STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465066	A. Building B. Wing	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare Taylorsville	6246 South Redwood Road Salt Lake City, UT 84123

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident 7 was admitted to the facility on [DATE] with diagnosis which included encephalopathy, end stage renal disease, spinal stenosis, weakness, limitation of activities due to disability, need for assistance with personal care, and adult failure to thrive. On 3/12/24 at 9:38 AM, an interview was conducted with resident 7. Resident 7 stated that on 12/29/23 he was going to be transported to dialysis. He stated that the van driver was new and it was the van drivers 3rd or 4th day. Resident 7 stated that the van driver strapped him in the van ok, with two straps at the front of his chair and two in the back. When resident 7 was asked about a lap and shoulder seat belt, he stated he did not have one on and did not remember the van diver attempting to put a shoulder or lap seat belt on him. He stated that he did not refuse to have the seatbelts put on. Resident 7 stated that they were on the freeway, the van driver was using a GPS [Global Positioning System] map to drive to the location, the van driver said that the exit should be coming up soon. Resident 7 stated he was looking out the window and told the van driver that they were about to miss the exit, and the van driver braked hard but not so hard the van squealed and darted over to the emergency lane. He stated the braking did pull him out of his chair feet first and he slammed into the back of the van drivers chair and could tell his legs were broken. Resident 7 stated he was then taken to the hospital and was told his femur bones were shattered. On 11/30/23 a quarterly Minimum Data Set (MDS) assessment documented, resident 7 had a Brief Interview for Mental Status (BIMS) of 15. The MDS also documented, resident 7 required extensive two person assistance with bed mobility, transfers, and toileting. On 9/14/21 a care plan documented resident 7 was at risk for falls related to deconditioning, gait/balance problems. Interventions included, ensure that resident 7 was wearing appropriate footwear when ambulating or mobilizing in w/c[wheelchair]. On 12/29/23 at 6:30 AM, an incident report documented, Van driver came back to facility saying [resident 7] did not make it to dialysis. Van dirvier[sic] stated that he did not fasten the safety belt because [resident 7] declined and stated he didn't need it. He stated while on highway, the driver had missed the turn off so [resident 7] shouted out and startled him so he braked. He stated [resident 7] slipped forward out of geri chair and landed on the van floor. Van driver called 911 and he was taken to [a local hospital]. Van driver called dialysis and updated dialysis center that he would not be at dialysis today due to hospital admission . Resident unable to give description. The document stated No injuries observed at time of incident. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/29/23 at 9:51 AM, a nursing note documented, Van driver came back to facility saying [resident 7] did not make it to Dialysis. He stated while on highway, he had missed the turn off, [resident 7] yelled at him and then he suddenly braked. He stated [resident 7] slipped forward out of geri chair and landed on the van floor. 911 was called and he was taken to [a local hospital]. Van driver called Dialysis and stated he would not be at dialysis today. On 12/29/23 at 4:33 PM, a nursing note documented, Contacted [local hospital] to see if res [resident] had been admitted to hospital. He is in the ICU [Intensive Care Unit], is receiving dialysis there, bilat [bilateral] LE [lower extremities] were affected and they both will be needing surgery. His stay will be awhile. [It should be noted that for the 12/29/23 incident, reporting to the SSA and Adult Protective Services (APS) was not completed.] On 3/12/24 at 11:08 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that the incident was not reported to the state agency because there was not an injury of an unknown source and did not feel that there was outright neglect or anything that could insinuate neglect. The RNC stated she had worked with resident 7 and that he was extremely difficult in a lot of incidence. She stated that he had depression and was frustrated and he would lash out at care givers and would refuse to cooperate. She stated that she was not present at the time he was being transported and can not say what happened. On 3/12/24 at 11:56 AM, an interview was conducted with the Previous Director of Nursing (PDON). The PDON stated that, she was notified of the incident by a nurse, and was told resident 7 had come out of his chair in transport and was taken to the hospital. The PDON stated that the transportation coordinator interviewed the Van Driver (VD) and stated that the VD said he was trying to fasten resident 7. The VD stated that resident 7 refused the safety belt, and during transport resident 7 slid off of he chair. The PDON stated that they did not report the event because resident 7 refused the seat belt and nothing was done purposeful to cause harm to the resident. The PDON stated that the risk of not having the waist and shoulder seatbelt on could cause a higher risk of falling out of a chair, a risk of injury such as skin injury or broken bones. On 3/12/24 at 2:26 PM, an follow up interview was conducted with the RNC. The RNC stated that best practice was for a resident to be buckled when being transported. The RNC stated that if a resident refused, they must look at the things that were important, and the residents had the right to choose. The RNC stated that with this situation the driver did attempt to do what he could with a reasonable attempt to buckle, and opted not to per resident 7's request. The RNC stated that for resident 7 dialysis was vital and that he had complications due to refusing dialysis. The RNC stated that ultimately it was best practice to secure residents in transport. [Cross refer F 689] (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, it was determined, that for 2 of 7 sampled residents, that the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hour if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Specifically, the facility did not report two instances of potential neglect related to serious bodily injury to the State Survey Agency (SSA). Resident Identifiers: 4,7. Findings Included: 1. Resident 4 was admitted [DATE], readmitted [DATE] with diagnoses including: fracture of unspecified part of neck of right femur subsequent encounter for closed fracture with routine healing, anterior cord syndrome at c (cervical) 3 level of cervical spinal cord subsequent encounter, complete lesion at c4 level of cervical spinal cord subsequent encounter, complete lesion at c5 level of cervical spinal cord subsequent encounter, complete lesion at c6 level of cervical spinal cord subsequent encounter, unspecified intracranial injury without loss of consciousness subsequent encounter, and major depressive disorder recurrent in partial remission. Resident 4's medical record was reviewed from 3/11/24 through 3/12/24. Resident 4's most recent Brief Interview for Mental Status (BIMS) score on 2/13/24 from his significant change Minimum Data Set (MDS) assessment was a 10, indicating a moderate cognitive impairment. Prior to this, a quarterly assessment had been completed on 1/22/24. Resident 4's BIMS score from this assessment was a 9, indicating a moderate cognitive impairment. An incident report dated 2/9/24 revealed, At 0645 res [resident] was trying to reach for his call light to be helped out of bed and slipped to the floor hurting R [right] hip. Nurse was called to evaluate, res was in grimacing pain and guardian R hip. Res was helped to his chair, he insisted on going to the dining room for breakfast. Res was then helped back into bed. Xray [sic] ordered. Dr notified, Sister [name redacted] called but left message. The incident report also noted that at the time of Resident 4's fall, his pain was rated as a 4 out of 10. A nursing progress note dated 2/9/24 revealed, At 0645 res [resident] was trying to reach for his call light to be helped out of bed and slipped to the floor hurting R [right hip]. Nurse was called to evaluate, res was in grimacing pain and guarding R hip. Res was helped to his chair, he insisted on going to the dining room for breakfast. Res was then helped back into bed. Xray [sic]ordered. Dr notified, Sister [name redacted] called but left message. A nursing progress note dated 2/9/24 revealed, Xray [sic] results reviewed, orders rec'd [recommend] to send res to hospital to more [sic] evaluation on the femual [sic] head Fx [fracture]. Res does not want any family called r/t [related to] his mother being in the hospital right now and doesn't want to [NAME] [sic] out his family further. Res took no personalitems [sic] with him. [Ambulance company redacted] transported to [hospital named redacted]. At 4:45 PM, ER called. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[It should be noted that no documentation could be found of a facility investigation into the incident as documented in the progress note on 2/9/24, and reporting to the SSA and Adult Protective Services (APS) was not completed.] Review of a facility policy titled, Abuse Reporting and Responsibilities of Covered Individuals revised 5/4/23, revealed, The facility will report alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, and submit investigation results, according to regulatory guidelines and in accordance with State law and within the time frames required by federal and state law. The policy also revealed, 5. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: a. Report immediately, but not later than 2 hours, all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, if the events that caused the allegation involve abuse or result in serious bodily injury. On 3/12/24 at 11:28 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 was the nurse on duty the day Resident 4 fell. RN 2 stated that another staff member that she cannot remember the name of called her into Resident 4's room. RN 2 stated that she examined the resident and lifted him onto his bed. RN 2 stated that she notified Resident 4's physician and facility administration after the fall. RN 2 stated that an x-ray was ordered and that the x-ray staff confirmed that Resident 4 had a hip fracture. RN 2 stated she could not recall what Resident 4's fall interventions were at the time of the fall. RN 2 stated that she could not recall the location of Resident 4's call light when she entered his room. RN 2 stated that CNAs should be checking on residents at least every 2 hours and that anytime a CNA enters a resident's room they should check the positioning of the resident's call light. On 3/12/24 at 2:30 PM, an interview was conducted with the facility administrator (ADM). The ADM stated that the fall was not reported to the state agency because it was investigated fully internally and it was determined that the resident did not experience neglect. On 3/12/24 at 2:32 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that the reason the fall was not reported to the stage agency was because multiple staff members had questioned the resident about whether or not he thought he had experienced abuse or neglect and the resident had provided the same answer to each staff member. The RNC stated that Resident 4 did not feel like he had experienced abuse or neglect.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 7 sampled residents, that the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, a resident with heart failure had hospital discharge orders for daily weights, the order was not implemented at the facility until 6 days after the resident was admitted . Resident Identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included heart failure, peripheral vascular disease, presence of prosthetic heart valve, and tricuspid stenosis. A review or resident 1's hospital discharge paperwork documented a discharge order, Monitor weight and record . Please weigh and record your weight: Daily. Call the provider if you have gained or lost pounds: 7-10. Resident 1's care plan did not include any focus areas involving daily weights. A physicians order dated 2/8/24 documented, DAILY WEIGHT R/T [related to] CARDIAC. [It should be noted that resident 1 was admitted to the facility on [DATE] and daily weights were not initiated until 2/8/24.] Resident 1's weights were reviewed from 2/2/24 through 3/2/24. a. On 2/2/24 at 4:59 PM, Resident 1's admission weight was 311.2 lbs. (pounds) b. On 2/8/24 at 11:55 AM, resident 1's weight was 299.2 lbs. [It should be noted there is a 12 pound weight loss during the 5 day period of not being weighed, and no documentation of notification to the provider was found.] c. On 2/8/24 at 1:50 PM, resident 1 was re-weighed 299.2 lbs. Resident 1 had weights missing on 2/3/24, 2/4/24, 2/5/24, 2/6/24, 2/7/24, 2/19/24 and 2/25/24. [Note: Resident 1 had a total of 7 weights missing in a 31 day period.] On 3/12/24 at 2:44 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that daily weights would be important for a resident with heart failure because the weights can make a huge difference. The weight can tell you what the cardiac volume and function and how they are doing. The DON stated that resident 1 was discharged with an order for daily weights from the hospital. The DON stated she was unable to find any documentation of weights for the missing days and stated that the facility missed putting the order in when resident 1 was admitted to the facility.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that for 2 of 7 sampled residents, that the facility did not ensure that the resident environment remains as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, the facility did not ensure that a resident transported to a dialysis appointment was properly secured with a seatbelt, and subsequently sustained fractures of both of his legs. In addition, the facility did not ensure that a resident's call light was within reach and the resident reached for the call light, fell out of bed, and fractured his hip. This will be cited at a HARM. Resident Identifiers: 4, 7. Findings included: 1. Resident 7 was admitted to the facility on [DATE] with diagnosis which included encephalopathy, end stage renal disease, spinal stenosis, weakness, limitation of activities due to disability, need for assistance with personal care, and adult failure to thrive. On 3/12/24 at 9:38 AM, an interview was conducted with resident 7. Resident 7 stated that on 12/28/23 he was going to be transported to dialysis. He stated that the van driver was new and it was the van drivers 3rd or 4th day. Resident 7 stated that the van driver strapped him in the van ok, with two straps at the front of his chair and two in the back. When resident 7 was asked about a lap and shoulder seat belt, he stated he did not have one on and did not remember the van diver attempting to put a shoulder or lap seat belt on him. He stated that he did not refuse to have the seatbelts put on. Resident 7 stated that they were on the freeway, the van driver was using a GPS [Global Positioning System] map to drive to the location, the van driver said that the exit should be coming up soon. Resident 7 stated he was looking out the window and told the van driver that they were about to miss the exit, and the van driver braked had but not so hard the van squealed and darted over to the emergency lane. He stated the braking did pull him out of his chair feet first and he slammed into the back of the van drivers chair and could tell his legs were broken. Resident 7 stated he was then taken to the hospital and was told his femur bones were shattered. On 11/30/23 a quarterly Minimum Data Set (MDS) assessment documented, resident 7 had a Brief Interview for Mental Status (BIMS) of 15. The MDS also documented, resident 7 required extensive two person assistance with bed mobility, transfers, and toileting. On 9/14/21, a care plan documented resident 7 was at risk for falls related to deconditioning, gait/balance problems. Interventions included, ensure that resident 7 was wearing appropriate footwear when ambulating or mobilizing in w/c[wheelchair]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/29/23 at 6:30 AM, an incident report documented, Van driver came back to facility saying [resident 7] did not make it to dialysis. Van dirvier[sic] stated that he did not fasten the safety belt because [resident 7] declined and stated he didn't need it. He stated while on highway, the driver had missed the turn off so [resident 7] shouted out and startled him so he braked. He stated [resident 7] slipped forward out of geri chair and landed on the van floor. Van driver called 911 and he was taken to [a local hospital]. Can driver called dialysis and updated dialysis center that he would not be at dialysis today due to hospital admission . Resident unable to give description. The document stated No injuries observed at time of incident. On 12/29/23 at 9:51 AM, a nursing note documented, Van driver came back to facility saying [resident 7] did not make it to Dialysis. He stated while on highway, he had missed the turn off, [resident 7] yelled at him and then he suddenly braked. He stated [resident 7] slipped forward out of geri chair and landed on the van floor. 911 was called and he was taken to [a local hospital]. Van driver called Dialysis and stated he would not be at dialysis today. On 12/29/23 at 4:33 PM, a nursing note documented, Contacted [local hospital] to see if res [resident] had been admitted to hospital. He is in the ICU [Intensive Care Unit], is receiving dialysis there, bilat [bilateral] LE [lower extremities] were affected and they both will be needing surgery. His stay will be awhile. On 1/1/24 at 8:35 AM, an administration note documented, in hospitalized [sic] A review of resident 7's hospital history and physical reports dated 12/29/23 documented, the patient is found to have bilateral femur fractures and other associated soft tissue injuries . On 3/12/24 at 10:40 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that she had not worked with resident 7, but knew that he was a full assist and required 2 people with transfers. On 3/12/24 at 10:43 AM, interview was conducted with Registered Nurse (RN) 3. RN 3 stated that resident 7 was preferably a 2 person assist with transfers and that he did not have much leg strength. She stated that he was typically transferred into a geri chair and transferred in that to dialysis. She stated she was unsure how he was typically strapped into the van. On 3/12/24 at 11:08 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that she had worked with resident 7 and that he was extremely difficult in a lot of incidences. She stated that he had depression and was frustrated and he would lash out at care givers and would refuse to cooperate. She stated that she was not present at the time he was being transported and can not say what happened. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/12/24 at 1:22 PM, an interview was conducted with the Van Driver (VD). The VD stated that he was new and had not received training, the only training received was to ride with another driver a couple of times. He stated that the other driver showed him how to strap a wheelchair into the van but never a geri chair. The VD stated that he arrived at the facility and a nurse brought resident 7 out to the van in the geri chair. The VD stated he thought resident 7 should not be transported like that but that he was new and was not sure. The VD stated he loaded resident 7 into the van and tied his chair down, then tried to put a shoulder strap and waist belt on resident 7, but that resident 7 refused the shoulder and waist belt. The VD stated he did not know the policy and was told that the customer was always right, and decided to transport the resident. The VD stated that on the freeway he was in the wrong land and the exit was difficult to get to. The VD stated that resident 7 told him they missed the exit. He stated he panicked and that resident 7 slid out of his chair onto the van floor. The VD stated he tried to help resident 7 back into his chair but that resident 7 refused and said to call 911 stating his legs were broken. The VD stated that the geri chair did not move, it was strapped to the van and the brakes were on. The VD stated he tried to call his supervisor and could not get a hold of him, then called dispatch to inform them of the incident. The VD stated that during his training no one said that it was mandatory to be strapped by the shoulder and lap belt and no one had informed him of the policy. The VD stated that he wanted to put the seatbelts on the resident but that the resident refused. The VD then terminated the interview. On 3/12/24 at 2:26 PM, an follow up interview was conducted with the RNC. The RNC stated that best practice was for a resident to be buckled when being transported. The RNC stated that if a resident refused, they must look at the things that were important, the residents have the right to choose. The RNC stated that with this situation the driver did attempt to do what he could with a reasonable attempt to buckle, and opted not to per resident 7's request. The RNC stated that for resident 7 dialysis was vital and that he had complications due to refusing dialysis. The RNC stated that ultimately it was best practice to secure residents in transport. On 3/13/24 at 9:22 AM, a follow up interview was conducted via telephone with the VD. The VD again stated that when he picked up resident 7, resident 7 was in a geri chair. The VD stated that technically you're not supposed to transport people in a geri chair. The VD stated that he loaded the resident in the geri chair into the van, and secured the wheels of the chair, making sure it didn't move. The VD stated that the resident refused to wear the shoulder lap belt. The VD stated that resident 7's exact words were 'I don't need it and I don't want it.' The VD stated that he had never transported someone without securing them completely. The VD stated that it was 5:00 in the morning, and I couldn't get a hold of my supervisor. The VD stated that the only training he had received prior to working alone was riding along with other van drivers. The VD stated that he was not trained on what to do if a resident refused to be secured, and was unsure if there was a specific company policy. The VD stated that he was terminated for transporting the resident without properly securing the resident. The VD stated that during the drive, resident 7 yelled out, and I reacted to his yelling, and he slid out when I hit the brakes. The VD stated that after he braked, the resident began screaming. The VD stated that he pulled over, and checked on the resident. The VD stated that the resident had slid out of the geri chair completely, and was sitting with his legs crossed in the space between the drivers seat and the geri chair, behind the driver. The VD stated that resident 7 told him to call 911. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Resident 4 was admitted [DATE], readmitted [DATE] with diagnoses including: fracture of unspecified part of neck of right femur subsequent encounter for closed fracture with routine healing, anterior cord syndrome at c [cervical] 3 level of cervical spinal cord subsequent encounter, complete lesion at c4 level of cervical spinal cord subsequent encounter, complete lesion at c5 level of cervical spinal cord subsequent encounter, complete lesion at c6 level of cervical spinal cord subsequent encounter, unspecified intracranial injury without loss of consciousness subsequent encounter, and major depressive disorder recurrent in partial remission. Resident 4's medical record was reviewed from 3/11/24 through 3/12/24. Resident 4's most recent Brief Interview for Mental Status (BIMS) score on 2/18/24 from his significant change Minimum Data Set (MDS) assessment was a 10, indicating a moderate cognitive impairment. Prior to this, a quarterly assessment had been completed on 1/22/24. Resident 4's BIMS score from this assessment was a 9, indicating a moderate cognitive impairment Resident 4's nursing care plan was reviewed. A care plan dated 6/5/20 revealed a focus area of, FALL RISK [Resident 4] is at risk for falls r/t [related to] deconditioning, gait/balance problems, psychoactive drug use and paraplegia in all extremities. This focus was revised on 9/15/20 The goal documented for this focus area was, [Resident 4] will have no unaddressed falls. This goal was initiated on 6/5/20 and was revised on 2/26/24. The interventions for this care area were documented as: a. Anticipate and meet [Resident 4]'s needs. b. Be sure [Resident 4]'s call light is within reach and encourage [Resident 4] to use it for assistance as needed. c. Encourage the [Resident 4] to participate in activities that promote exercise, physical activity for strengthening and improved mobility. d.Encourage/remind [Resident 4] to use mobility aides [sic] (walker, cane, crutches, etc.) when ambulating/transferring to aide with fall prevention. e. Ensure commonly used items (ice water, glasses if applicable, call light, phone, remote) are within reach of resident prior to leaving room. A care plan dated 6/5/20 revealed a focus area of, ACTUAL FALL [Resident 4] has had an actual fall with no [sic] r/t [related to] poor balance, unsteady gait and hemiplegia in all extremities. This focus was revised on 11/17/23. The goal documented for this focus area was,[Resident 4] will resume usual activities without further incident within 90 days. This goal was initiated on 6/15/20 and revised on 2/26/24. The interventions for this care area were documented as: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. 1/15/24 fall Therapy to room eval [evalute] with OT [occupational therapy] r/t [related to] room transfer. b. 2/9/24 offered room change resident refused loves room [ROOM NUMBER]/9/24 fall education with staff 2/9/24 call light also attached to dresser. c. FALL 2/20/24 asked resident to move closer to nursing station refused again educated use of call light and using and NWB [non-weight bearing] status talked to sister he is very adamant to maintain independence. d. Fall 6/4/22 - OT [occupational therapy] to eval [evaluate] and treat for safety awareness. e. Fall 9/13/22- PT [physical therapy] to eval [evaluate] and treat for leg strength for safety and positioning when in wheelchair. Staff education provided to encourage [Resident 4] to use leg rests when in wheelchair. f. [Resident 4] will not be left unattended in bathroom (pt [patient] at times toilets self) d/t [due to] safety awareness. g. Monitor/document/report PRN [as needed] x 72h [hours] to MD [doctor of medicine] for s/sx [signs/symptoms]: pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. h. OT [occupational therapy] to eval [evaluate] and treat for use of self releasing seat belt to assist with autonomy. i. Provide activities that promote exercise and strength building where possible. Provide 1:1 [one on one] activities if bedbound. An incident report dated 2/9/24 revealed, At 0645 res [resident] was trying to reach for his call light to be helped out of bed and slipped to the floor hurting R [right] hip. Nurse was called to evaluate, res was in grimacing pain and guardian R hip. Res was helped to his chair, he insisted on going to the dining room for breakfast. Res was then helped back into bed. Xray [sic] ordered. Dr notified, Sister [name redacted] called but left message. The incident report also noted that at the time of Resident 4's fall, his pain was rated as a 4 out of 10. A nursing progress note dated 2/9/24 revealed, At 0645 res [resident] was trying to reach for his call light to be helped out of bed and slipped to the floor hurting R [right hip]. Nurse was called to evaluate, res was in grimacing pain and guarding R hip. Res was helped to his chair, he insisted on going to the dining room for breakfast. Res was then helped back into bed. Xray [sic] ordered. Dr notified, Sister [name redacted] called but left message. A nursing progress note dated 2/9/24 revealed, Xray [sic]results reviewed, orders rec'd [recommend] to send res to hospital to more [sic] evaluation on the femual [sic] head Fx [fracture]. Res does not want any family called r/t [related to] his mother being in the hospital right now and doesn't want to [NAME] [sic] out his family further. Res took no personalitems [sic] with him. [Ambulance company redacted] transported to [hospital named redacted]. At 4:45 PM, ER called. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interdisciplinary team progress note dated 2/15/24 revealed, Event: Fall with hip injury 2/9/24 Resident status prior to event: Sleeping in bed reached for call light fell and slipped out of bed fell with hip pain Risk factors: Epilepsy, Hemiplegia, C3-C6 spinal cord injury, language barrier, immobility, Bipolar disorder Preventive measures prior to event: Bed to be placed in lowest position for safety r/t to seizure hx [history] and mattress to be placed next to his bead. Medications routinely reviewed with pharmacy Care plan risk factors and interventions: [resident 4] is atrisk [sic] for fall r/t Deconditioning, Gait/balance problems, Psychoactive drug use and paraplegia in all extremities; Anticipate and meet [Resident 4]'s needs. Be sure [Resident 4]'s call light is within reach and encourage [Resident 4] to use it for assistance as needed. New device to hook to [Resident 4] [sic] dresser to help hold call light. The following areas reviewed - -Medication Review Regimen: Senna, Miralax, Flomax, Phenobarbital, Melatonin, Carbamazepine, Tylenol - Weight Loss: no weight loss - Dehydration: Average fluid intake 1500ml (millileter)/day -Pain: Resident reported pain to hip after fall. Sent out to ER -ADL [activities of daily living]: Requires one person extensive assistance with bed mobility, transfers and toileting. Set up and supervision for meals. Resident insist [sic] on transferring self often to toilet. -Decline in mobility: Dependent on w/c [wheelchair] for mobility -Psychotropic Drug Use: Sertraline Root Cause Analysis. After further investigation this incident has been reasonably r/t call light falling and resident reaching for. Offered resident to movecloser [sic] to nursing station on main hall 100 and resident declined. Offered to hook call light to dresser also as a back up and resident liked this idea. New interventions implemented: Continue working with therapy, sat with resident on ideas to help and came up with new way to help hook cord to dresser and than [sic] bed. Attendees: ED [executive director], DON [director of nursing], ADON [assistant director of nursing], Therapy, MDS [minimum data set], Resident Advocate. A pain assessment dated [DATE] revealed that at the time of Resident 4's fall, his pain was rated as a 6 out of 10. A change in condition evaluation dated 2/9/24 revealed that at the time of assessment that Resident 4's pain was rated as a 7 out of 10. A grievance filed 1/16/24 revealed, [Resident 4] was told, [sic] in order to eat meals in the dining area, [sic] that he would have to wheel himself down. [Resident 4] is unable to do this safely, he is a fall risk. [Resident 4] stated this happened two weeks ago with the CNA's [sic] in 200 hall as well as the nurse in 200. The corrective action for the grievance dated 1/18/24 revealed, Coaching and teaching staff - (CNA's [sic]) about when the resident needs something they need to do it in a timely manner. The findings of the investigation of the grievance dated 1/18/24 revealed, The resident did indeed ask for help down to the dining room, but was told he could wheel himself down to go eat. The recommendation for corrective action for the grievance dated 1/18/24 revealed, When residents ask certain things (tasks) to be done and they need help, staff members need to act accordingly in a timely respectful manner. The results of the action taken for the grievance dated 1/18/24 revealed, Staff members (cna's [sic], nurses) know to help the resident down to the dining room when they ask for help. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/10/24, the facility provided an in-service on fall safety for Resident 4. The training stated, [Resident 4] Fall Training C.N.A updated reminders 1. Bed to be placed in low position at all times r/t safety and seizures 2. Floor mat next to bed 3. Seat Belt is safely in place 4. Call light placement (prefers on pillow) education on new clips if needed. (can get from maintenance) 5. Encourage [Resident 4] when rounding to let you help toilet him if needed. Management Side 1. Review chart of all previous care plan items noted in past 2. Do education with staff regarding the care plan item in place 3. Speak with [Resident 4] regarding how we can better team up with him to prevent falls 4. Follow up on seat belt orders, can be released, being used, still needs to be used 5. Offer change in room to 101 busy hall with lots of eyes on resident. On 2/24/24, the facility provided an in-service with topics including, Fall prevention: call lights close, bed side tables close, ask if we can do anything else to help, anticipate needs, ask questions, non skid socks, talk to managers if you see a risk. The training summary revealed, Falls training prevention 1. Ensure call lights are always next to resident 2. Bed side tables are close to residents 3. Anticipate needs 4. Non ski socks for resident getting up and out of bed. 5. Always say before leaving a room is there anything else I can get you 6. If you suspect some one has a change in condition or is a high fall risk please notify nurse, if no change happens notify Nurse manager. If a fall happens you are required to Nurse 1. Complete incident report, get a set of ortho static [sic] vitals and record in Progress note (updated 3/11) 3. Complete fall and pain assessment 4. Start neuro (all falls not witnessed BY STAFF 5. PN [progress note] what happened, what you did to keep resident safe, notification family, MD, Text on call manager 6. Any wound orders if required 7. Notify your abuse coordinator ASAP [name redacted] administrator if you suspect fracture or abuse in any way. C.N.A. 1. Get a nurse to assess patient 2. Start Vital signs on Neuro sheet 3. Get a set or [sic] ortho static [sic] vitals with nurse if your [sic] not trained on this please see nurse or ADON [assistant director of nursing]. The facility conducted fall audits. The audit form revealed, DON/designee will conduct random audits on 5 residents and fall preventions interventions in place weekly x 4 weeks, then monthly x 3 months or until substantial compliance has been maintained to ensure decrease in falls. For the week of 2/19/24 through 2/25/24, Resident 4 was selected to be audited. The audit form stated that Resident 4 had his fall precautions in place when facility staff entered his room. Per the audit form, Resident 4 had the comment, seatbelt, call light. For the week of 2/26/24 through 3/3/24, Resident 4 was selected to be audited. The audit form stated that Resident 4 had his fall precautions in place when facility staff entered his room. Per the audit form, Resident 4 had the comment, low bed, call light pillow. For the week of 3/4/24 through 3/10/24, Resident 4 was selected to be audited. The audit form stated that Resident 4 had his fall precautions in place when facility staff entered his room. Per the audit form, Resident 4 had the comment, seatbelt/safety reminder. For the week of 3/11/24 through 3/17/24, Resident 4 was selected to be audited. The audit form stated that Resident 4 had his fall precautions in place when facility staff entered his room. Per the audit form, Resident 4 had the comment fall mat - behind bed pt [patient] up [sic]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/11/24 at 12:39 PM, an interview was conducted with Resident 4. Resident 4 stated that he remembered his fall that resulted in his hip fracture. Resident 4 stated that the night of the fall, his call light had dropped onto the floor and that the remote control for his bed had also dropped onto the floor. Resident 4 stated that he was unable to lower his bed further. Resident 4 stated that he tried to reach for his call light and fell out of bed. On 3/11/24 at 12:39 PM, an observation was made of Resident 4's room. The call light was taped to the side of his nightstand and clipped to the right side of his pillow. On 3/12/24 at 1:17 PM, an additional observation was made of Resident 4's room. Resident 4's bed was in the low position and his fall mat was behind his bed. On 3/12/24 at 1:17 PM, an interview was conducted with Resident 4. Resident 4 stated that staff stopped putting the fall mat on the floor at bedtime when he was moved from the 200 hall to the 400 hall. A review of Resident 4's room history revealed that Resident 4 was moved from the 200 hall to the 400 hall on 1/15/24. On 3/12/24 at 9:31 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that residents should be checked on every 2 hours. CNA 1 stated that he should check a resident's call light position every time he enters their room. CNA 1 stated that Resident 4 was not a high fall risk. CNA 1 stated that he has never heard of Resident 4 having experienced a fall. CNA 1 stated that he can see what fall interventions a resident had in place by looking at notes in the Resident's electronic medical record. On 3/12/24 at 1:23 PM, an additional interview was conducted with CNA 1. CNA 1 stated that to his knowledge, Resident 4 did not use a fall mat at night. CNA 1 stated that Resident 4's bed should have been in the low position. On 3/12/24 at 9:38 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that CNAs should check on residents every 2 hours. LPN 1 stated that each time a CNA completed their rounds they should check the position of each resident's call light. LPN 1 stated that Resident 4 was a high fall risk. LPN 1 stated that information about a resident's fall interventions could be found in the electronic medical record. LPN 1 stated that Resident 4 needed to be checked on more frequently due to him having an independent mindset and that he frequently tried to self transfer. On 3/12/24 at 11:28 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 was the nurse on duty the day Resident 4 fell. RN 2 stated that another staff member called her into Resident 4's room. RN 2 stated that she examined the resident and lifted him onto his bed. RN 2 stated that she notified Resident 4's physician and facility administration. RN 2 stated that an x-ray was ordered and that the x-ray staff confirmed that Resident 4 had a hip fracture. RN 2 stated she could not recall what Resident 4's fall interventions were at the time of the fall. RN 2 stated that she could not recall the location of Resident 4's call light when she entered his room. RN 2 stated that CNAs should check on residents at least every 2 hours and that anytime a CNA enters a resident's room they should check the positioning of the resident's call light. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/12/24 at 2:24 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff should check on residents at least every 2 hours. The DON stated that staff should check the position of a resident's call light each time they enter a resident's room. The DON stated that staff can check to see what a resident's fall interventions were by looking at the Kardex in the electronic medical record. The DON stated that Resident 4 was a fall risk due to him wanting to maintain his independence. The DON stated that Resident 4 used a fall mat at night. The DON stated that Resident 4's fall mat should have been on his care plan. (Note: the usage of a fall mat was not documented on Resident 4's care plan). The DON stated that she had interviewed Resident 4 and Resident 4 had stated that he was not sure if he had knocked his call light out of place. On 3/12/24 at 2:24 PM, an interview was conducted with the facility administrator (ADM). The ADM stated that the facility does not track exact times that facility staff exit and enter a resident's room. The ADM stated that Resident 4's call light had been attached to the bar on Resident 4's bed and had fallen onto the ground prior to Resident 4's fall.