STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted on 5/22/2025. Event ID # NBMP11. The following intake was investigated: NC00230004. Two of the two complaint allegations resulted in a deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to immediately evaluate a resident for injury after a fall for 1 of 3 residents reviewed for falls (Resident #1). Nurse #1 observed Resident #1 on the floor and instead of immediately assessing the resident she went to find the resident's assigned nurse to complete an assessment. Findings included: Resident #1 was originally admitted to the facility on 10/17/2023 and had multiple diagnoses, some of which included intellectual disabilities, dementia, and age-related osteoporosis. Documentation on a quarterly Minimum Data Set assessment dated 2/12/2025 revealed Resident #1 was severely cognitively impaired. Resident #1	F 684	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #1 was sent to the hospital to be evaluated on 4/27/25. Nurse #1 & Nurse Aide #1 were suspended pending investigation on 5/1/25. Nurse #1 & Nurse Aide #1 were terminated on 5/6/25. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE.	6/5/25

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

Electronically Signed | 06/07/2025

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F 684	Continued From page 1 was also assessed as being able to go from a sitting to a standing position independently but required supervision or touching assistance, once standing, to walk 10 feet. Resident #1 was independent with the use of a manual wheelchair and she had a history of falls. Resident #1 was not coded as receiving anticoagulant or antiplatelet medication. The documentation in the nursing progress notes dated 4/27/2025 at 6:00 AM written by Nurse #2 revealed she was notified by staff that Resident #1 was on the floor. The note indicated Resident #1 was observed lying on the floor complaining of pain in her left shoulder. Resident #1 had a large knot on the left side of her forehead. A neurological check was completed prior to moving her from the floor to the wheelchair. Resident #1 was alert and oriented at the base level. Staff contacted the Physician Assistant (PA) and informed her that Resident #1 had fallen, had a knot on her forehead, and complained of pain to her left shoulder. The PA advised to send Resident #1 to the hospital for evaluation. Nurse #2 was interviewed on 5/22/2025 at 1:45 PM. Nurse #2 provided the following information. Nurse #2 was assigned from 3:00 PM on 4/26/2025 to 7:00 AM on 4/27/2025 to the hallway where Resident #1 resided. Resident #1 had been a fall risk since she arrived at the facility. Resident #1 was a resident who always required close monitoring. At approximately 11:00 PM on 4/26/2025 Resident #1 was put in the dining room near the nursing station so she could be monitored more closely. There were two nurses and three nurse aides (Nurse #1, Nurse #2, NA #1, NA #2, and NA #4) who were taking turns watching Resident #1 as she sat in the dining	F 684	All residents have the potential to be affected. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR. The Director of Health Services will educate 100% of Licensed Practical Nurses and Registered Nurses regarding the expectation to follow the company Occurrences Policy regarding falls and rendering immediate assistance. All education will be completed by 6/5/25. Any staff on a leave of absence will be educated prior to the beginning of their next shift or removed from the schedule until they are educated. The Director of Health Services will educate all new hire Licensed Practical Nurses and Registered Nurses in orientation moving forward regarding the expectation to follow the company Occurrences Policy regarding falls and rendering immediate assistance. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Inter-Disciplinary Team (Administrator, Director of Health Services, Minimum Data Set Case Mix Coordinator, Infection Preventionist, and Admissions Director/ Social Services	

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F 684	Continued From page 2 area. Nurse #2 indicated she went down the hallway with her medication cart to start administering medications when a staff member Nurse #1 came to her telling her Resident #1 had fallen in the dining room. Nurse #2 went immediately to the dining room to assess Resident #1 and help her. Nurse #2 revealed Resident #1 had a knot on her head and complained of pain in her shoulder. The PA was called, and Resident #1 was sent to the hospital. Nurse #1 was interviewed on 5/22/2025 at 1:31 PM. Nurse #1 provided the following information. Nurse #1 worked from 7:00 PM on 4/26/2025 to 7:00 AM on 4/27/2025 and was not assigned to the hallway where Resident #1 resided. Nurse #1 returned from her break at approximately 5:45 AM on 4/27/2025. Nurse #1 noted Resident #1 was leaning on the table trying to stand up from her wheelchair when she walked past the dining area. Nurse #1 then went to her medication cart outside the dining room when she heard a loud "thump." Nurse #1 entered the dining room and saw Resident #1 on the ground. Nurse #1 noted that a nurse aide (NA #1) was at a table in the dining room with her back to Resident #1. Nurse #1 walked past Resident #1, who she noted was alert and awake on the ground, and approached NA #1. Nurse #1 did not recall any other details of how Resident #1 appeared. Nurse #1 revealed NA #1 was sleeping. She woke NA #1 up by jerking her arm and shaking her. Nurse #1 had to keep jerking her arm to get NA #1 alert to the fact Resident #1 was on the ground. When Nurse #1 was able to get NA #1 alert, she then told NA #1 to stay with Resident #1 while she went down the hall to let Nurse #2 know that Resident #1 had fallen. Nurse #2 immediately went to assess Resident #1. Nurse #2 declined any further help	F 684	Director) will meet weekly to discuss residents on the fall reduction plan. Any noted deficiencies will be corrected immediately. The Director of Health Services will audit all falls that occur for two weeks to ensure that immediate assistance was rendered. Any noted deficiencies will be corrected immediately. The Director of Health Services will audit six falls that occur weekly for four weeks to ensure that immediate assistance was rendered. Any noted deficiencies will be corrected immediately. The Director of Health Services will audit two falls that occur weekly for four weeks to ensure that immediate assistance was rendered. Any noted deficiencies will be corrected immediately. The Director of Health Services will audit one fall that occurs monthly for four months to ensure that immediate assistance was rendered. Any noted deficiencies will be corrected immediately. The Director of Health Services will report the findings to the Quality Assurance and Process Improvement Committee monthly for four months. The Quality Assurance and Process Improvement Committee will determine if sustained compliance has been achieved and if ongoing monitoring is needed. DATE OF COMPLIANCE: 6/5/25	

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F 684	Continued From page 3 from Nurse #1, so she (Nurse #1) went back to her medication cart to start to administer medications. Nurse #1 admitted she did not do any assessment of Resident #1 because Resident #1 was not her assigned resident. Attempts were made to contact NA #1 for an interview on 5/22/2025 without any response. Documentation in a hospital discharge summary dated 4/29/2025 revealed Resident #1 was admitted to the hospital after a fall in the facility and sustained a frontal scalp hematoma (a solid swelling of clotted blood within the tissues) and a non-operable clavicular (collarbone) fracture. An interview was conducted with the Director of Nursing (DON) on 5/22/2025 at 1:25 PM. The DON was adamant that all the residents should receive care and attention from all the staff members utilizing their skills and training abilities. In addition, the DON felt Nurse #1 should have been the one to assess and evaluate the care needs of Resident #1 immediately instead of walking past the resident to wake up NA #1. The DON indicated that nursing standards would be for the nurse to stay with the resident to at least do an initial assessment or find a pillow for her head rather than walk past and leave her on the floor with a less trained staff member.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		6/16/25

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F 689	Continued From page 4 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide effective supervision to prevent avoidable falls for 2 of 3 residents reviewed for high risk of falls (Resident #1 and Resident #2). Resident #1, a severely cognitively impaired resident, sustained a collarbone fracture and a hematoma (a solid swelling of clotted blood within the tissues) on the left side of the forehead from a fall that occurred after staff monitoring her fell asleep (Nurse Aide #1) and ignored her attempt to stand (Nurse #1). Findings included: 1. Resident #1 was originally admitted to the facility on 10/17/2023 and had multiple diagnoses, some of which included intellectual disabilities, dementia, and age-related osteoporosis. Review of the resident profile in the electronic medical record revealed Resident #1 was at high risk for falls. Documentation on the care plan dated as initiated on 1/25/2024 for Resident #1 revealed a focus area for fall risk related to generalized weakness. Documentation on the care plan listed a recent unwitnessed fall on 2/6/2025 requiring hospitalization for a forehead hematoma. The short-term goal was to not sustain injury related to falling through the next review. Some interventions included keeping the environment safe and queueing for safety awareness. Documentation on a quarterly Minimum Data Set	F 689	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #1 was sent to the hospital to be evaluated on 4/27/25. Nurse #1 & Nurse Aide #1 were suspended pending investigation on 5/1/25. Nurse #1 & Nurse Aide #1 were terminated on 5/6/25. Resident #2 was immediately assessed. Vital signs (blood pressure, pulse, respirations, temperature, and oxygen saturation) were obtained for Resident #2; all vital signs were stable and within normal limits. A pain interview was conducted with Resident #2; no pain was noted. A full body skin check was conducted on Resident #2; basic first aid was administered to a small laceration to the forehead. A mental status evaluation was conducted for Resident #2; no changes were noted. Resident #2 discharged on 5/26/25. Nurse Aide #3 was educated on monitoring Resident #2 while toileting in the bathroom on 5/10/25. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE.	

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F 689	Continued From page 5 assessment dated 2/12/2025 revealed Resident #1 was severely cognitively impaired. Resident #1 was also assessed as being able to go from a sitting to a standing position independently but required supervision or touching assistance, once standing, to walk 10 feet. The same assessment documented Resident #1 as independent with the use of a manual wheelchair and with a history of falls. Resident #1 was not coded as receiving anticoagulant or antiplatelet medication. The documentation in the nursing progress notes dated 4/27/2025 at 6:00 AM written by Nurse #2 revealed she was notified by staff that Resident #1 was on the floor. The note indicated Resident #1 was observed lying on the floor complaining of pain in her left shoulder. Resident #1 had a large knot on the left side of her forehead. A neurological check was completed prior to moving her from the floor to the wheelchair. Resident #1 was alert and oriented at the baseline level. Staff contacted the Physician Assistant (PA) and informed her that Resident #1 had fallen, had a knot on her forehead, and complained of pain in her left shoulder. The PA advised to send Resident #1 to the hospital for evaluation. Nurse #2 was interviewed on 5/22/2025 at 1:45 PM. Nurse #2 provided the following information. Nurse #2 was assigned from 7:00 PM on 4/26/2025 to 7:00 AM on 4/27/2025 to the hallway where Resident #1 resided. Resident #1 had been a fall risk since she arrived at the facility. Resident #1 was a resident who always required close monitoring. Nurse #2 explained she would sometimes keep Resident #1 near her medication cart, taking her from doorway to doorway down the hallway to keep an eye on her. Resident #1	F 689	All residents who score high as a fall risk have the potential to be affected. 100% of the current residents will have a Morse Fall Scale Observation completed to determine who is at high risk for falls. The Morse Fall Scale Observations were completed by 5/26/25. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR. The Director of Health Services educated 100% of staff regarding the expectation to intervene to prevent a resident from potentially falling. All education was completed by 5/23/25. Any staff on a leave of absence will be educated prior to the beginning of their next shift or removed from the schedule until they are educated. The Director of Health will educate all new hires in orientation moving forward regarding the expectation to intervene to prevent a resident from potentially falling. All residents identified as high fall risk had their care plans audited to ensure updated and appropriate fall interventions are in place. All care plans were audited to ensure that fall interventions are available on the resident profile. Audits were completed by 5/28/25. The Director of Health Services educated 100% of Licensed Practical Nurses, Registered Nurses, and Certified Nursing Assistants regarding the expectation to	

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F 689	Continued From page 6 would not stay in bed and kept trying to get up on the evening of 4/26/2025. At approximately 11:00 PM on 4/26/2025 Resident #1 was put in the dining room by Nurse #2 near the nursing station so she could be monitored more closely. There were two nurses and three nurse aides (Nurse #1, Nurse #2, NA #1, NA #2, and NA #4) who were taking turns watching Resident #1 as she sat in the dining area. Nurse #2 went down the hallway with her medication cart to start administering medications when Nurse #1 came to her telling her Resident #1 had fallen in the dining room at approximately 5:45 AM. Nurse #2 went immediately to the dining room to assess Resident #1 and help her. Nurse #2 revealed Resident #1 had a knot on her head and complained of pain in her shoulder. The Physician's Assistant was called, and Resident #1 was sent to the hospital. Nurse #1 was interviewed on 5/22/2025 at 1:31 PM. Nurse #1 provided the following information. Nurse #1 worked at the facility for "a couple of weeks." Nurse #1 was not assigned to the hallway in which Resident #1 resided. Nurse #1 worked from 7:00 PM on 4/26/2025 to 7:00 AM on 4/27/2025. Nurse #1 returned from her break at approximately 5:45 AM on 4/27/2025. Nurse #1 noted Resident #1 was leaning on the table trying to stand up from her wheelchair when she walked past the dining area. Nurse #1 did not intervene as it was not her assigned resident and she did not know her very well. Nurse #1 went to her medication cart outside the dining room when she heard a loud "thump." Nurse #1 entered the dining room and saw Resident #1 on the ground. Nurse #1 noted that a nurse aide (NA #1) was at a table in the dining room with her back to Resident #1, the only resident in the dining room.	F 689	monitor Resident #2 while toileting in the bathroom. All education was completed by 5/30/25. Any staff on a leave of absence will be educated prior to the beginning of their next shift or removed from the schedule until they are educated. The Director of Health Services will educate all new hire Licensed Practical Nurses, Registered Nurses, and Certified Nursing Assistants in orientation moving forward regarding the expectation to monitor residents identified as a high fall risk while toileting in the bathroom. All residents identified as high fall risk had their care plans audited to ensure updated and appropriate fall interventions are in place. All care plans were audited to ensure that fall interventions are available on the resident profile. Audits were completed by 5/28/25. The Director of Health Services will educate 100% of Licensed Practical Nurses, Registered Nurses, and Certified Nursing Assistants regarding the expectation to supervise residents identified as high risk for falling in accordance with their plans of care to potentially prevent a resident from falling. All education will be completed by 6/13/25. Any staff on a leave of absence will be educated prior to the beginning of their next shift or removed from the schedule until they are educated. The Director of Health will educate all new hire Licensed Practical Nurses, Registered Nurses, and Certified Nursing Assistants in orientation moving forward regarding	

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F 689	Continued From page 7 Nurse #1 approached NA #1. Nurse #1 revealed NA #1 was sleeping. She woke NA #1 up by jerking her arm and shaking her. Nurse #1 had to keep jerking her arm to get NA #1 alert to the fact Resident #1 was on the ground. When Nurse #1 was able to get NA #1 alert, she then told NA #1 to stay with Resident #1 while she went down the hall to let Nurse #2 know that Resident #1 had fallen. Nurse #2 declined any further help from Nurse #1, so she returned to her medication cart to start administering medications. Review of the facility nursing staffing schedule dated 4/27/2025 revealed NA #1 was assigned to care for Resident #1 on the 11:00 PM to 7:00 AM shift. Attempts were made to contact NA #1 for an interview on 5/22/2025 without any response. The facility Administrator, on 5/22/2025 at 1:20 PM, provided the following statement taken by the Director of Nursing on 5/1/2025 with NA #1 over the telephone: "[Certified Nursing Assistant] stated that she was sitting in the dining room, but she was sitting with her back turned to the resident when [the] fall occurred. She stated that she did not know how the resident fell." An interview was conducted with NA #2 on 5/22/2025 at 2:13 PM. NA #2 revealed she was working on the 11:00 PM to 7:00 AM shift ending on 4/27/2025. NA #2 explained she was not assigned to care for Resident #1 on 4/27/2025, but everybody watched out for all the residents. NA #2 revealed Resident #1 kept getting out of bed on 4/27/2025 so she was put in the dining room so everybody could watch out for her. NA #2 stated that earlier in her shift she was in the	F 689	the expectation to supervise residents identified as high risk for falling in accordance with their plans of care to potentially prevent a resident from falling. The Administrator will educate 100% of staff that sleeping while on duty is conduct which is considered extremely serious and unacceptable, which may subject partners to immediate discharge without the possibility of being rehired by the Organization. All education will be completed by 6/13/25. Any staff on a leave of absence will be educated prior to the beginning of their next shift or removed from the schedule until they are educated. The Administrator will educate all new hires in orientation moving forward that sleeping while on duty is conduct which is considered extremely serious and unacceptable, which may subject partners to immediate discharge without the possibility of being rehired by the Organization. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Inter-Disciplinary Team (Administrator, Director of Health Services, Minimum Data Set Case Mix Coordinator, Infection Preventionist, and Admissions Director/ Social Services Director) will meet weekly to discuss residents on the fall reduction plan. Any	

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F 689	Continued From page 8	F 689		

dining room making sure Resident #1 was occupied and safe but when Resident #1 fell, NA #2 was in another resident's room.

Documentation in a hospital discharge summary dated 4/29/2025 revealed Resident #1 was admitted to the hospital after a fall in the facility and sustained a frontal scalp hematoma and a non-operable clavicular (collarbone) fracture.

An interview was conducted with the Director of Nursing (DON) on 5/22/2025 at 1:25 PM. The DON stated that all staff are responsible for all the residents. The DON indicated the facility census was small enough that it would not take long to get to know the residents. The DON stated the staff should be aware of which residents were at risk for a fall and assist in monitoring those residents. The DON revealed the fall Resident #1 sustained could have been prevented if Nurse #1 had intervened when she saw Resident #1 starting to stand as she walked by and if NA #1 had been paying attention instead of resting in the dining room. The DON thought this was an isolated incident caused by the two specific staff members because the staff in the facility are aware of working together to care for the residents.

2. Resident #2 was admitted to the facility on 8/16/2023 and had cumulative diagnoses, some of which included seizures, cerebral vascular accident, and vascular dementia.

Review of the resident profile in the electronic medical record revealed Resident #2 was at high risk for falls.

Documentation on a care plan for Resident #2

noted deficiencies will be corrected immediately.

The Inter-Disciplinary Team will observe that fall interventions (to include interventions to supervise in accordance with the plan of care) are in place on all shifts daily for two weeks. Any noted deficiencies will be corrected immediately.

The Inter-Disciplinary Team will then observe that fall interventions (to include interventions to supervise in accordance with the plan of care) are in place on all shifts twice a week for four weeks. Any noted deficiencies will be corrected immediately.

The Inter-Disciplinary Team will then observe that fall interventions (to include interventions to supervise in accordance with the plan of care) are in place on all shifts weekly for four weeks. Any noted deficiencies will be corrected immediately.

The Inter-Disciplinary Team will then observe that fall interventions (to include interventions to supervise in accordance with the plan of care) are in place on all shifts monthly for four months. Any noted deficiencies will be corrected immediately.

The Director of Health Services will report the findings to the Quality Assurance and Process Improvement Committee monthly for four months.

The Quality Assurance and Process Improvement Committee will determine if

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F 689	Continued From page 9 revealed a problem area dated as initiated on 8/16/2023 for a risk for falls due to a cerebral vascular accident, a history of falls, and generalized weakness. One of the interventions initiated on 12/24/2024 included, "Resident noncompliant with interventions to use the call bell for assistance with transfers. Staff will continue to offer assistance with use of toilet." Documentation on an annual Minimum Data Set assessment dated 5/5/2025 coded Resident #2 as having moderately impaired cognition. Resident #2 was also coded as requiring substantial assistance with going from sitting to standing position. Resident #2 was coded as always incontinent of bowel and bladder. Resident #2 was coded as having fallen since his last assessment. Resident #2 was coded as able to independently use a manual wheelchair and as receiving antiplatelet medication. NA #3 was interviewed on 5/22/2025 at 3:09 PM. NA #3 provided the following information. NA #3 had been employed at the facility since February 2025, and she had once or twice been assigned to care for Resident #2. Resident #2 was steady with transfers and could bear his weight with assistance to straighten up from a sitting position. It was unknown if Resident #2 could use a call bell because he was always out of bed and away from the call light. On 5/10/2025 in the morning, Resident #2 vocalized to NA #3 that he wanted to go to the toilet. This was the first occasion NA #3 assisted Resident #2 to the toilet. NA #3 wheeled Resident #2 into the bathroom, locked his wheelchair, and helped him transfer to the toilet. NA #3 then instructed Resident #2 to use the call bell to let her know when he was finished and she would assist him back in the wheelchair. NA #3	F 689	sustained compliance has been achieved and if ongoing monitoring is needed. DATE OF COMPLIANCE: 6/16/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 05/22/2025

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F 689	Continued From page 10	F 689		

went into the hallway and stayed within view of the call light outside the door of Resident #2. NA #3 went back to check on Resident #2 approximately 10 minutes later and she found him on the floor in the bathroom. Resident #2 had attempted to transfer himself and had not pulled the call light to alert her he was finished. NA #3 then alerted Nurse #3 that Resident #2 had fallen. NA #3 explained that she figured out the care needs of the residents as she assisted them or she would ask a coworker.

Documentation in a nursing progress note dated 5/10/2025 at 4:51 PM written by Nurse #3 revealed Nurse Aide (NA) #3 reported to Nurse #3 that Resident #2 was on the floor in the bathroom. The documentation in the progress note further revealed NA #3 told Nurse #3 that Resident #2 was taken to the bathroom and was advised to ring bell when finished but, Resident #2 did not ring the call bell and attempted to transfer into his wheelchair falling to the floor. The progress note also indicated Nurse #3 educated NA #3 to monitor Resident #2 while he was using the bathroom. NA #3 verbalized her understanding.

Nurse #3 was interviewed on 5/22/2025 at 4:36 PM. Nurse #3 revealed the following information. Nurse #3 had been employed at the facility for two months. Nurse #3 revealed she had documented her actions in the electronic medical record on 5/10/2025 when Resident #2 fell. Resident #2 was able to follow simple commands and that was the first occasion that Nurse #3 had known Resident #2 to request to be taken to the bathroom. Nurse #3 assessed Resident #2 after the fall in the bathroom. Resident #2 sustained a small laceration on his head that was not

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F 689	Continued From page 11	F 689		

bleeding and did not require wound care. Nurse #3 confirmed she educated NA #3 not to leave Resident #2 unattended in the bathroom.

The Director of Nursing (DON) was interviewed on 5/22/2025 at 3:44 PM. The DON revealed that NA #2 was a new employee who helped care for residents all over the building. The DON indicated that NA #2 would need to be educated that the care needs of the residents could be found on the resident profile in the electronic medical record. The DON felt Resident #2 was very impulsive and NA #3 should have stayed with Resident #2 instead of instructing him to use the call light. The DON stated that NA #3 was educated not to leave Resident #2 in the bathroom.