Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4047	A. BUILDING: _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT RIO RANCHO	1000 RIVERVIEW DRIVE SE RIO RANCHO, NM 87124

(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) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on [redacted]23 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities for Adults. Complaint Intake ID #[redacted] was investigated with deficiencies cited. Complaint Intake ID #[redacted] (associated with NM67215) was investigated with deficiencies cited. Complaint Intake ID #[redacted] (associated with NM67215) was investigated with deficiencies cited. Complaint Intake ID [redacted] was investigated with no deficiencies cited. Complaint Intake ID [redacted] was investigated with deficiencies cited. Complaint Intake ID [redacted] was investigated with no deficiencies cited. Complaint Intake ID [redacted] was investigated with deficiencies cited. Complaint Intake ID [redacted] was investigated with no deficiencies cited. Census: 81	A 000		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies.	A 026	A-026 – ISP's will be updated and reviewed in accordance with NMAC 7.8.2.26. Change of condition will be captured through the practice of our Daily Standup meetings that occur Mon-Friday and will include a dedicated Clinical Standup meeting in which the ED, Director of Health Services, Resident Care Coordinators and Arbor Administrator review the dashboards of the current EHR, the communities EMR and Care Planning software. Upon notice of a change of condition, a member of the team will update the residents ISP.	2/12/2024

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tara Blount — Interim Director — 2-1-24

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A 026	Continued From page 1 (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (2-3) Based on record review and interview, the facility failed to ensure for [redacted] residents whose Individual Service Plans (ISPs)	A 026		

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A 026	Continued From page 2 were reviewed for compliance, that they were updated when there was a significant change in the resident's health status. This deficient practice could likely result in the residents to be at risk of not receiving appropriate care/services if the ISP's are not updated to reflect the level of assistance the resident requires do to a change in health status. The findings are: A. Record review of R #1's ISP dated [redacted], revealed that it was not updated to reflect that R #1 was treated at the hospital on [redacted], for a [redacted] B. On 10/25/23 at 2:30 pm, during an interview, the Wellness Director confirmed that R #1's ISPs dated [redacted] was not updated to address a change in condition for the injury to the left [redacted]	A 026		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted.	A 032	A-032 – Reporting of Abuse, Neglect and Exploitation will be reviewed again at the scheduled All Staff meeting for February 2024. The Executive Director, Director of Health Services, Resident Care Coordinators and Arbor Administrator will report any concerns of abuse, mistreatment, neglect, or exploitation in a manner that is compliant with NMAC 7.1.13.	2/12/2024

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B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following:
(1) a narrative description of the incident;
(2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and
(3) plans for further actions in response to the incident.
[7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.32 A (1) and B

7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS

Refer to 7.1.13.7 W. and 8 B. (2)

W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor 's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation.

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A 032	Continued From page 4 B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure for 2 (R #'s 2 and 4) of 4 (R #'s 1-4) residents whose Internal Incident Reports were reviewed for compliance that: 1. The facility reported incidents of unusual occurrence which has, or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. 2. A copy of the Investigation/Follow-Up Report was submitted to the Licensing Authority within five (5) business days from the date the incident occurred. These deficient practices could likely result in the residents to be at risk of harm, injury, and/or death, if incidents occur and there is no oversight by the Licensing Authority.	A 032		

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A 032	Continued From page 5	A 032		

The findings are:

Finding for R #2

A. Record review of Complaint Intake NM [redacted] received on [redacted]23, revealed the Complainant reported:

1. Sometime during mid-[redacted] 2022, [redacted] (Complainant) showed up to work at [Name of Assisted Living Facility next door (not same company)] at approximately 8:00 am; there were police around the area. R #2 from this Assisted Living Facility was found sleeping in a vehicle belonging to at resident living in [Name of the Assisted Living Facility next door].

2. R #2 had a big bump on [redacted] head, did not have shoes on, had wrapped [redacted] in blankets tha[redacted] R #2) found inside the vehicle, and had been in the vehicle sleeping since 2:00 am.

3. About two (2) weeks after the incident, R #2's [redacted] showed up at ALF #2 to give back the blankets that R #2 was found in and stated that the resident was still in the hospital due to the incident that occurred in December. [redacted] did not [redacted] was going to make it through the incident.

B. On [redacted]23 at 10:00 am, during an interview, the Complainant confirmed:

1. When she (Complainant) arrived at work (could not recall the exact date) she saw multiple police in the parking lot of [name of Assisted Living next door]. She was told that a resident (R #2) had eloped from the [redacted] [redacted]f this Assisted Living Facility and was found in a vehicle that belonged to one of the residents at the [redacted] next door.

2. R #2 found blankets in the car and was asleep there all night, and from what she heard, [redacted] had been there from around 2:00 am in the

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morning.

3. R #2 had a big bump on [redacted] head, and the Complainant thinks that [redacted] had fallen, it was cold outside, did not have any shoes or socks on and was taken to the hospital.

C. On [redacted]23 at 8:57 am, during an interview with the prior Memory Care Unit (MCU) Director she confirmed:

1. The resident (R #2) left the facility's [redacted] around 4:00 am, according to (unknown) Direct Care Staff (DCS). There had been a fire drill the day before, the alarms on the doors in the MCU were not reset, and when the resident left the facility, the alarm did not go off to alert the staff.

2. R #2 left the facility's [redacted] by walking out of the back exit door and into the backyard; But because the gate was not locked, the resident was able to leave the secured [redacted] patio.

3. R #2 was known to be an elopement risk when [redacted] moved into the facility and had a history of watching the exit doors.

4. When staff noticed (unknown time) R #2 was missing, they notified management (at an unknown time) and began searching for the resident; The police were called, and they activated a silver alert.

5. Prior MCU Director found R #2 in a vehicle at the facility next door and immediately alerted the police.

6. R #2 did have a fall; there was a cut on [redacted], and [redacted] (R #2) was sent out immediately to the hospital; The [redacted] Director could not recall what hospital [redacted] was sent to.

D. Record review of the Facility's Investigation/Follow-Up Report dated 01/03/23 revealed it was not submitted to the Licensing Authority within five (5) business days from the date the incident occurred on [redacted]

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E. On [redacted]/23 at 2:32 pm, during an interview, the Wellness Director (WD) confirmed the Investigation/Follow-Up Report [redacted]/23 was not submitted to the Licensing Authority within five (5) business days from the date of R #2 incident. Findings for R #4

F. Record review of Complaint Intake NM [redacted] received on [redacted]/23 revealed on [redacted] at 11:00 pm, R #4 had a fall and did not get help (was not checked on by staff for injuries or given assistance) until 6:30 am on [redacted].

G. Record review of R #4's resident file revealed:

1. An Internal Incident Report dated [redacted]/23 at 2:03 pm was created by DCS #11.
2. The Internal Incident Report stated DCS #s 6 and 10 picked up R #4 off the floor into [redacted] (no time noted).
3. No injuries were observed at the time of the incident.
4. There were no witnesses to the incident.
5. The section labeled "investigation" of the incident report dated [redacted] stated R #4 fell without injury and was positive for [redacted] with weakness.
6. Intervention portion of the incident report dated [redacted] stated staff to check hourly and push fluids.

H. On [redacted]23 at 1:18 pm, during an interview, the Executive Director (ED) confirmed:

1. He reviewed the videos from the camera in R #4's [redacted] that showed R #4 falling out of bed at 11:11 pm and being picked up the following morning at 6:16 am on [redacted].
2. He was informed of the incident by R #3's family.

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A 032	Continued From page 8 I. Record request for a Facility Self Report to the Licensing Authority revealed the record did not contain a report submitted to the Licensing Authority and a Follow-Up Report (FUR) was not submitted within five (5) business days from the date the incident occurred. J. On [redacted]23 at 2:32 pm, during an interview, the Wellness Director (WD) stated she believed the facility reported the incident to the Licensing Authority, but could not locate a copy of it or the facility's FUR.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or	A 033	A-033 – If a resident's ISP denotes the need for 2-3 hr safety checks, there is an associated task tied to the ISP, which will be documented in the Point of Care (POC) system through current EHR. The RCC's, Arbor Administrator, Executive Director and Director of Health Services will review the POC compliance through the Clinical Standup as part of the Daily Standup meetings that occur Monday through Friday. If deficiencies are noted, the appropriate department head will take corrective action which will include but not be limited to, coaching, re-education and as appropriate, corrective action as outlined by the community's policies and procedures regarding corrective action with team members.	2/12/2024

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(9) the ombudsman.
C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program.
D. To protect resident rights, the facility shall:
(1) treat all residents with courtesy, respect, dignity and compassion;
(2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality;
(3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes;
(4) provide residents with a safe and sanitary living environment;
(5) provide humane care for all residents;
(6) provide the right to privacy, including privacy during medical examinations, consultations and treatment;
(7) protect the confidentiality of the resident ' s medical record;
(8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room;
(9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations;
(10) prohibit the use of any and all physical and chemical restraints;
(11) ensure that residents:
(a) are free from physical and emotional abuse neglect and misappropriation/or exploitation;

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A 033	Continued From page 10 (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management;	A 033		

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A 033	Continued From page 11 (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (4) (11) (a) (i) Based on record review, and interview, the facility failed to ensure for [redacted] residents: 1. Were provided with with a safe environment. 2. Were free from neglect and were checked on during sleeping hours. 3. Legal representatives were informed when residents who reside in the Memory Care Unit (MCU) elope and able to participate in medical treatment decisions. These deficient practices could likely affect the safety and wellness of the residents if: 1. Residents who reside in the MCU are not being monitored to prevent elopement from the facility. 2. Are not getting care and services needed . 3. Fall during the night and are not checked for injuries. The findings are:	A 033		

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Findings for R #1:

A. Record review of Complaint Intake NM[redacted] received on [redacted]/23 revealed the Complainant reported on [redacted]/23:

1. R #1 eloped from the facility and was missing for at least two (2) hours. The facility staff did not notice [redacted] (R #1) was missing until [redacted] arrived to pick [redacted] up. R #1 was later found down the road from the facility at a nearby cemetery and had soiled [redacted]

2. R #1's Power of Attorney (POA) was not notified of the elopement. The Executive Director of the facility was defensive and reported that R #1 was only gone for thirty (30) minutes and had crawled out of a window.

B. Record review of Facility Self-Report # [redacted] Same incident as Intake NM [redacted] received on [redacted]23 revealed the complainant reported:

1. On [redacted]23 at 12:00 pm, R #1's [redacted] visited and was looking for R #1. The facility staff and R #1's [redacted] could not find [redacted] inside the building, then proceeded to look outside, and started looking at surrounding areas at 2:50 pm.

2. R #1 was found close by at the cemetery at 3:36 pm, put in the car, and taken back to the facility, and [redacted] vitals (Vital signs are a group of the four to six most crucial medical signs that indicate the status of the body's vital functions) were checked.

3. The initial actions taken by the facility to assure health and safety state, "Facility will ensure the main door to [redacted] is closed before walking away.

C. Record review of an Internal Incident Report for R #1 dated [redacted] (a different date than the

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	4047	A. BUILDING: _____ B. WING _____	C 10/26/2023

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AVAMERE AT RIO RANCHO	1000 RIVERVIEW DRIVE SE RIO RANCHO, NM 87124

(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) COMPLETE DATE
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one listed on the Facility Self-Report) at 3:44 pm revealed:

1. R #1's [redacted] came to visit the resident; when looking for R #1 they could not find [redacted] inside the building and went to look outside, and then started looking at close surrounding areas around 2:50 pm, and found the resident close by at the cemetery at 3:36 pm.

2. A few of the Direct Care Staff (DCS) drove around the surrounding areas to see where R #1 could be walking and found [redacted] at 3:36 pm, got R #1 in the car, drove [redacted] back to the facility, and looked for any visible injuries. No injuries were observed at the time of the incident and post-incident.

3. It was believed that R #1 was able to grab the door as someone walked in or out of the [redacted] and everyone who went in and out of the [redacted] ensured the door was closed behind them.

4. The Maintenance Director did thorough walk around to ensure latches, locks, and maglocks were all functioning properly and checked the windows that open into unsecured areas have proper lockouts in place.

D. On [redacted] 23 at 10:23 am, during an interview, with R #1's [redacted] confirmed:

1. On the date of the incident, [redacted] received a call from R #1's [redacted] advising [redacted] that R #1 was missing from the facility and staff could not find [redacted] R #1's [redacted] then handed the phone to a nearby DCS (name unknown) and requested to speak with the Executive Director (ED). R #1's [redacted] was given the phone number to contact the ED, but never received an answer or a call back.

2. R #1's [redacted] is R #1's emergency contact/POA:

a. [redacted] never received a call from the facility advising that R #1 was missing from the facility.

b. Was never asked by the facility if [redacted]

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wanted R #1 to be sent out or evaluated by Emergency Medical Services (EMS) following the incident.

c. Wanted R #1 to be sent out to the hospital for a medical evaluation.

3. When [redacted] made contact with the ED days (unknown number of days) after the incident, the ED refused to provide a copy of their internal investigation and told him that R #1 had crawled out of a window.

E. On [redacted]23 at 12:39 pm, during an interview, the Wellness Director confirmed;

1. During the incident, the POA was not directly notified by the facility because R #1's [redacted] was already at the facility during the incident and was aware of what happened.

2. R #1's [redacted] later got involved and ended up discharging R #1 from the facility because of the incident.

3. After R #1 was found, she conducted a medical evaluation on R #1.

4. The family declined to send R #1 to the hospital, but she (Wellness Director) confirmed that this communication was not documented in R #1's progress notes or the incident report.

F. On [redacted]/23 at 1:10 pm, during an interview, the ED confirmed:

1. R #1 was not sent out to the hospital following the incident, and was not sure if there was an option to have [redacted] sent out for evaluation.

2. R #1's [redacted] who is also the emergency contact/POA for R #1, and was not contacted by the facility regarding the incident because [redacted] was present.

Findings for R #2

G. Record review of Complaint Intake [redacted]

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A 033	Continued From page 15 received on [redacted]/23, revealed the Complainant reported: 1. Sometime during mid-[redacted], 2022, she (Complainant) showed up to work at Assisted Living Facility #2 (ALF #2) at approximately 8:00 am and there were police around the area because a resident (R #2) from the [redacted] (ALF #1) was found in a vehicle sleeping that belonged to a resident (name unknown) who resides at ALF #2. 2. R #2 had a big bump on [redacted] head, did not have shoes on, and had wrapped [redacted] in blankets that [redacted] (R #2) found inside the vehicle. and had been in the vehicle sleeping since 2:00 am. 3. About two (2) weeks after the incident, R #2's [redacted] showed up to ALF #2 to give back the blankets that R #2 was found in, stated that the resident was still in the hospital, and [redacted] didn't think [redacted] was going to make it through the incident. H. On [redacted]23 at 8:57 am, during an interview with the prior Memory Care Unit (MCU) Director she confirmed: 1. The resident (R #2) left the facility's [redacted] around 4:00 am according to (unknown) DCS. Because there was a fire drill the day before, the alarms on the doors in the MCU were not reset, and when the resident left the facility, the alarm did not go off to alert the staff. 2. When R #2 walked out of the exit door, [redacted] went into the [redacted] and because the gate was not locked, was able to leave the secured MCU patio. 3. R #2 was known to be an elopement risk when [redacted] moved into the facility and had a history of watching the exit doors. 4. When staff noticed R #2 was missing, they notified management and began searching for	A 033		

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the resident, the police were called, and they activated a silver alert.

5. She (prior MCU Director) found R #2 in a vehicle at the facility next door and immediately alerted the police by yelling "here [redacted]s".

6. R #2 did have a fall, there was a cut on [redacted] head and knee, and [redacted]R #2) was sent out immediately to the hospital, but the MCU Director could not recall what hospital [redacted] was sent to.

I. Record review of an emergency department physician note dated 12/21/22 revealed:

1. A differential diagnosis of:

[redacted]

Findings for R #4:

J. Record review of Complaint Intake [redacted] received on [redacted]23 revealed that on [redacted] at 11:00 pm, R #4 had a fall and did not get help until 6:30 am on [redacted].

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K. Record review of R #4's resident file revealed an internal (facility-created) incident report dated [redacted] at 2:03 pm by DCS #11 revealed:

1. DCS #s 6 and 10 got R #4 off the floor into [redacted]

2. No injuries were observed at the time of the incident.

3. No witnesses were found.

4. The investigation portion of the incident report dated [redacted]23 stated R #4 fell without injury and was positive for [redacted] with weakness.

5. The intervention portion of the incident report dated [redacted]23 stated that staff should check hourly and push fluids (encourage drinking fluids to combat or prevent dehydration).

L. Record request for the facility Self-Report submitted to the Licensing Authority, revealed there was no documentation that a report was submitted to the Licensing Authority and no Follow-Up Report (FUR) submitted within 5 days documenting an internal investigation.

M. Record review of R #4's Progress Notes dated [redacted] through [redacted] revealed:

1. There was no entry or documentation on [redacted] to document the fall the resident had at 11:00 pm.

2. There was an entry dated [redacted] at 1:05 pm by the Wellness Director stating the reason for the follow-up visit was a fall. The note stated R #4 was up in [redacted] chair in the common area, was sleepy but aroused to [redacted] name, and the plan was to continue to monitor [redacted]

3. An entry dated [redacted] at 2:12 pm by DCS #11 stating the resident had a fall in [redacted] bedroom and there were no changes to [redacted] mobility status and no injuries or pain. Vital signs

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were taken, and no issues reported.

4. An entry dated [redacted] at 10:24 am by DCS #10 stating the resident had been hospitalized.

5. No documentation of [redacted] having been checked on during the night on [redacted] into the morning hours of [redacted]

M. Record review of R #4's Individual Service Plan (ISP) dated [redacted] revealed:

1. [redacted] was identified as a fall risk.
2. [redacted] required safety checks every 2-3 hours during the day, evening, and night shift.

N. Record review of time cards for the facility revealed the following staff were working during the incident:

1. DCS #12 worked on [redacted] at 9:57 pm to [redacted] at 6:05 am.
2. DCS #13 worked on [redacted] at 10:08 pm to [redacted] at 6:06 am.

O. On [redacted]23 at 12:53 pm, during an interview, DCS #12 stated:

1. R #4 needed to be checked on every hour to every hour and a half.
2. When they (DCS) checked on residents throughout the night from 10:00 pm to 6:00 am, they would go in and turn on the front light and make sure they were dry; if not, they would change their adult diaper as needed.
3. She (DCS #12) did not recall R #4 falling out of bed at 11:00 pm and could not remember if [redacted] fell any time during her shift from 10:00 pm to 6:00 am.
4. R #4 had a camera in [redacted] room on [redacted] and [redacted]
5. She (DCS #12) could not explain why the camera footage showed R #4 falling out of [redacted] bed at 11:11 pm on [redacted] and being picked up

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off the floor the following morning at 6:16 am and stated she could not remember anything about that day or night.

6. She (DCS #12) stated there would be two DCS on duty, and sometimes they would split up the halls and would each check on different residents, and she could not recall if she checked on R #4 on [redacted] and did not remember which other DCS worked with her during that shift.

N. On [redacted]23 at 11:27 am, during an interview with [anonymous], they confirmed R #4 fell on [redacted] at 11:11 pm and was not checked on by staff until the following morning on [redacted] at 6:16 am.

O. Observation of video recorded by the camera set up by R #4's family in R #4's room revealed:

1. On [redacted] at 11:11 pm, the video showed R #4 fell out of [redacted] bed and onto the floor.

2. R #4 was picked up off the floor from the same spot the following morning on [redacted] at 6:16 am.

P. On [redacted]23 at 1:18 pm, during an interview, the Executive Director confirmed he reviewed the videos that showed R #4 falling out of bed at 11:11 pm and being picked up the following morning (staff not identified) at 6:16 am on [redacted] and was informed of the incident by R #4's family.