the fall. The Facility Investigation File included the following written Staff Statements: Staff Q, Certified Medication Aide (CMA) and Restorative Aide (RA), wrote: On 2/2/26 about 8:00 AM, a CNA came to me saying Resident #1 was in pain. APAP (Tylenol) was given at that time. I helped the CNA set Resident #1 up, pulled up her pants and placed her in the wheelchair. I did not notice anything out of the ordinary. Staff F, CNA, wrote: On 2/3/26, I was not assigned to the West hall and did not have any contact with Resident #1. Staff G, agency CNA, wrote: I worked on 2/3/26 from 10 PM to 6 AM and was assigned to the North/West hall. Staff G had no knowledge of Resident #1 having a fall and did not hear anyone call for help. Staff H, CNA, wrote: I was the CNA for Resident #1 last night. Resident #1 was perfectly fine when Staff H put Resident #1 to bed around 8:00 PM. Resident #1 had no bruises on her body, and she was very aware and normal. Her bed was lowered and she was positioned in the middle (of the bed). Staff H peeked in on Resident #1 before leaving her shift and did not notice Resident #1 on the floor. Staff B, agency LPN, wrote: On 2/3/26, I worked the overnight shift from 10 PM to 6 AM. After I got report and checked all of the residents. Nothing seemed out of normality. I did rounds on the South side and			

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	checked on Resident #1. I did not see any bruises on the right side. It was hard to get a complete look as her right side is next to the roommate's bed and the curtain was in the way. The left side had no bruises. It seemed unlikely that she would fall on her right side as the beds are too close together and her roommate is alert. I did not hear or see anything on my shift that would lead me to believe anyone had any knowledge of a fall. I do apologize for overlooking the injury. I looked at it on 2/5/26. Bruises are on the right side of her face and body. The hip and above the left eye looked swollen or had a hematoma. Staff I, CNA, wrote: My only involvement with Resident #1 on 2/3/26 was I helped give report with Staff H to help Staff L understand his assignments. I did not help put Resident #1 to bed. I brought Resident #1 down to supper and saw nothing that seemed like she had fallen. Staff O, CNA, wrote: On 2/3/26, I worked on the South hall (assigned to rooms 212A- 216). Around 3:30 PM, we dropped to 5 staff so I then had rooms 208 - 213B. Resident #1 was in her recliner when I checked on her. I talked to her and told her Staff I and I would be back soon to get her up for supper. We went back in to get her up about 15 minutes later. At that time, Resident #1 went to the dining room for supper. At 6:00 PM, Staff H took over that section of the hall. Staff K, LPN, wrote: I was working on 2/3/26 but did not work with Resident #1. A typed note signed by Staff R, agency CNA, revealed: On 2/3/26, Staff C and I took Resident #1 to the commode at approximately 3:15 PM. We transferred her with a two person stand pivot. I did not see any			

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	bruising to her face or hip. She did not complain about anything. We finished cares and put her back in the recliner. I gave her the call light and walked out of the room. Staff J, CNA, wrote: I got Resident #1 up on 2/4. I noticed Resident #1 had a big bruise on her forehead when I brushed her hair. Staff J reported it immediately to Staff P and to the nurse. Staff L, CNA, wrote on 2/4/26: I worked on the South wing where 209A was last night and assisted her roommate. I did not witness Resident #1 on the floor at any time during the shift. Staff E, agency CNA, wrote: I was assisting residents at breakfast this morning (2/4) and looked over at Resident #1 and asked if she was ok. She said no, and tears came to her eyes and she started to vomit. Staff E noticed Resident #1 had a black eye and bruise on her forehead, and took Resident #1 to her room. Staff E gave Resident #1 a bath and noticed her right hip had a bruise. Staff E called the charge nurse. The charge nurse looked at it. Staff E noted she had worked with Resident #1 on 2/3/26 in the AM and there were no bruises or anything at that time. Staff A, RN, wrote on 2/4/26: I was told by Staff M, LPN, that they just took Resident #1 out of the dining room and she was vomiting. After entering the room, the CNA's pointed out the bruises on her forehead and right eye. It was decided to give Resident #1 a bath because she had diarrhea and vomiting. During the bath, Staff E called me and reported Resident #1 had a hematoma on her right hip and thigh. Staff A showed the DON after Resident #1 was placed in bed. Resident #1 stated "no" when asked if she fell. Resident stated			

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	"yes" when asked if she rolled out of bed. I asked Resident #1 how she got back into bed and she stated they picked me up. Nothing was passed on in shift report about a fall. Staff P, CNA, wrote: I came in at 4:17 AM, and went to 209A room around 4:30 AM and checked her brief. The brief was wet so Staff P changed Resident #1 and rolled her. Staff P thought it was a bit dark and did not see anything on Resident #1's right side. Staff M, LPN, wrote on 2/4/26: A CNA in the dining room asked if we had the blue puke containers. I said no, why, what's going on. The CNA proceeded to say the resident was throwing up. Another CNA rushed to get the resident to her room. The CNA's gave the resident a quick bath and laid the resident down. The CNA's reported bruises to another nurse on duty. Staff M came to the resident's room to get a set of vital signs and saw the DON and another nurse in the room looking at bruises on the resident. Nothing was passed along in report from the night shift. Staff S, CNA, wrote: Resident #1 showed no signs of injury. She was pleasant to staff. She was sound asleep in bed when I was in her room at 8:00 PM or so. Staff T, CNA, wrote on 2/4/26 at 7:30 AM: I helped Staff J with Resident #1. We rolled her to the right to change her in bed. We got her dressed in bed and then put the resident into the wheelchair, then put her finger glove and sling on. I did not notice anything about her. Staff C, agency CNA, note dated 2/6/26 revealed: On Monday 2/2/26 on the evening shift, Staff D and I put Resident #1 on the bedside commode before putting			

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	her to bed. We gave her the call light before leaving the room. While she was on the commode, Staff D dressed her into a gown. Staff C left the room to attend to another resident. Staff D came to get Staff C to transfer Resident #1 off the commode. We found her on the floor. We picked her up and sat her on the bed and asked her if she hurt. She stated no. I checked her over for any bruises on her body and head. I did not see anything at that time. Staff D, CNA, wrote the following statement dated 2/8/26: Staff C and I walked into Resident #1's room and put her on the commode. Staff C sat her down and I just pulled down her pants. I then gave her the call light and made sure she was okay. Staff C and I walked out of the room to give her privacy. We were not even gone five minutes and the call light came on, so we knocked and went in. Staff C was in front of me and saw her laying on the floor first. She was laying on her left side. I pulled out my walkie talkie and asked Staff C what room number it was, and he told me not to say anything because "she had no bruises and appeared to not be hurt". Staff C then picked Resident #1 up and sat her back onto the commode to let her finish. We did not leave the room this time. Staff C then stood her up, Staff D wiped her, and then we sat her down and changed her gown because BM had gotten on it. Staff C laid Resident #1 down in bed. In an interview on 6/4/26 at 9:00 AM, Staff A, RN, confirmed she worked on 2/2/26, 2/3/26 and 2/4/26 on the day shift. Staff A stated a CNA assisted Resident #1 to the stool because Resident #1 had loose stools. The CNA came to tell the nurse that Resident #1 had bruising on her forehead under her hair(line). The CNA's decided to give the resident a bath and found a bruise on the resident's right hip when the staff got her			

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	into the bath. The bruise was a large purple hematoma and had a knot. Staff A reported she did not remember if Resident #1 had any falls prior to this time but no one had reported that Resident #1 had a fall or any other concerns about Resident #1 in shift report. Resident #1 did not have behaviors or situations when she tried to self-transfer. Staff A reported she did not even know if the resident could roll out of bed. Resident #1 required assistance of two staff and a gait belt for transfers. Staff A believed the scoop mattress was implemented after they found the bruises on Resident #1. Staff A stated she had not been aware of any staff not reporting something to her, however the CNA's were very concerned when they came to her when they saw the bruises. In an interview on 6/4/26 at 9:45 AM, Staff L, CNA, reported he was unable to recall Resident #1. He had only worked at the facility for three months. The surveyor read the statement Staff L wrote on 2/4/26. Staff L stated he vaguely recalled the resident or anything. He did not believe there were any bruises on the resident. What he wrote in his statement is true. Staff L reported he got a little orientation when he started working at the facility. He got a paper that showed the residents and what he needed to do for the residents and how they transferred. He asked questions if he was not sure about something. Staff L stated if a resident had a fall, he would let the charge nurse know. (Per staff assignment/ schedule, Staff L was in training with Staff O for the dates 2/2/26 to 2/4/26. In an interview on 6/4/26 at 10:10 AM, Staff B, agency LPN, reported she recalled an incident about bruises on Resident #1. The bruises did not happen on her			

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	shift when she worked though. Resident #1 was sleeping and lying on her side when Staff B checked on the resident that night (2/2/26). At that time, Staff B stated she did not see any bruises but she did not roll the resident over to look at her other side while she was sleeping. She only saw the side that was not covered. Staff B reported she knows Resident #1 did not fall on her shift. There was a male CNA working on the night shift. It was his first night there and he wanted help for everything. The other CNA was getting annoyed with him asking for assistance all of the time. The other CNA that was working was a small girl and could not pick a resident up by herself. Staff B said nothing was reported to her about any concerns or falls that night. Staff B stated she heard that Resident #1 was up for breakfast and that was when the staff noticed the bruises. Staff B reported she had already gone home but she wrote a statement when she came into work the next day. Staff B also reported Resident #1 had a roommate in the room with her. The roommate was alert and oriented. The roommate would have screamed and said something if Resident #1 had a fall. Staff B stated she had not had any staff that did not report things to her. She would have reported if something happened. In an interview on 6/4/26 at 10:30 AM, Staff O, CNA, reported she would immediately get the nurse if she noticed a change in condition or if the resident had a fall. She would also make sure the resident was safe if the resident had a fall. She would get the resident up or do what was needed after the nurse did an evaluation. Staff O confirmed she worked on 2/2/26, and she had worked with Resident #1 prior to this date. Staff O reported she only gave a snack to Resident #1 and talked to her in the hall when she passed by but she did not provide care and had no physical/ hands on			

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	contact with the resident. Staff O reported she had not had a coworker tell her not to report something. Staff O said she would report if she saw or heard something. In an interview on 6/4/26 at 11:01 AM, Staff R, agency CNA, reported she did not recall a resident by the name of Resident #1. She never worked at the facility in 2/2026. In an interview on 6/4/26 at 11:05 AM, Staff Q, Restorative Aide, reported she was unaware of Resident #1 having any falls and she had never seen Resident #1 fall. Staff Q reported she had not observed Resident #1 trying to get up on her own but she had seen Resident #1 try to move her chair when she did not want to attend an activity or something. Staff Q confirmed she had not seen bruises on Resident #1. Staff Q reported she always let the nurse know if a resident had a fall, a bruise or other skin condition. In an interview on 6/4/26 at 11:20 AM, Staff H, CNA, reported Resident #1 needed the assistance of two staff and a gait belt for transfers and had dependence on staff to move her. Staff H stated she would not try to move Resident #1 by herself because it was hard to move her. Resident #1 tells them what she needs and used her call light. Resident #1 had a hard time talking but she could say a full word and Staff H could tell what Resident #1 wanted by the resident's facial expression and when she pointed at things. Staff H reported she had never observed Resident #1 trying to get up on her own. When Resident #1 was awake, she stayed in bed until staff could get her up. Staff H reported she heard that Resident #1 had falls but Staff H had not been present when Resident #1 fell. Staff H confirmed she was working at the facility on 2/3/26 night. Staff H put Resident #1 in bed on the evening of 2/3/26 and			

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Health & Safety Division
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	lowered the bed to the floor. The next day the DON sent her a text and wanted to know what happened. Staff H heard that Resident #1 may have had a fall and then some bruises showed up. Staff H did not see any bruises on Resident #1 when she transferred her on 2/3/26 evening. Staff H asked the resident what happened. The resident told her that someone picked her up and put her in bed. It was a guy. It was a day or two after the bruises were found that the resident told her that. Staff H reported she would call the nurse on the walkie or report to the nurse as soon as she observed a bruise or skin condition. Staff H stated she had not seen any staff be rough with a resident. She would tell the nurse or the DON if she saw something or had a concern. Staff H reported Resident #1 had a fall mat and they lowered the bed all of the way. Lowering the bed had always been an intervention that was in place but the fall mat was added after bruises were found on her. The fall mat was put in place because the facility staff thought the resident had rolled out of bed because Resident #1 said someone picked her up and put her back into bed. In an interview on 6/4/26 at 1:03 PM, Staff E, agency CNA, reported she worked the day shift on 2/2, 2/3 and 2/4/26. On 2/4/26 she looked over at Resident #1 in the dining room and asked Resident #1 if she was ok. Resident #1 vomited. Staff E lifted up Resident #1's hair and called the nurse over. Staff E went to give Resident #1 a bath and noticed a large purplish/blue bruise on her hip. Staff E stated she then called the nurse into the shower room and reported to the nurse what she saw. There were no falls or anything unusual reported during shift change. Prior to this day, Resident #1 was a fall risk and they checked on her more than usual. Staff E stated she did not ever see Resident #1 fall. Resident #1 did not use her call light much. The			

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	interventions that were in place prior to the incident with Resident #1 were: Do not leave the resident alone on the commode and use two staff for assistance. A fall mat placed on the floor was added after the bruises were found because the resident had a questionable fall. Staff E confirmed she had not had any staff tell her not to report things. She always reported to the nurse whenever she had a concern. It was safer to report than not to report anything. She would also report if she saw staff being rough with a resident. In an interview on 6/4/26 at 1:35 PM, Staff D, CNA, reported she had worked at the facility since 1/2026. Resident #1 required assistance of two staff for transfers and used the commode. Staff did most of Resident #1's cares for her because Resident #1 was paralyzed on one side of her body and could not do anything. Resident #1 used her call light on a rare occasion. Resident #1 never tried to get out of bed without assistance. Staff D reported she believed Resident #1 had fallen on the floor besides the one other time when Resident #1 fell off the commode when Staff D was working. The surveyor asked Staff D to talk about the incident when the resident fell off the commode. Staff D stated she was new to the facility. She had only worked at the facility less than two months when the incident happened. She and Staff C, CNA, walked into the room and put Resident #1 on the commode. Staff C said we will give her a few minutes. They gave Resident #1 the call light and left the room. When the call light was on, Staff D and Staff C came back to Resident #1's room and found Resident #1 on the floor. Resident #1 was lying face down and bent over like she was trying to fix something. Staff C looked Resident #1 over and instructed Staff D not to say anything because she had no bruises and she was not bleeding. Staff D stated she did not say anything at			

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	the moment but when the DON asked her a few days later about if she knew anything that happened, then Staff D told the DON about the incident. At that time, the resident had bruises to her forehead and arms. Staff D stated she felt deeply sorry about what happened, and to this day she thinks about it. Staff D reported she had a "cheat sheet" that she looked at to know what was needed for the residents and how they transferred. Resident #1 had always required the assist of two for transfers since Staff D had worked at the facility. A fall mat placed on the floor was added after the incident. Staff D reported on the day Resident #1 fell off the commode, that was the first time Staff D had ever experienced a resident that had had a fall and she did not know what to do at the time. Staff D stated now, if a resident had a fall she would not leave the resident's side, call for someone on the walkie talkie, and let the nurse do an assessment before they got the resident back up. In a follow up interview on 6/4/26 at 2:20 PM, Staff D reported she had six shifts of orientation on the evening shift, and then she got three additional days of training on the hall where Resident #1 resided after Resident #1 had the fall. Staff D oriented with another staff person showing her how to do things, how to care for each resident, how to lift the residents, and different procedures. They went over what to do in a fire. She also took dependent adult abuse training and completed some on-line education on Healthcare Academy. In a follow up interview on 6/8/26 at 5:48 PM, Staff D reported Resident #1 had a fall a few days later (after she fell off the commode) and when the facility started to investigate that fall, the bruises or injury did not match up with that fall. Staff D stated the facility had a			

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	book with policies but the facility management or staff did not go over specific policies with her. They just told her to go to the nurse about things. If a resident had a change in condition or she noticed a skin issue, she would go to the nurse. If a resident had a fall, she would also go and let the nurse know. In an interview on 6/8/26 at 8:10 AM, Staff N, RN, confirmed per the schedule that she worked the night shift on 2/2/26 and 2/3/26. Staff N stated she did not notice any bruises on Resident #1 at that time but she had seen bruises on this resident from time to time a while ago. Staff N reported she had noticed Resident #1's legs a little over the edge of the bed when she went in to see the resident so she would move her over on the bed. Resident #1 wiggles and will work herself out of bed. She had falls in the past and had a mat on the floor by her bed due to a history of a fall. Staff N reported she was unsure exactly when the mat was put in place as an intervention. In an interview on 6/8/26 at 9:30 AM, Staff I, CNA, reported she noticed some bruises just showed up on Resident #1 one day when she worked. She told the nurse about it. She was not aware that the resident had had any falls or injury. Resident #1 used a commode and required the assistance of two and a gait belt for stand pivot transfers. Staff I stated interventions for Resident #1 included placing the bed in a low position. A mat placed by the resident was a new intervention after bruises were found. Staff I stated she had never had anyone tell her not to report something if the resident had a change in condition or a fall/incident. She would report it to the nurse immediately. In an interview on 6/8/26 at 11:05 AM, Staff J, CNA, reported she was the one who found the bruises on			

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	Resident #1 and reported it to the charge nurse because she did not get anything in report about Resident #1 having bruises or anything. The resident had bruises on her scalp, a bruise on her hip, and on her arm. Staff J stated the nurse came and did an assessment and also called the DON. Resident #1 has always required assistance of two staff for transfers with a gait belt and toileting. Resident #1 had never tried to get up on her own, and she used her call light. In an interview on 6/8/26 at 1:25 PM, the DON, confirmed she and the Interim Administrator were involved in the investigation of bruises that were found on Resident #1. The DON believed Staff A, RN, came to her and told her Resident #1 had bruises on her and the staff did not know what it is from. Resident #1 was in the tub when the staff found the bruises, and staff noticed Resident #1 had extensive bruising when they got Resident #1 back to her room. The DON stated she helped moved Resident #1 to a new room the day before and did not see any bruising at that time. Resident #1 was sent to the ED for evaluation since she was vomiting and had bruising. The DON stated she called staff and tried to find out what happened. She thought it happened the night before so she called the staff who worked that night. When they did not figure anything out from the staff who worked the night shift, she broadened out their investigation and talked to staff that worked on the evening and day shift. She also requested all staff to fill out a statement. The DON reported she spoke with Staff C, agency CNA, that worked that evening. She requested him to fill out the form. He kind of held back a while. She noticed Staff C had not filled anything out so she approached him and said she needed his statement before he left that night, then he finally said he put Resident #1 on the commode. Staff C was in the room with Staff D, then			

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	Staff C went to do something else and when he came back, Resident #1 was on the ground. The DON reported Resident #1 had no falls previously that she can recall. Keeping the bed in a low position was on Resident #1's care plan already due to the resident had a risk for falls and paralysis. The interventions added for Resident #1 were a fall mat and not to leave the resident alone on the commode. The DON reported she expected staff to let the charge nurse know when something happens. In an interview on 6/9/26 at 8:50 AM, Staff C, agency CNA, reported he had been certified and worked as a CNA for 10 years, and worked through an agency for less than one year. His assignment at the facility started in late 11/2025 and he stopped working at the facility in 2/2026. During his contract he worked 40 hours per week at the facility. Staff C stated he knew what needed to be done for residents or how a resident transferred because he trained as a CNA and he knew how to take care of residents. The facility also had a Kardex that had information regarding the things residents needed, he got information from another CNA or a nurse informed him if the resident had a change in condition. Staff C reported the proper procedure if he saw a fall would be to automatically go to the nurse and let the nurse know the resident had a fall. The nurse would do an evaluation of the resident and check the resident over for any trauma or injury. If he saw the fall happen then he made a report. Some places he had worked did 15-minute checks after a resident had a fall. The charge nurse made all of the decisions on what to do when a resident had a fall or change in condition. The CNA should report to the charge nurse so they can go through the protocol and address the situation. Staff C confirmed per the schedule that he worked the evening shift on 2/2/26 and 2/3/26. When the surveyor			

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	asked if anything unusual happened on those shifts or if there were any residents that had a fall on that shift, Staff C stated he assumed the surveyor was referring to the resident that had a fall. Staff C said he was working with a brand new CNA. The CNA needed help to transfer the resident onto the portapotty (commode), then he left the room and went to help other residents. The other CNA was responsible for the cares for Resident #1. Staff C stated he did not know if the CNA stayed in the room but she came and got him to help get the resident off the commode. When they went back into the room, they saw the resident on the floor. He checked the resident over and she was fine, so they put her in bed. It was a busy time, it was after supper, it was late, and they were putting residents to bed. It was around 9 PM or 10 PM when the incident happened. Staff C stated from what he assumed being a veteran CNA, the new and younger CNA did not remove or lift the resident's skirt or gown for her to use the bathroom. He does not know if the other CNA tried to stand or pivot the resident to lift the resident's skirt up and then the resident went to the floor, or if the other CNA stayed with the resident while she was on the portapotty or not. She came and got him when she needed help to get her off the portapotty. When he found the resident on the floor, he looked at her and made the assumption and checked her over. She did not appear to have any bruises or injury and did not complain about anything. Staff C and the other CNA dressed the resident and got her ready for bed and she was fine. Staff C reported he felt uncomfortable working with a new CNA with no experience, and he did not know what she could do or not do. He had heard that many days later, the DON checked the resident out and moved the resident to another room, then someone found some bruises. Staff C stated he did not know if the resident got the bruises when she got moved to another room or when it had			

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	happened. The DON told him she checked the resident out before she got moved to another room, then after that the bruises were found. Staff C reported the DON requested staff to write something about what they knew so he wrote a statement. He did not receive any other follow up so he does not know what transpired from all of this. The surveyor inquired since Staff C had at least 10 years of experience as a CNA why he did not report to the nurse when they found the resident on the floor. Staff C acknowledged he made a mistake. He should have said something. It was busy and they were trying to get residents to bed that night. Staff C said I should have told the nurse. I made the decision. I checked the resident over and she was fine. I should have reported it. That is what he told the facility and the agency. He reported he has not had any other problems in his career with not reporting incidents. He usually told the nurse when something happened. Resident #1 needed assistance of two staff for transfers because she had had a stroke. Staff C reported he did not think Resident #1 could move herself off the toilet. Staff C was not aware that Resident #1 went to the hospital. He was told she had a bruise and he was told to write a statement. He had been off multiple days when the DON said she had bruises. He pulled the DON aside and told her "this is what transpired". He was not trying to cover things up. He wrote a statement and gave it to the DON. Staff C reported he got little to no orientation when he came to work at the facility. He went into work and was shown where things were and the resident rooms. He does not recall signing off on a checklist. He was just expected to do CNA duties. He was not sure if the facility had a book about changes on residents. The nurse or other aides would tell him about things that had changed or what was needed on the residents.			

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	In an interview on 6/10/26 at 9:11 AM, the former Interim Administrator at the facility, reported she worked at the facility from 8/27/25 to 3/6/26. She was in the office when the DON was completing an investigation of the incident related to Resident #1 in 2/2026. A CNA had shared with the nurse some concerns that Resident #1 had bruises on her forehead and on her side. The resident had thrown up, and the staff gave her a bath. The nurse let the DON know. Resident #1 had moved from one room to another room two days prior. The DON and daughter moved Resident #1's things and Resident #1 did not have bruises at that time. They called staff that had worked during that time. They looked at the timeframe from when the bruises were found and talked with staff that had worked. They began staff education about reporting injuries. The former Administrator reported she came in on the weekend to ask staff about what they knew. A male agency CNA took the DON aside and told the DON what he knew. He said the resident was on the commode and fell, and he told the CNA to put Resident #1 back into bed. The former Administrator stated she thought the newer CNA wanted to do the proper thing but she did what the male CNA told her. After the incident, the new CNA was given another week of orientation and worked with a stronger CNA on taking care of the residents. The former Administrator reported facility staff went over policies and an orientation checklist with agency staff when they came to work at the facility. The former Administrator confirmed a policy about reporting was on the checklist. The former Administrator stated it was her expectation that the staff should immediately tell the nurse when something happened such as a fall, and the DON and Administrator should be notified.			

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	An Agency Orientation checklist revealed a Policy book at the Nurse's Station must be signed before working the floor. Review of facility policies revealed the following: An undated Abuse, Neglect and Exploitation policy revealed the facility developed and implemented policies and procedures to prohibit and prevent abuse and neglect. Possible indicators of abuse include but not limited to physical marks such as bruises on a resident's body or a physical injury of a resident of an unknown source. An undated Fall Prevention Program Policy revealed a resident will be placed on the facility's Fall Prevention Program when a resident experiences a fall and does not have a history of falling. Whenever a resident experienced a fall the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Document all assessments and actions. An undated Falls Management and Prevention policy revealed residents are assessed for their risk of falling upon admission, a significant change and quarterly thereafter. Residents at risk for falling will have interventions implemented through the resident centered care plan. The license nurse is notified when a resident falls, and the licensed nurse assessed the			

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	resident's condition following a fall. The DON and Administrator or their designees are notified of the fall. **FACILITY RESPONSE**			

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