DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Hospital for the Chronically Ill **DATE SURVEY COMPLETED:** October 3, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint survey was conducted at this facility from September 30, 2025, through October 3, 2025. The deficiencies contained in this report are based on observations, interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was seventy-four (74.) The survey sample totaled three (3) residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:**		
	Cross Refer to the CMS 2567-L survey completed October 3, 2025: F689	Cross Refer to the CMS 2567-L survey completed October 3, 2025: F689	11/17/2025

Provider's Signature Geraldine Stuart Title RN, BSN, Licensed Nursing Home Administrator Date 11/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD , SMYRNA, Delaware, 19977

(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
F0000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from September 30, 2025, through October 3, 2025. The deficiencies contained in this report are based on observations, interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was seventy-four (74.) The survey sample totaled three (3) residents. Abbreviations/definitions used in this report are as follows: ADLs – activities of daily living/ tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; BIMS - Brief Interview for Mental Status/assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions); CNA – Certified Nurse's Aide; DON – Director of Nursing; MDS – Minimum Data Set/standardized assessment forms used in nursing homes; NHA – Nursing Home Administrator; RN – Registered Nurse; QA – Quality Assurance.	F0000		11/01/2025
F0689 SS = SQC-J	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	F0689	R1. The facility failed to provide adequate supervision or assistive devices to ensure that R1 did not exit the building unsupervised. R1 was observed entering his room from the hallway on 9/26/25 at 12:08 AM. He was found walking on the highway approximately 17 to 20 miles from the facility on 9/26/25 at 8:38 AM.	11/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0689 SS = SQC-J	Continued from page 1 §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 observation, interview, record review and other facility documentation, it was determined that for two (R1and R2) out of three residents sampled for accidents, the facility failed to ensure that R1 and R2 received adequate supervision to prevent accidents. R1, a severely cognitively impaired resident, was able to elope from the building on 9/26/25 during the 11:00 PM to 7:00 AM shift. R1 was found on 9/26/25 at 8:38 AM, approximately 17-20 miles from the facility. This failure put R1 at immediate risk for severe injury or death due to exposure to traffic and environmental hazards while walking on the road unsupervised. An immediate jeopardy (IJ) was called at 12:30 PM on10/1/25. The facility abated the IJ on 10/2/25 at 3:00 PM. R2, a completely dependent resident, sustained a right femur fracture from a fall from the bed to the floor while a staff member was providing care and the resident rolled off the bed. Findings include: 12/4/23 - A facility document entitled, "Elopement of Resident," documented, "...The facility provides a safe environment and adequate supervision that respects the residents' dignity and minimizes the residents' risk for accidents or harm. Residents identified as "at risk for elopement" requires the vigilance of all staff. Residents identified as being at risk for elopement will have person- centered interventions to monitor and manage their risk as reflected in the care plan." 1. Review of R1's clinical records revealed: 10/24/24 – R1 was admitted to the secured unit of the facility with diagnoses including but not limited to mild cognitive impairment, major neurocognitive disorder and impaired decision making. R1's elopement assessment documented a score of 4, indicating a high risk for elopement. 10/30/24 – R1's admission MDS assessment documented a BIMS score of 99, indicating the inability to conduct a cognitive interview. 10/31/24 (revised 1/29/25) - R1's elopement care plan documented, ".... Unaware of safety risk...at risk for wandering and eloping... want to return to the community." The interventions included, "...Complete frequent face to face checks..."	F0689	Continued from page 1 Upon return to the facility on 9/26/25: R1 was placed on 1:1 supervision for 72 hours (Friday, 9/26/25 – Monday, 9/29/25). On Monday, 9/29/25, R1 was transitioned from 1:1 supervision to every 30 minutes face-to-face checks at 12:00 Noon. The nurse practitioner assessed R1 for any potential injuries and none were noted. Vital signs were within normal limits. An elopement risk assessment was completed/updated for R1. R1's care plan was updated to reflect that he was on close observation. Limiters were placed on R1's window for safety; however, when the fire marshal was called, the limiters were removed because the windows are considered egress, and this was considered a fire hazard. On 9/30/25, R1 was transferred to Lakeview, a secure unit with locked doors at both entrances and windows with hardwired alarms. All facility staff completed a mandatory in-service training to be re-educated on the current elopement policy. In addition, nursing staff were trained on face-to-face checks. This training started 9/26/25 during the day shift (7:00 AM – 3:00 PM) and continued through the weekend. Training for full-time staff was completed on 10/2/25. Casual/seasonal staff and alternate work schedule staff were in-serviced at the start of their next scheduled shift. All residents who are independently mobile, have verbalized wanting to leave the facility, and based on their elopement risk assessment, have the potential to be affected by this deficient practice. Risk assessments for all residents were reviewed and updated as appropriate by nursing management to ensure an elopement risk assessment was completed within the past three months. Residents deemed at highest risk for elopement were placed on every 30-minute face-to-face checks. All other residents at risk for elopement were placed on every one-hour face-to-face checks. All care plans for residents who were deemed at risk for elopement were updated to reflect person-centered interventions for elopement risk. The root cause of this deficient practice is staff's failure to follow the facility's protocol and training	

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F0689 SS = SQC-J	Continued from page 2 1/22/25 7:33 AM – R1's clinical record documented, "Resident was noted to be up at the nurses' station, fully dressed, with his shoes on.... Resident repeatedly asked to leave his unit so he could walk to [previous place of residence] to get his hair cut. Resident informed that we could cut his hair but refused, insisted that he needs to go to [previous place of residence.] Resident remained near the nurses' station repeatedly asking people to let him out so he can walk to [previous place of residence]." 1/22/25 7:46 AM – R1's clinical record documented, "Resident standing in front of the unit manager's office pleading with all the staff that passed by to let him out of the door." 1/23/25 12:28 PM – R1's clinical record entitled "Plan of Care Note," included, "Risk for elopement due to recent talk of going to [name of recent place of residence.]" 1/23/25 2:54 PM – R1's clinical record documented, "...Stated multiple times...been a year.... want to go to [name of previous residence.] Please help [R1's name.]" 8/12/25 10:19 AM – R1's clinical record documented, "Resident pacing up and down the hallway." 8/15/25 4:44 PM – R1's clinical record documented, "Resident was observed in the back hallway by the emergency exit door." 9/4/25 12:02 PM – R1's clinical record documented, "Resident expressed desire to leave the facility, per resident, it's been two years since he was taken to the hospital and then brought here. He stated, "I am not sick, I want to go to [previous place of residence.]" 9/4/25 9:01 PM – R1's clinical record documented, "Resident expressed desire to leave the facility to go [previous place of residence.]" 9/8/25 1:03 PM – R1's clinical record documented, "Resident requested to speak with someone about getting out of this facility. Stated, "I am not sick, I don't need to be here." Social Services came to speak with resident, reassured him that everything is being done to help him. Resident pulled out a piece of paper with his address written on it and stated, "That's where I live." Resident spoke very clearly, explaining his experience in the hospital and how he got there and how he came to be at this facility. Resident expressed that he is very eager to get out of [name of current	F0689	Continued from page 2 related to completing rounds on every resident according to the Elopement of Resident policy, Policy Memorandum Number #500, Nursing Department. On 10/17/25, the Elopement of Resident policy (Attachment #1) was updated to include the importance of face-to-face checks and the increased frequency of elopement risk assessments for all residents. All current staff will be in-serviced on the updated policy by the Nursing Home Administrator (NHA), Director of Nursing (DON), or designee by 11/3/25. All newly hired staff will be educated on the elopement policy in new employee orientation. All facility staff will be required to complete online mandatory annual in-service training on the updated Elopement of Resident policy. On Tuesday, 9/30/25, when it was reported that there were 8 unsecured windows on Parkside, staff immediately checked and locked all resident bedroom windows. Windows that were found to be damaged or have broken locks were repaired by maintenance. Repairs were completed by 10/3/25. Window alarms were installed on all Parkside bedroom windows on 10/3/25. Fire Marshall-approved window limiters were installed on Parkside windows on 10/24/25. The Candee Building Elopement Prevention Audit Tool (Attachment #2) will be used by RN Unit Managers, RN Nursing Supervisors, or designees to conduct reviews of documentation for 30% of residents who are independently mobile, have verbalized wanting to leave the facility, and are at increased risk of elopement. In addition, they will assess staff knowledge and ensure face-to-face check sheets are completed as required. This tool will be used every shift until 100% success has been achieved for four (4) consecutive weeks. Then, this tool will be used daily during 11:00pm – 7:00am shift until 100% success has been achieved for four (4) consecutive weeks. Then, this tool will be used once a week during 11:00pm – 7:00am shift until 100% success has been achieved for four (4) consecutive weeks. Then, this tool will be used every other week during 11:00pm – 7:00am shift until 100% success has been achieved for four (4) consecutive evaluations. This tool will be used monthly during 11:00pm – 7:00am shift until 100% success has been achieved for two (2) consecutive months. Any deficient findings will be immediately addressed and forwarded to the NHA, DON, or designee for appropriate corrective action. The Environmental Elopement Prevention Audit Tool (Attachment #3) will be used by Risk/Safety Manager or designee to conduct environmental rounds to ensure	

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F0689 SS = SQC-J	Continued from page 3 facility.]" 9/13/25 11:06 AM – R1's clinical record documented, "Resident up out of his room, pacing around more than usual and expressing verbally the desire to leave, saying he's been here too long and wants to go back to where he used to live." 9/14/25 8:53 PM – R1's clinical record documented, "…Continues to stand in the hallway staring at the back and side doors." 9/15/25 2:57 PM – R1's clinical record documented, "Engaged in conversation with resident during which resident expressed his interest in going back to live the community…" 9/16/25 1:08 AM – R1's clinical record documented, "…. Ambulating back and forth in the hallway asking to go to [place of previous residence.]" 9/22/25 1:33 PM – R1's clinical record documented, "…. [R1] very vocal about his wants. Stated that he was brought to [name of facility] from the hospital and was supposed to stay here for a bit…." 9/23/25 – R1's annual MDS documented a BIMS score of 99, indicating the inability to conduct a cognitive interview. 9/25/25 2:38 PM – R1's clinical record documented, "Resident noted with slight agitation, kept saying he needs to get to [previous place of residence] to see his family. Redirected with little success. Noted to be standing by front doors of unit but no attempt to leave." 9/26/25 6:00 AM – R1's clinical record documented, "During unit rounds at 6:00 AM, resident was not noted to be in his usual sleeping position in his room. After a brief search of resident's room and his usual unit locations, still unable to locate resident, resident's window noted to be opened…" 9/26/25 8:38 AM - The facility's investigation documented, "E5 (QA) successfully located [R1] walking on the road. E5 was trying to convince him to get into the vehicle and he went into the cornfield. Later, more staff came from [the facility] including the police. We searched the cornfield for approximately 45 minutes but could not locate him. After 45 minutes to one hour, a driver passing by stopped and asked if we were searching for someone. We said "yes", and he described the person and said he fit the description of someone	F0689	Continued from page 3 resident bedroom windows and all emergency exit doors are secured and alarmed properly. This tool will be used daily (random sample of two (2) resident bedroom windows per unit and all emergency exit doors) until 100% success has been achieved for seven (7) consecutive days. Then, this tool will be used once a week (random sample of two (2) resident bedroom windows per unit and all emergency exit doors) until 100% success has been achieved for three (3) consecutive weeks. Then, this tool will be used monthly (random sample of five (5) resident bedroom windows per unit and all emergency exit doors) until 100% success has been achieved for three (3) consecutive months. Any deficient findings will be immediately addressed and forwarded to the NHA, DON, or designee for appropriate corrective action. The Elopement Prevention Audit Tool (Attachment #4) will be used by Continuous Quality Improvement Nurse (CQI RN III) or designee to conduct audits of Attachment #2 and Attachment #3. All audits will be completed based on the schedules documented for Attachment #2 and Attachment #3. The results of these audits will be reviewed at the quarterly Quality Assurance Performance Improvement (QAPI) Committee meetings. If it is determined that 100 percent compliance is achieved based on the schedules documented for Attachment #2 and Attachment #3, then the facility will conclude that we have successfully addressed this deficient practice. R2. The facility failed to ensure adequate supervision to prevent R2's fall with injury. R2's care plan was immediately updated to include fall risk and 2-person assist with repositioning in bed. E6 was immediately pulled from resident care and required to re-take new hire orientation, which included shadowing another CNA (certified nursing assistant) before she could return to provide resident care independently. All residents who are dependent on staff for turning and repositioning during care have the potential to be affected by this deficient practice. Care plans for all of the affected residents were reviewed and updated as appropriate. The root cause of this deficient practice was staff's failure to follow standards of practice for basic resident activities of daily living care. All nursing	

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F0689 SS = SQC-J	Continued from page 4 he had just passed about two miles down from the location where we were searching.... We saw [R1] walking on the road...and he was brought back to the facility. An alarm was put on the window, and he was placed on 1:1 close supervision for safety." 9/30/25 11:00 AM – The Surveyor observed that R1's bedroom window had a device that sounded an alarm when the window was opened. A check of the windows on the secured unit revealed that 8 out of 10 windows were unlocked and easily opened by the Surveyor. There was a total of 18 residents who resided on this secure unit. 9/30/25 12:00 PM – During an interview E1 (NHA) stated, "We knew that the resident [R1] was an elopement risk on admission. He was placed in the secure unit for close monitoring. He placed on 1:1 supervision for 72 hours from 9/26/25 through 9/29/25 after the elopement, then hourly visual checks. Window limiters were approved by the fire marshal and will be installed on all the windows on [name of unit] upon delivery." 9/30/25 12:30 PM – A review R1's clinical records from his admission to the date of the elopement lacked evidence of a person-centered care plan for elopement despite multiple episodes of exiting seeking and verbalization of wanting to leave the facility. 9/30/25 1:00 PM – A review the facility's video recording from 9/26/25 at 12 midnight to 6:30 AM revealed: 12:03 AM – R1 was observed exiting his room and entering the hallway. 12:08 AM – R1 was observed returning to his room. 12:21 AM – Staff member was observed walking past the resident's room, did not enter. 12:25 AM – Staff member was observed looking at the resident's room from the end of the hallway. 12:58 AM – Staff member was observed walking past the resident's room, did not enter. 1:39 AM – Staff member was observed walking past the resident's room, did not enter. 1:52 AM – Staff member was observed walking past the resident's room, did not enter. 2:20 AM - Staff member was observed walking past the resident's room, did not enter.	F0689	Continued from page 4 staff were retrained on fall prevention during resident care, with an emphasis ensuring there is an appropriate number of staff and the proper positioning of the resident in bed prior to turning them. The last training was completed on 5/16/25. R2's fall was reviewed at the fall committee meeting on 5/16/25 and at the QAPI (Quality Assurance and Performance Improvement) meetings on 6/30/25 and 7/28/25. A review of all falls since 5/11/25 during the fall committee meeting and QAPI meetings revealed no falls related to resident positioning in bed or during care; therefore, it is believed this is an isolated incident.	

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F0689 SS = SQC-J	Continued from page 5 2:45 AM – Staff member was observed walking past the resident's room, did not enter. 3:44 AM – Staff member was observed walking past the resident's room, did not enter. 4:02 AM – Staff member was observed walking past the resident's room, did not enter. 4:26 AM – Staff member was observed walking past the resident's room, did not enter. 4:41 AM – Staff member was observed walking past the resident's room, did not enter. 4:46 AM – Staff member was observed walking past the resident's room, did not enter. 4:56 AM – Staff member was observed walking past the resident's room, did not enter. 4:59 AM – Staff member was observed walking past the resident's room, did not enter. 5:10 AM – Staff member was observed walking past the resident's room, did not enter. 5:40 AM – Staff member was observed walking past the resident's room, did not enter. 5:55 AM – Staff member was observed walking past the resident's room, did not enter. 6:04 AM – Staff member was observed walking past the resident's room, did not enter. 6:07 AM – New staff on the unit, entered, exited the resident's room and walked back to the nursing station. 6:10 AM – Staff members entered the resident's room, other rooms, and checked the back doors. 6:11 AM to 6:18 AM staff members were observed outside of the building. The staff failed to follow R1's care plan for visual check for 18 out of 20 opportunities. 10/1/25 10:00 AM – During an interview E8 (CNA) stated, "The last time I saw the resident in the hallway was around midnight." The Surveyor asked E8 whether R1 had verbalized that he wanted to leave the facility. E8 stated, "Yes, all the time."	F0689		

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F0689 SS = SQC-J	Continued from page 6 10/1/25 10:10 AM – During an interview E7 (CNA) stated, "He [R1] was independent with going to the bathroom so I did not know I have to do anything for him at night. I did not know he was an elopement risk and needed to be checked every hour. I now know that I must see him with my eyes every 30 minutes." The Surveyor asked E7 whether R1 had verbalized that he wanted to leave the facility. E7 stated, "Yes, many times." 10/1/25 10:30 AM – During an interview E13 (LPN) stated, "I check on my residents when I come on shift. I went into the room around 6:10 AM but did not see the resident. I checked the bathroom and the closet but did not see him. I went outside and saw that the window was open. I went to the tell the supervisor right away." 10/1/25 4:00 PM - The facility's abatement plan for the immediate jeopardy included: - All staff in the facility and staff reporting for scheduled shifts were in-serviced on the current elopement policy and face-to-face checks for residents at risk for elopement. - The facility reviewed all current residents and identified 8 residents deemed to be at higher risk for elopement. These residents were placed on every one-hour face-to-face checks. - The care plans were updated to reflect specific interventions for high elopement risks. - An alarm was placed on R1's window and all the windows on the units were checked and locked. When windows were found to be damaged, maintenance was called for immediate repair. - R1 was moved to another secure unit with alarm on the window and double locks on both entrances. - All the windows on the secure unit have hard wired alarms and were tested on this same day. - Window limiters were approved by the fire marshal and will be installed upon delivery. 10/1/25 1:00 PM - Staff interviews conducted, and in-service education and training verified. 10/2/25 2:45 PM - Staff training records reviewed and verified. The IJ was abated at 3:00 PM. 10/2/25 3:30 PM – Findings were verified with E1 (NHA)	F0689		

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F0689 SS = SQC-J	Continued from page 7 and E2 (DON.) 2. Review of R2's clinical records revealed: 4/7/20 – R2 was admitted to the facility with diagnoses including severe intellectual disability, cerebral palsy and morbid obesity12/4/23 – A facility document entitled, "Fall Risk Prevention Policy," documented, "…The facility will ensure that the resident environment is safe and free of hazards. That each resident receives adequate supervision and assistance to prevent falls or minimize the risk for fall related injuries." 3/14/25 – R2's quarterly MDS documented a BIMS score of 00, indicating an inability to conduct a cognitive interview. R2 was non-ambulatory and completely dependent on staff for all activities of daily living. 5/11/25 8:57 PM – A facility incident report submitted to the Division documented, "Resident fell from the bed to the floor during care and sustained a right eyebrow cut/swollen and Rt [right] knee abrasion. Provider was notified and resident sent to the ER for evaluation." 5/13/25 11:00 AM – R2's clinical record documented, "Resident seen today for decreased ROM [range of motion] to right knee. Right knee noted with swelling and warm to touch. Resident moaned and grimaced when the right knee was touched. Right knee tender to touch, resident unable to flex knee to 90 degrees. X-ray of right knee ordered." 5/13/25 8:40 PM – R2's clinical record documented, "…Showed that the resident's right femur is fractured…Send the resident out via 911." 5/16/25 11:35 AM – The facility's 5 day follow up report to the Division documented, "…Admitted for right knee surgery due to a right femur fracture. She [R2] had surgery and returned on 5/16/25." 10/1/25 2:00 PM – The facility's post fall investigation documented, "[R2] was not care planned for falls because she is unable to move herself." E6 (CNA) interview statement documented, "…[R2] does not move at all and cannot scoot because she is heavy. E6 advised that she turned [R2] on her right side as she reached for a washcloth. Resident was being turned towards the window and as she reached for the washcloth R2 rolled off the bed. She fell face down on the floor." The facility failed to provide adequate supervision to	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = SQC-J	Continued from page 8 prevent R2's fall with injury. 10/2/25 1:30 PM – A review of the facility's actions after R2's fall revealed: - R2's care plan was revised and updated for 2 staff members assistance with bed mobility. - All nursing staff were trained on fall prevention during resident care. The training included not rolling the resident away from the staff's body. Ensure that the resident is in the middle of the bed before turning him/her away from your body (if you must turn the resident away from you.) - The certified nursing assistant (CNA) involved in the fall was required to re-take new hire orientation, which included shadowing another CNA before she could return to provide resident care independently. - The fall was discussed and reviewed at the fall committee meeting on 5/16/25 and at QAPI meetings 6/30/25 and 7/28/25. - A review of all falls since 5/11/25 during the fall committee meeting and QAPI meetings revealed no falls relating to resident's positioning in bed or during care. 10/2/25 3:30 PM – During an interview, findings were confirmed with E2 (DON). 10/3/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference.	F0689		