STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255308	A. BUILDING _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CTR INC	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI), MS #22402 and MS #22664, at the facility, from 8/31/23 through 9/8/23. Both MS #22402 and MS #22664 were investigated related to neglect. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F580, F655, and F689. The facility held a license for 59 beds, with a census of 49.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		10/6/23

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

Electronically Signed | 09/22/2023

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to notify the physician of blood glucose readings of 60 or below for one (1) of two (2) residents reviewed for glucose readings. Resident #4. Findings Include: Record review of the facility's policy, "Hypoglycemia Management" policy, dated 3/27/23, revealed, " ...It is the policy of this facility to ensure effective management of a resident who experiences a hypoglycemic episode	F 580	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action taken for the resident found to be affected include: • The Director of Nursing (DON)	

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F 580	Continued From page 2 ...Compliance Guidelines ...5. If the blood glucose reading is 60 mg/dL(milligrams/deciliter) or below, the nurse will utilize the hypoglycemia protocol as per the practitioner's orders, with follow up blood glucose as indicated, and notify the practitioner of the results as ordered ..." Record review of the "Face Sheet" revealed the facility admitted Resident #4 on 8/5/23 with a diagnoses that included Type 2 Diabetes Mellitus. Record review of the "Physician Orders" for the month of August 2023 revealed there were no physician orders for routine accu-checks after 8/16/23. Record review of the "Therapeutic Protocols" revealed there were standing Physician Orders for Hypoglycemia as follows: Obtain accu-check, if Blood Glucose (BG) less than 60 and resident is able to swallow, give four (4) ounces of milk/juice or one (1) pack of Insta Glucose. If resident is unable to swallow, give Glucagon one (1) Milligram (MG) Intramuscular (IM). Recheck accu-check in 15 minutes (mins). Notify Medical Doctor (MD)/Nurse Practitioner (NP) if BG is still less than 60. Record review of the "Departmental Notes" revealed there was a "Nurse Notes", completed by Licensed Practical Nurse (LPN) #3, dated 8/26/23 at 3:15 AM, for " ...glucose reading was 49 ... After about 30 minutes I rechecked his glucose and his reading at that time had increased to 72." Record review of the "Departmental Notes" revealed, on 8/31/23 at 6:11 AM, " ...Glucose this am was 55 ... Rechecked @ 0600 and only	F 580	notified the nurse practitioner of resident #4 blood glucose readings of 55 and 56 from August 31, 2023 on September 8, 2023. • An in-service was conducted by the DON on September 8, 2023, with Nursing Staff on hypoglycemic protocol, using therapeutic protocol, writing a physician order, and notifying the provider or practitioner and notifying resident or resident representative of blood glucose of 60 and below as well as any signs or symptoms and on Notification of Changes. 2. Identification of other residents having the potential to be affected was accomplished by: • The facility determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: • All Nurses were in-serviced regarding the facility policy on Resident Rights, 24-hour Report, Documentation, Physician Orders, Therapeutic Protocol, Customer Service, Care Plans, Notification of Changes, Survey Readiness, Abuse and Neglect, Hypoglycemia on September 14, 2023, and September 18, 2023. • Quality Assurance Performance Improvement (QAPI) Plan implemented for Notification of Changes, Therapeutic Protocol, Hypoglycemia, on September 11, 2023. • Face Sheets of all residents have been updated with current resident	

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F 580	Continued From page 3	F 580		

increased to 56. 0600 this am A tube of Instaglucose was given and will inform oncoming nurse to recheck in about 30 minutes ..." Signed by: LPN #3

On 9/7/23 at 1:00 PM, an interview with the NP confirmed that when a resident has a BG of less than 60, she expected the staff to follow the therapeutic protocol, but to notify her when they use the protocol. She conveyed she was not notified of Resident #4's BG results of less than 60 at any time.

On 9/8/23 at 12:28 PM, an interview with the Director of Nurses (DON), she revealed that on 8/26/23 and 8/31/23, Resident #4 had a BG result of less than 60 and although the staff followed the therapeutic protocols, or standing orders, a Physician's Order should have been written and the physician should have been notified. The DON stated that she expected staff to write a Physician's Order with the date and time and follow through with the order onto the medical record, including the Medication Administration Record (MAR) when they are utilizing therapeutic protocols. She confirmed the staff did not write orders for the therapeutic protocol or notify the physician.

On 9/8/23 at 12:30 PM, an interview with License Practical Nurse (LPN) #3 revealed she used the Therapeutic Orders for Resident #4 when his blood sugar was less than 60 on 8/26/23 and 8/31/23. She explained that she did not get a repeat BG within 15 minutes as per the orders and did not notify the physician on 8/31/23 when his repeat BG reading was less than 60. She confirmed that she did not write a Physician's Order for the Therapeutic Protocol for

representative information, completed September 21, 2023 by the Administrator and Assistant Administrator.

4. How the corrective actions will be monitored to ensure the practice will not recur:

- The DON, Assistant Director of Nursing (ADON), and Resident Care Manager (RCM) will complete weekly audits for 12 consecutive weeks starting September 11, 2023 of all residents with the diagnosis of Diabetes to ensure that physician/practitioner orders are followed for monitoring blood glucose and notifying the physician/practitioner of blood glucose levels of 60 or below. This will be measured by checking the nurse's notes and the Medication Administration record (MAR) to ensure the physician was notified.
- The DON, ADON and RCM will complete weekly audits for 12 consecutive weeks beginning on September 11, 2023, of residents who have required use of therapeutic protocols to ensure the order was written in the resident's medical record and the provider and resident/ resident representative was notified of changes in condition.
- Validation checklist will be reviewed by the Administrator weekly beginning September 11, 2023 and go on for 12 weeks.
- The Pharmacy Consultant will conduct audits of blood glucose levels during the next three monthly visits beginning in October 2023.
- Audit records will be reviewed by the Quality Assurance Committee on October

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F 580	Continued From page 4 Hypoglycemia. On 9/8/23 at 1:44 PM, an interview with the facility's Pharmacist revealed that if a resident had a BG result of less than 60, the nurse should notify the physician.	F 580	6, 2023 and the following three months or until such time consistent substantial compliance has been achieved as determined by the committee.	
F 655 SS=G	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		10/6/23

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F 655	Continued From page 5 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to implement the baseline care plan interventions related to the equipment required for ambulating a resident and the assistance required for toileting for one (1) of four (4) residents care plans reviewed. Resident #1. Findings Include: A record review of the facility's "Baseline Care Plan" policy, dated 2/16/23, revealed, " ...The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care ...Policy Explanation and Compliance Guidelines ...2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders ...b. interventions shall be initiated that address the resident's current needs including i. Any health and safety	F 655	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan correction is submitted as the facility's credible allegation of compliance. 1. Immediate action taken for the resident found to have been affected include: Director of Nursing (DON), Assistant Director of Nursing (ADON) and Resident Care Manager (RCM) in-serviced Care Plan Nurse on Baseline Care plans on September 11, 2023. Baseline Care plans were updated on September 11, 2023 by the Care Plan Nurse to include equipment, and assistance required for ambulation/toileting residents. Certified Nursing Assistant CNA#1 was re-educated on Baseline Care plans.	

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F 655	Continued From page 6 concerns to prevent ...injury, such as ...fall ..." A record review of the "Baseline Care Plan", dated 8/11/23, revealed Resident #1 required the assistance of one staff member for walking and toileting and indicated the equipment to be used as a wheelchair or Front Wheeled Walker (FWW). A record review of the "PT (Physical Therapy) & Plan of Treatment", dated 8/11/23, revealed, " ...Prior Equipment Prior to Onset: Cane, rollator, tub chair and grab bars ...Functional Mobility Assessment ...Resident uses a wheelchair? = Yes ..." During an interview, on 8/31/23 at 11:40 AM, CNA #1 confirmed that on 8/13/23 she assisted Resident #1 to the restroom and did not use a walker or wheelchair. She explained that he ambulated himself but held on to her arm for stability and he had a slow, unsteady gait while walking to the toilet. She stated that she gave him the call bell and advised him to call when he needed assistance back to bed. She then closed the bathroom door for privacy and left the resident's room. CNA #1 explained that after approximately five (5) minutes, his call light came on and she returned to the resident's room. She opened the bathroom door and Resident #1 was sitting on the toilet. He stated that he had fallen off the toilet and had gotten himself back onto the toilet without assistance. He complained of left leg pain at that time. CNA #1 said that the staff reviewed the baseline care plan on the kiosk to determine how much assistance is required to safely ambulate and toilet residents. She confirmed that she did not review the kiosk because a night shift CNA had reported to her	F 655	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All interdisciplinary care plan team members responsible for writing baseline care plans were in-serviced on the facility policy and procedure for developing Baseline Care plans by the DON. All nursing staff was in-serviced on implementation of the baseline care plan on September 14 and September 16, 2023 by the DON and ADON. 4. How the corrective actions will be monitored to ensure the practice will not recur: The DON/ADON will complete weekly audits of baseline care plans for twelve consecutive weeks beginning September 11, 2023. Audits will be completed to ensure that baseline care plan summaries are being provided to residents and that a copy has been placed in the medical record. Audit records will be reviewed by the Quality Assurance Committee on October 6, 2023 and the following three months, until such time consistent substantial compliance has been achieved as determined by the committee.	

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that the resident could ambulate without a walker or wheelchair.

Record review of "Departmental Notes, Category Nurses Notes" dated 8/13/23 at 9:41 AM, revealed "...Resident was sent out to (Proper Name of Local Emergency Room) (ER) via (Proper Name of Ambulance Service)...ER nurse called back at 09:40 stating resident's hip was out of place..."

During an interview on 8/31/23 at 12:57 PM, with the Physical Therapist (PT), he stated Resident #1 needed the assistance of one staff member for toileting, transferring and ambulating and recommended the use of a wheelchair or walker for safety. He confirmed that he expected the facility staff to follow his recommendations.

During an interview on 8/31/23 at 1:06 PM, with the Physical Therapy Assistant (PTA), she confirmed that she reviewed the Occupational Therapy and Physical Therapy recommendations and completed the base care plan to indicate the level of assistance required with ambulation, transfers, and mobility. The PTA recommended that Resident #1 have assistance from one person with either a walker or wheelchair for ambulation. She confirmed she expected that if a wheelchair or walker was recommended, then the staff should follow the care plan for the resident's safety.

On 8/31/23 at 1:23 PM, an interview with the Director of Nurses (DON) revealed that it was her expectation that the nursing staff follow the care plans of all residents because the care plans provided a detailed and effective personalized outline of the care for the residents.

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F 655	Continued From page 8 On 8/31/23 at 2:21 PM, an interview with the Care Plan Nurse confirmed that staff should follow the care plans for residents' dignity, integrity, and safety. He reported that care plans were developed for individualized care and to ensure consistency in the nursing care of the resident, which helped improve services. He added that he expected all nursing staff in the facility to follow care plans for the residents. A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 8/11/23 with diagnoses including Left Femur Fracture, Presence of Left Artificial Hip Joint, Hemiplegia following Cerebral Infarction affecting Left Side, and History of Falling.	F 655		
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 §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 interviews, record reviews, and facility policy review, the facility failed to use the appropriate equipment during ambulation and provide adequate supervision to prevent an injury for one (1) of three (3) sampled residents, as evidenced by a resident who had a fall, sustained a left hip dislocation, and required hospitalization after he was ambulated without a walker or	F 689	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of	10/6/23

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wheelchair and left unsupervised on the toilet. (Resident #1)

Findings include:

A review of the facility policy, "Incidents and Accidents", dated 5/13/23, revealed " ...It is the policy of this facility for staff to report, investigate and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident ..."

A record review of the facility-reported investigation, dated 8/16/23, revealed, " ...Summary: On 8/13/23 (Proper name of Resident #1) was assisted to the toilet by a CNA (Certified Nurse Aide). CNA left room and returned when his call light came on again. CNA went to his restroom where (Proper name of Resident #1) was seated on the toilet. (Proper name of Resident #1) stated that he fell off the toilet..."

A record review of the "Resident Incident Report" revealed the "Incident Type" as "Fall/Unobserved" and the "Date/Time" was listed as 8/13/23 08:00 AM. Further review revealed that the "Narrative of incident and description of injuries" indicated "Resident stated after CNA put him on the toilet, he fell and had put himself back on the toilet before CNA returned to room". "Resident Condition at Time of Incident" revealed "Mobility" as "WC (Wheelchair) - non-motorized". "Medical risk factors" indicated "Fall History" and "Fracture/Amputee" and "Activity at time" indicated "To/frm (from) bathrm (bathroom)-alone ..."

A record review of the "Diagnostic Imaging"

correction. This plan correction is submitted as the facility's credible allegation of compliance.

1. Immediate action(s) taken for the resident found to have been affected include:

• The Director of Nursing (DON) and Assistant Director of Nursing (ADON) met with Certified Nursing Assistant (CNA) #1, Registered Nurse (RN) #2 and Licensed Practical Nurse (LPN) #1 on September 8, 2023, and in-serviced on review of baseline care plan of residents to determine how much assistance is required, supervision and if any medical equipment is required. DON met with CNA#1, RN#2, and LPN#1 on September 8, 2023, and in-serviced on safety, and incidents and accidents, supervision, and devices.

2. Identification of other residents having the potential to be affected was accomplished.

• The facility has determined that all residents have the potential to be affected.

3. Actions taken/systems put into place to reduce the risk for future occurrences include:

• All LPN's, RN's and CNA's were in-serviced by the DON, ADON and Administrator on the facility policy for Accidents and Supervision and Falls on September 14 and September 18, 2023.

• On September 11, 2023, all resident falls/accidents were reviewed by the nursing management team to ensure appropriate implementation of safety interventions including updating the plan

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F 689	Continued From page 10 report, dated 8/13/23, from a local acute care hospital revealed, "History: Hip pain status post fall, with a history of recent surgery" and "Impression: Superior dislocation of a left hip arthroplasty, without discrete or displaced fracture ..." A record review of "Departmental Notes", for Resident #1, dated 8/11/23 at 12:32 PM, revealed a "Nurse Notes" that indicated, " ...Weakness noted to BLE (Bilateral Lower Extremities) mobility via wheelchair ..." A record review of "Departmental Notes", for Resident #1, dated 8/12/23 at 11:24 AM, revealed a "Nurse Notes" that indicated, " ...Transfer x 1. Needs assist with ADL's (Activities of Daily Living) ..." Record review of "Departmental Notes, Category Nurses Notes" dated 8/13/23 at 9:41 AM, revealed "...Resident was sent out to (Proper Name of Local Emergency Room) (ER) via (Proper Name of Ambulance Service)...ER nurse called back at 09:40 stating resident's hip was out of place..." A record review of the "PT (Physical Therapy) & Plan of Treatment", dated 8/11/23, revealed, " ...Patient Referral and History Current Referral Reason for referral/current illness: Patient is a 90 yo (year old) male who suffered a fall in his garden on 7/23/23 resulting in a L (Left) displaced femoral fx(fracture) ...Medical Factors Precautions: Falls risk ...Fall Risk Assessment History of Falls Has Patient fallen in past year? = Yes How many times? = 6 ...Steadiness Does Patient feel unsteady when standing? = Yes Does Patient feel unsteady when walking? = Yes	F 689	of care. This will continue for 12 weeks. • On September 11, 2023, all therapy recommendations are reviewed Monday through Friday by nursing management team, equipment is ordered and available to the resident, and care plans updated. This will be on going. • The DON, ADON, and Resident Care Manager (RCM) reviewed the Minimum Data Set (MDS)Assessments on September 11, 2023 for all residents who have been identified as having a potential risk for falls and fall and safety risk assessments were checked for completeness and interventions currently in place are appropriate. DON, ADON will continue to review these weekly for 12 weeks. 4. How the corrective action will be monitored to ensure the practice will not recur: • The DON/ADON/RCM will complete weekly audits beginning September 11,2023 for 12 consecutive weeks of monitoring staff to make sure they are using the proper equipment while transferring residents. This will be monitored by the DON, ADON or RCM two times a week for 5 residents in the building for 12 weeks. • Audit records will be reviewed by the Quality Assurance Committee on October 6, 2023 and the following three months until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255308	A. BUILDING _____ B. WING _____	C 09/08/2023

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F 689	Continued From page 11 ...Does Patient worry about falling? = Yes ...Functional Mobility Assessment ...Resident uses a wheelchair? = Yes ...Reason for Therapy Clinical Impressions/Reason for Skilled Services: Skilled services required to address deficits in strength, endurance and balance affecting safety with functional mobility ..." Record review of the "Nurse Data Collection and Screening" document for Resident #1, dated 8/11/23, revealed, "Risk: Fall Risk Form ...History of Falls 3 or more falls in past 3 months ..." On 8/31/23 at 11:40 AM, in an interview with CNA #1, she confirmed that on 8/13/23, before breakfast trays were delivered, she assisted Resident #1 without his walker to the restroom. She said that he ambulated himself but held on to her arm for stability and he had a slow, unsteady gait while walking to the toilet. She stated that she gave him the call bell and advised him to call when he needed assistance back to bed. She then closed the bathroom door for privacy and left the resident's room. CNA #1 explained that after approximately five (5) minutes, his call light came on and she returned to the resident's room. She opened the bathroom door and Resident #1 was sitting on the toilet. He stated that he had fallen off the toilet and had gotten himself back onto the toilet without assistance. He complained of left leg pain at that time. CNA #1 said that the staff is supposed to review the baseline care plan on the kiosk to determine how much assistance is required to safely ambulate and toilet residents. She confirmed that she did not review the kiosk because a night shift CNA had reported to her that the resident could ambulate without a walker or wheelchair.	F 689		

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F 689	Continued From page 12	F 689		

On 8/31/23 at 12:57 PM, an interview with the Physical Therapist (PT) revealed that Resident #1 needed the assistance of one staff member for toileting, transferring and ambulating. The PT also recommended the use of a wheelchair or walker for safety and confirmed that he expected the facility staff to follow his recommendations.

On 8/31/23 at 1:06 PM, an interview with the Physical Therapy Assistant (PTA) confirmed that she reviewed the Occupational Therapy and Physical Therapy recommendations and completed the base care plan to indicate the level of assistance required with ambulation, transfers, and mobility. The PTA recommended that Resident #1 have assistance from one person with either a walker or wheelchair for ambulation.

On 9/1/23 at 11:28 AM, during an interview with the Director of Nurses (DON), she stated that Resident #1 was assisted without his walker to the bathroom by CNA #1 and he had been left alone in the bathroom. The resident reported that he had fallen and gotten himself back up to the toilet without any assistance. She revealed that according to CNA #1, the resident requested privacy and she felt she could leave him alone in the bathroom. The DON confirmed that CNA #1 should have used a walker or wheelchair as per the care plan to assist Resident #1 with walking to the restroom.

On 9/1/23 at 11:48 AM, an interview with the Administrator revealed that on 8/13/23, Resident #1 was assisted to the toilet by CNA #1 and the resident stated that he had fallen and gotten back onto the toilet within approximately three (3) minutes.

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On 9/8/23 at 2:00 PM, in an interview with CNA #1, she confirmed that even though Resident #1 was a new admission, had a slow and unsteady gait, a history of falls, and a diagnosis of Hemiplegia, she thought that because he had asked for privacy and he was alert and oriented, she could leave him unsupervised while on the toilet, and walk away from the resident's room. CNA #1 also confirmed because Resident #1 reported that he had fallen and had left leg pain, she used a wheelchair and transferred the resident from the toilet to the wheelchair and assisted him to his bed.

On 9/8/23 at 2:30 PM, an interview with the DON revealed that she expected new residents who required assistance with toileting to be supervised and not left alone. She confirmed that CNA #1 should not have left the resident in his bathroom alone and unsupervised.

On 9/8/23 at 4:00 PM, during an interview with Registered Nurse (RN) #2 revealed, that on 8/13/23, LPN #1 informed her that Resident #1 had reported that he had fallen off the toilet, but that he put himself back on the toilet without any assistance. RN #2 said that Resident #1 was back in his bed at that time and complained of left hip pain. She described Resident #1 as "weak and confused." RN #2 notified the Nurse Practitioner (NP) of the allegation of a fall and the resident's pain and the NP gave an order to send Resident #1 to the local Emergency Department (ED) for evaluation and treatment.

A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 8/11/23 with diagnoses including Left Femur Fracture, Presence of Left Artificial Hip Joint, Hemiplegia

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F 689	Continued From page 14 following Cerebral Infarction affecting Left Side, and History of Falling. A record review of the Discharge Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 8/13/23 revealed Resident #1 was admitted by the facility on 8/11/23 from an inpatient rehabilitation facility. He was discharged to an acute hospital on 8/13/23, which was two (2) days after his admission to the facility.	F 689		