STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00456781. Complaint IN00456781- Federal/state deficiencies related to the allegations are cited at F689. Unrelated deficiencies are cited at F641. Survey dates: April 10 and 11, 2025 Facility number: 000020 Provider number: 155059 AIM number: 100288690 Census Bed Type: SNF: 2 NF: 52 Total: 54 Census Payor Type: Medicare: 5 Medicaid: 43 Other: 6 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 23, 2025.	F 0000	For F 689 We are Disputing the Level G because we believe we were working to keep the residents from falling and had interventions in place for the residents noted. We feel we presented documentation of interventions.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded for 2 of 3 residents' MDS assessments reviewed. (Resident	F 0641	Preparation and/or execution of this plan of correction in general, or this corrective action in	05/07/2025

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

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	B and D) Findings include: 1. Resident B's clinical record was reviewed on 4/10/25 at 9:30 a.m. A progress note, dated 12/25/24 at 2:18 p.m., indicated Resident B was observed sitting on the floor in the doorway of his room. A head-to-toe assessment was completed with redness noted to the residents' left elbow. A progress note, dated 12/21/24 at 6:15 a.m., indicated Resident B was on the floor in front of his recliner. Resident B was fully clothed and had socks and shoes on. The resident's vital signs were slightly elevated but came back down to normal range after a few minutes. No injuries were noted, and the resident denied any pain. A progress note, dated 12/9/24 at 7:36 p.m., indicated Resident B was noted lying on the floor in his room. Resident B was fully dressed and had socks and shoes on. The resident's wheelchair was beside him. The resident was assessed without any injuries noted. Neurological assessments were initiated, and the resident was assisted into his wheelchair. A quarterly Minimum Data Set (MDS) assessment, dated 1/21/25, indicated Resident B had no falls since his prior assessment. 2. Resident D's record review was completed on 4/11/25 at 9:30 a.m. A progress note, dated 2/11/25 at 2:48 p.m., indicated Resident D was found on the floor next to his wheelchair by his bathroom. The resident		particular does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 22, 2022. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after March 22, 2022. **F- 641 Accuracy of Assessments** It is the intent of this facility to ensure assessments are coded accurately. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The MDS Nurse/Designee completed an amended MDS for Resident B and D on 04/14/2025. 2 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be**	

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	appeared to have slid out of his wheelchair. The resident denied any pain. No bruising or redness was noted. Resident D stated he was trying to stand up out of his wheelchair and used the bathroom door for support. The resident lost his balance and slid out of his chair. The resident's vital signs were stable, 24-hour neurological checks were in place. NP, DON, and the resident's representative were notified. A progress note, dated 1/12/25 at 2:58 a.m., indicated Resident D was heard yelling. Resident D was noted to be lying on the floor in his room. Resident D indicated he needed to urinate. The resident had regular socks on without shoes. Resident D's wheelchair was several feet away from him and the wheels were not locked. Resident D was assisted by three staff members onto his feet and placed him in his wheelchair. A quarterly MDS assessment, dated 3/15/25, indicated Resident D had no falls since his prior assessment. During an interview, on 4/11/25 at 12:05 p.m., the MDS Coordinator indicated she reviewed the risk management section of the clinical record to see when the resident's last fall was. If the resident fell before the assessment date was due, she would mark it on the MDS assessment. If the risk management assessment had been locked and signed, she was unable to see the report. She was only able to see active reports. During an interview, on 4/11/25 at 12:18 p.m., the DON indicated prior risk management reports were under the historical tab. Even if the assessment was locked and signed, it would still show up under the historical tab.		**taken?** An audit was completed by the MDS Nurse/Designee on all resident with falls in past 90 days for accurate coding on the Minimum Data Set Assessment. Any concerns were immediately addressed. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 4/14/24 the Regional MDS Coordinator conducted an in-service with the MDS coordinator on accurate coding of the MDS assessment. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** *The MDS Consultant/Designee will audit MDS's accuracy audit related to falls for accurate coding weekly x 6months. If the facility is within 95% compliance after the 6 months, the monitoring will be stopped.* Results of the monitoring	

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	During an interview, on 4/11/25 at 1:15 p.m., the Administrator indicated the facility did not have a specific MDS assessment policy. 3.1-31(d)(3)		will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. 5 **By what date the systemic changes for each deficiency will be completed?** 05/07/2025	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to provide supervision for a resident with known fall risk and ensure the implementation of fall interventions to prevent repeated falls for 2 of 3 residents reviewed for falls. (Resident B and Resident D) This deficient practice resulted in Resident B sustaining a left ankle fracture during a fall. Findings include: 1. Resident B's clinical record was reviewed on 4/10/25 at 9:30 a.m. Diagnoses included fracture of the left tibia (shin bone), a sprain of the left wrist, type 2 diabetes, muscle weakness, hypertension (high blood pressure), dementia, visual hallucinations, and repeated falls. Current physician orders included escitalopram (antidepressant), 10 milligrams (mg), metoprolol	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** It is the intent of this facility to ensure to provide supervision for residents with known fall risk and implement fall interventions to prevent repeat falls, **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The DON/Designee reviewed Resident B and D, interventions were implemented, and care plans updated on 04/10/2025. **2 How other residents having the potential to be affected by**	05/07/2025

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	succinate (antihypertensive) 50 mg, hydrocodone-acetaminophen (for pain) 5-325 mg, and safety checks every 30 minutes for fall interventions. A quarterly Minimum Data Set (MDS) assessment, dated 1/21/25, indicated Resident B was severely cognitively impaired. He had no upper or lower extremity impairment. He required supervision/ touching assistance with toileting hygiene, upper and lower body dressing, rolling to the left and right, sitting to lying, lying to sitting, sitting to stand, chair/bed to chair transfers, toilet transfers, and walking 10 feet. A current care plan, initiated on 10/26/22 and revised on 3/10/25, indicated Resident B was at risk for falls related to his condition and risk factors. His falls would be reduced in an attempt to avoid significant injury related to falls. Interventions included 60 minute checks for fall safety/prevention/interventions, anti-rollbacks to the wheelchair, anti-tippers applied to the wheelchair, resident's call light within reach, Dycem (a non-slip pad) on the wheelchair, encourage and assist with wearing non-skid foot wear, encourage resident to use handrails or assistive devices properly, encourage to use a grabber tool to retrieve items out of reach, non-skid strips in front of toilet, notify physician of changes in condition, nurse practitioner to do medication review, use overnight briefs to reduce wake times, reinforce need to call for assistance, smart audio monitor to help with falls, grab bars on the left side of the bed for safety, a mat on the floor next to the bed, and anti-tippers to the front of the wheelchair. A progress note, dated 3/6/25 at 9:39 p.m., indicated Resident B was sitting on the floor in		**the same deficient practice will be identified and what corrective action(s) will be taken?** The DON/Designee completed an audit of falls for the last 90 days for IDT note, fall interventions and care plan updated with intervention on 04/14/2025. The DON/Designee completed a Fall Risk assessment for residents, those at high risk were reviewed and interventions implemented, and care plans updated on 04/14/2025. The DON/Designee reviewed residents care plans and resident's rooms for fall interventions on 04/14/2025. Any concerns were immediately addressed. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/Designee in-serviced the nursing staff on policy "Guidelines for Incidents/Accidents/Falls to include implementing an immediate fall intervention at the time of the fall and documentation on 04/14/2025. The Regional Nurse Consultant in-serviced the Nurse Managers and Director of Nursing on completing a review of residents	

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	front of his recliner. The resident was laughing and appeared to have slipped out of his chair. Staff assessed the resident for any head injury. The resident was smiling, laughing, and playful. Fall precautions and 24-hour neurological checks were in place. Staff were to continue to monitor. A progress note, dated 3/7/25 at 9:20 a.m., indicated Resident B was found lying on his right side, unclothed and under a blanket. Staff attempted to assist resident getting dressed but the resident began screaming and stated, "Don't do that, that hurts, feel it?" Staff assessed the residents left shoulder and the resident screamed. The resident also complained of left hip pain. The nurse contacted the Nurse Practitioner (NP), who ordered the resident sent to the emergency room (ER) for better imaging. No immediate interventions were implemented to prevent further falls. The clinical record lacked indication of the outcome of the ER visit. A progress note, dated 3/10/25 at 4:38 a.m., indicated Resident B was noted on the floor in front of his recliner. Resident B had been sitting in his recliner. The resident was lying on his left side. He was wearing pants, a shirt, and shoes. The resident was assessed without any injuries noted. The resident was assisted onto his feet, then placed into his recliner. No immediate interventions were implemented to prevent further falls A progress note, dated 3/10/25 at 1:30 p.m., indicated the Interdisciplinary Team (IDT) met to review a fall from 3/10/25 at 3:30 a.m. Resident B		falls and completing an IDT note after a resident fall and updating care with new intervention on 04/11/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** ="" p="">="" p="">="" span=""> If the facility is within 95% compliance at the end of 3 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. 5 **By what date the systemic changes for each deficiency will be completed:** 05/07/2025	

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	was found next to his recliner on his left side. Neurological checks continued from a previous fall. The NP, DON, and the resident's representative were notified. The IDT recommended 60-minute safety checks to ensure the resident was safe and not on the floor. A progress note, dated 3/15/25 at 8:42 a.m., indicated Resident B was found on the floor scooting to the bathroom. The resident was wearing non-skid footwear. Neurological checks and vital signs were within normal limits. The resident was not incontinent at the time of the fall. A head-to-toe assessment was performed without any injury noted. No immediate interventions were implemented to prevent further falls. A progress note, dated 3/17/25 at 9:50 a.m., indicated the IDT met to review an unwitnessed fall on 3/15/25 at 8:30 a.m. Resident B was found scooting on the floor in his room. The resident could not relay how the fall occurred. The resident was assessed without any injuries noted. The IDT recommended nonskid strips by his bed. The NP, DON, and the resident's representative were notified. A progress note, dated 3/21/25 at 5:43 p.m., indicated Resident B was in front of his wheelchair on his knees. Resident B had his left hand on the bed and his right hand on the bedside table. The resident was assisted up and into his wheelchair by two staff members. No immediate interventions were implemented to prevent further falls. A fall risk assessment, dated 3/23/25, indicated			

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	Resident B was at high risk for falls. A progress note, dated 3/22/25 at 4:07 a.m., indicated Resident B was found on the floor with no brief, pants, or shoes on. The side of his bed was wet. There was blood on the floor. The resident was assessed, and his vital signs were within normal limits. Resident B had a cut on the tip of his left middle finger. No immediate interventions were implemented to prevent further falls. A progress note, dated 3/24/25 at 11:11 a.m., indicated the IDT met to review a fall on 3/22/25 at 3:15 a.m. The staff responded to the resident's room after hearing the resident talking and found the resident sitting on the floor in the restroom with blood on his finger. Resident B was unable to give a description of the incident. The resident was unaware if he hit his head. Neurological checks were initiated. Staff assisted Resident B to his feet, helped him get dressed, and placed him into his wheelchair. All the resident's needs were met at that time. The NP, ADON, Administrator, DON, and the resident's representative were notified. The IDT recommended staff offer the use of overnight briefs to reduce wake times. A progress note, dated 3/31/25 at 11:00 p.m., indicated Resident B was standing at the foot of his bed. He lost his balance and sat on the floor. The resident denied any complaints of pain. A skin tear was noted to his left forearm. Resident B was dressed in clothes and shoes and had been toileted. The resident did not hit his head during the fall. Resident B was assisted to his feet by two staff members and placed in his wheelchair. No immediate interventions were implemented to prevent further falls.			

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	A progress note, dated 4/1/25 at 11:17 a.m., indicated staff were called to Resident B's room due to Resident B being on the floor in front of his recliner. Upon entering the room, Resident B was sitting on the floor in front of his recliner with blood on the left side of his face. Resident B was dressed in a shift, his pants were half down his leg, wearing a brief and socks. The resident was not wearing shoes. His wheelchair and walker were within reach. Staff assessed Resident B and obtained his vital signs. Resident B was noted with a gash to his left eyebrow and a small skin tear to his left thumb near his palm. The resident was continent at the time of the fall. Swelling was noted to his left wrist and an x-ray was ordered. No immediate interventions were implemented to prevent further falls. A progress note, dated 4/1/25 at 2:41 p.m., indicated Resident B was noted to have left wrist swelling with the resident moaning and holding his left wrist with his right hand. The NP ordered an x-ray. A fall risk assessment, dated 4/1/25, indicated Resident B was at high risk for falls. A progress note, dated 4/2/25 at 9:56 a.m., indicated the IDT met to review Resident B's fall from 3/31/25 at 11:00 p.m. Resident B was standing at the foot of his bed, lost his balance and sat on the floor. The resident had no complaints of pain. A skin tear was noted to his left forearm. The resident was dressed in clothes and was wearing shoes. Resident B had been previously toileted. He did not hit his head during the fall. Resident B was assisted to his feet by two staff members and seated in his wheelchair. The IDT recommended a			

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	"baby monitor" so staff would hear when the resident was moving around in his room. The ADON, NP, and the resident's representative were made aware. A progress note, dated 4/2/25 at 6:53 a.m., indicated x-ray results showed a fracture to his left wrist. The NP and the resident's representative were notified. A progress note, dated 4/2/25 at 8:33 a.m., indicated a new order was received to send Resident B to the emergency room (ER) for evaluation and treatment of the wrist fracture. A progress note, dated 4/2/25 at 10:01 a.m., indicated the IDT met to review Resident B's fall from 4/1/25 at 11:00 a.m. Staff were called to the resident's room due to the resident being on the floor in front of his recliner. Upon entering the room, the resident was sitting on the floor in front of his recliner with blood on the left side of his face. The resident was dressed in a shirt, was wearing a brief with his pants halfway down his legs and had socks on. Resident B was without shoes and his wheelchair and walker were within reach. Staff assessed the resident and obtained his vital signs. The resident was noted with a gash to his left eyebrow and a small tear to his left thumb by his palm. The resident was continent at the time of the fall. Swelling was noted to his left wrist and a stat x-ray was ordered. The IDT recommended staff offer diversional activities when the resident was noted alone in his room. NP, ADON, and resident's representative were made aware. A left ankle x-ray, performed at the local hospital, on 4/2/25 at 10:38 a.m., indicated irregularity of remote injury or acute nondisplaced fracture.			

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A progress note, dated 4/2/25 at 12:49 p.m., indicated the emergency room staff found Resident B had a left ankle fracture and would be returning to the facility with a boot. The resident's left wrist did not show signs of a fracture.

A fall risk assessment, dated 4/4/25, indicated Resident B was at high risk for falls.

A progress note, dated 4/7/25 at 8:32 a.m., indicated the IDT met to review Resident B's fall on 4/4/25 at 5:00 p.m. Resident B was sitting in his wheelchair at the nurse's station. Resident B was seen trying to get out of his chair and fell out before staff could stop him. The wheelchair tipped over along with the resident. No injury was noted. The ADON, NP, and the resident's representative were notified. The IDT recommended anti-tippers to the front of his wheelchair, which was added to the care plan.
No immediate interventions were implemented to prevent further falls on 4/4/25.

A progress note, dated 4/8/25 at 22:45 p.m., indicated Resident B was in the recliner at the nurse's station. Staff saw him try to get up and ran toward the resident to prevent a fall. Resident B slid against the recliner onto the floor. Resident B was assessed for injuries, but none were found. No redness, swelling, or bleeding was present. A pain scale for the cognitively impaired was used. No sign of distress was noted. His vital signs were stable. Fall precautions were in place. The DON and NP were notified.

No immediate interventions were implemented to prevent further falls.

A fall risk assessment, dated 4/8/25, indicated

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	Resident B was at high risk of falls. During an interview, on 4/10/25 at 11:15 a.m., LPN 5 indicated resident fall assessments should be documented under the risk management tab. As soon as the DON was notified, the DON would inform the nurse of the new intervention. The DON or the nurse updated the care plan. During an interview, on 4/10/25 at 11:25 a.m., LPN 6 indicated the nurse or management came up with the new fall intervention after a fall occurred. Some interventions were placed right away, other times it took a while. Management would update the care plan with the new interventions. Resident B was on 30-minute safety checks. The facility tried to keep him out of his room as much as possible. When agitated, he would be a one on one. During an interview, on 4/10/25 at 11:35 a.m., LPN 7 indicated after a fall occurred, the assessment was completed under the risk management tab. Staff needed to fill out the residents fall risk, change of condition, and pain assessments. The ADON or DON tried to come up with new interventions as soon as possible. During an interview, on 4/10/25 at 11:36 a.m., CNA 8 indicated she was unsure what Resident B's fall interventions were. She needed to check with the nurse. During an observation, on 4/10/25 at 11:36 a.m., Resident B was sitting in the main dining room. He did not have anti-tippers on the front of his wheelchair. During an interview, on 4/10/25 at 11:45 a.m., CNA 8 indicated she was unsure if the CNAs had			

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	155059	A. BUILDING 00 B. WING	04/11/2025

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	access to the resident's care plan. They would be notified during shift change of any interventions or changes to the resident's care. During an interview, on 4/10/25 at 11:43 a.m., Housekeeper 9 indicated she was unaware of Resident B's fall interventions. He usually propelled himself up and down the hallway or preferred to color. During an observation, on 4/10/25 at 12:03 p.m., Resident B was propelling himself down the hallway. He propelled himself up to the nurse's station and asked the CNA to give him a report. He did not have anti-tippers on the front of his wheelchair. During an interview, on 4/10/25 at 12:03 p.m., CNAs 10 and 11 indicated Resident B was on 30-minute safety checks, had fall strips in his room, and a monitor. They were unsure of other fall interventions. There was a communication book at the nurse's station but was unsure if it was directly used for Resident B. CNA 9 left to speak with the DON, and after returning, CNA 9 indicated anything new with any of the residents was discussed during shift change. During an interview, on 4/10/25 at 2:00 p.m., the DON indicated the nurse wrote the intervention under the immediate action taken. Resident B's fall interventions include 30-minute safety checks and a monitor in his room. CNAs normally had a huddle at the end of their shifts where everything was discussed. During an observation, on 4/10/25 at 2:15 p.m., Resident B was sitting at a small table near the nurse's station while a staff member sat beside him in a chair. The small table had coloring books,			

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	colored pencils, and a puzzle activity for the resident. He did not have anti-tippers on the front of his wheelchair. During an observation, on 4/11/25 at 9:36 a.m., Resident B's room was located at the end of the hallway. Resident B did not have a floor mat at his bedside. During an interview, on 4/11/25 at 9:40 a.m., the ADON indicated she felt the 30-minute safety checks were sufficient in preventing Resident B from falling. The facility had been able to provide enough staff for Resident B to receive one-on-one staff assistance twice a week. Resident B needed to be one on one when he was agitated. The anti-tippers to the front of his wheelchair were on backorder. At the time of the interview, with the ADON present, Resident B's room was measured 102 feet away from the nurse's station using therapy's walking stick. During an interview, on 4/11/25 at 10:08 a.m., the DON indicated 30-minute safety checks were not sufficient in preventing Resident B from falling. Staff tried to keep Resident B in eyesight. The DON felt the resident receiving one-on-one staff assistance would prevent future falls. She was unaware he was supposed to have anti-tippers on the front of his wheelchair. 2. Resident D's clinical record review was completed on 4/11/25 at 9:30 a.m. Diagnoses included dementia, anxiety, opioid dependence, chronic kidney disease, hypertension, psychotic disturbance and mood disturbance. Current physician orders included hydrocodone-acetaminophen (opiate pain medication) 5-325 mg, mirtazapine (antidepressant)			

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	7.5 mg, and sertraline (antidepressant) 25 mg. A quarterly MDS assessment, dated 3/15/25, indicated Resident B was severely cognitively impaired. He required partial/ moderate assistance with toileting hygiene, lower body dressing, rolling to the left and right, sitting to lying, lying to sitting, sitting to stand, chair/bed to chair transfers, toilet transfers, and walking 10 feet. He required substantial/ maximal assistance with upper body dressing. A current care plan, initiated on 1/2/24 and revised on 12/30/24, indicated Resident D was at risk for falls related to his condition and risk factors. His fall risk factors would be reduced in an attempt to avoid significant injury related to falls. Interventions included, anti-rollbacks to his wheelchair, the bed in lowest position, call light within reach, do not leave resident in the bathroom unattended, encourage and assist resident with wearing non-skid footwear, ensure Dycem (anti-skid mat) is in his wheelchair, keep most used items in arm's length to prevent bending/reaching, monitor for changes in gait/positioning, non-skid strips to floor in front of toilet, place mat on floor beside bed, reassess fall risk factors annually and PRN, and reinforce the need to call for assistance. A progress note, dated 4/9/25 at 1:08 p.m., indicated staff found the resident on the floor beside his bed next to his wheelchair. The resident stated he was trying to get into his wheelchair, but he unlocked his wheelchair and fell to the floor. Resident D was wearing regular socks without shoes. Anti-slip strips were in place. Resident D had no complaints of pain in his legs, back, hips or arms. The DON, ADON, and the resident's representative were notified.			

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	No immediate interventions were implemented to prevent further falls. A progress note, dated 3/17/25 at 9:27 a.m., indicated Resident D was found on the floor at the foot of his bed. He was next to his shoes, but only had socks on. Resident D's shoes were wet. The resident stated he was trying to get up to go to the bank. Resident D did not have any complaints of pain or discomfort at the time of assessment. No redness or bruising was noted. The resident was assisted off the floor and into his wheelchair. The DON, ADON and the resident's representative were notified. No immediate interventions were implemented to prevent further falls. A progress note, dated 2/11/25 at 2:48 p.m., indicated Resident D was found on the floor next to his wheelchair by his bathroom. The resident appeared to have slid out of his wheelchair. The resident denied any pain. No bruising or redness was noted. Resident D stated he was trying to stand up out of his wheelchair and used the bathroom door for support. The resident lost his balance and slid out of his chair. The resident's vital signs were stable, 24-hour neurological checks were in place. NP, DON, and the resident's representative were notified. No immediate interventions were implemented to prevent further falls. During an observation, on 4/11/25 at 11:07 a.m., Resident D's room did not have a floor mat observed in the room or non-skid strips on the floor in front of his toilet.			

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	During an observation, on 4/11/25 at 11:11 a.m., Resident D was sitting in his wheelchair in the main dining room. No anti-rollbacks were attached to his wheelchair. During an interview, on 4/11/25 at 11:20 a.m., CNA 12 indicated there was a communications binder at the nurse's station for residents that had fall interventions in place. Floor mats were not used in Resident D's room, as he got up on his own and it was a trip hazard. During an interview, on 4/11/25 at 12:44 p.m., the ADON indicated no one in particular was responsible for implementing new fall interventions. The MDS Coordinator was responsible for updating the resident care plan. During an observation, on 4/11/25 at 12:45 p.m., Resident D propelled himself backwards out of his bathroom and had his pants pulled down to his knees. The resident indicated he needed his pants pulled up. A CNA entered Resident D's room and assisted the resident with pulling up his pants. When Resident D stood up, a Dycem pad was not observed on his wheelchair seat. During an interview, on 4/11/25 at 12:52 p.m., LPN 7 indicated she needed to look at Resident D's care plan for his fall interventions. LPN 7 asked the ADON to help her navigate the resident's care plan to find his fall interventions. At the same time as the interview, LPN 7 did not observe a fall mat in Resident D's room and indicated his anti-rollbacks were on backorder. During an interview, on 4/11/25 at 1:01 p.m., CNA 13 indicated she was made aware of fall interventions during the nurse's report and the CNA communication binder between shifts. She			

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	did not recall seeing a floor mat in the resident's room. She adjusted the bed so Resident D's knees were at a 90-degree angle. During an interview, on 4/11/25 at 1:08 p.m., LPN 7 indicated maintenance was putting Resident D's anti-rollbacks on his wheelchair at this time. During an interview, on 4/11/25 at 1:40 p.m., the DON, ADON, and MDS Coordinator indicated maintenance was responsible for implementing any new fall interventions. After maintenance was notified, nurses and CNAs were notified of the new interventions during their daily huddles. A current policy, titled "Guidelines for Incident/Accidents/Falls", provided by the DON, on 4/11/25 at 1:15 p.m., indicated the following: " ...Based on the results of the incident/accident/fall, the resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place ...." This citation is related to complaint IN00456781. 3.1-45(a)(2)			