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	IL6010227	A. BUILDING: _____ B. WING _____	04/15/2022

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CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.	S9999		

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on observation, interview and record reviewed, the facility failed to provide supervision and progressive interventions to prevent falls for 4 of 8 residents (R14, R28, R40, R64) reviewed for falls in the sample of 35. This failure resulted in R64's fall sustaining a jaw and cheek bone fractures, R14's fall sustaining fractured left hip. Findings include: 1. R64's Admission Record, dated 4/14/22, documents R64's admission date of 8/30/21. It also documents diagnoses to include Cerebral Palsy and Parkinson's Disease. R64's Minimum Data Set (MDS), dated 2/26/2022, documents moderately cognitively impaired, requires extensive assistance and one person physical assist for bod mobility, transfers, walk in room, walk in corridor, dressing and eating and total dependence with one person physical assist for locomotion off unit, toilet use and personal hygiene. R64's balance was not steady, only able to stabilize with staff assistance with moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface transfer. Mobility devices wheelchair. 2 falls no injury and 2 falls with injury. R64's Incident by Incident Type Report, dated 4/12/22, documents R64 has had 18 unwitnessed falls from admission on 8/30/21-3/26/22. R64's Nursing Note, dated 12/28/21 at 7:49 PM, documents found on floor laceration to right eye area clean and dry pressure dressing applied neurological checks started vital signs within normal limits (WNL) says that she had emesis	S9999		

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S9999	Continued From page 3 (vomit) and was trying to get her nurse to let her know when she fell. Physician and family to be notified by her nurse shortly. R64's Nursing Note, dated 12/28/21 at 8:53 PM, documents nurse notified the physician that C hall nurse observed resident on floor with a gash to right eye with blood. At lunch, the nurse observed no body surface lacerations, beside right eye. Above right eye a fingertip laceration was observed with slight blood. Nurse applied 3 steri strips. Resident complained of pain. Resident states "I regurgitated in my bed and was crawling towards the door. I sat up, and fell over, hit my head." Resident states "I was crawling for assistance." Family was contacted. Administration notified. Neurological observations were started and fall report completed. R64's At Risk for Falls Care Plan, dated 8/31/21 with revision on 4/13/22, does not include this fall and has no progressive interventions initiated for this fall on 12/28/21. R64's Nursing Note, dated 1/12/22 at 8:46 PM, documents resident observed on the floor crying in the bathroom with wheelchair seen half way out the bathroom door in the room. Nurse observed 90% of ear middle cartridge split straight through. No complaint of pain was voiced when questioned. A continuous flow of blood observed. Nurse believes stitches should be applied. Nurse awaits physician for further notice of such an area of cut. R64's Hospital After Visit Summary, dated 1/12/2022, documents diagnoses fall and laceration of helix of right ear. R64's At Risk for Falls Care Plan, dated 8/31/21	S9999		

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S9999	Continued From page 4 with revision on 4/13/22, does not include this fall and has no progressive interventions initiated for this fall on 1/12/22. R64's Nursing Note, dated 1/18/22 at 7:56 PM, documents nurse received order from physician to send resident out to ED (emergency department.) Nurse noted to physician that nurse has observed previous laceration of resident incidents. This laceration is not deep, and doesn't continue a blood flow, but it clotted quick. R64's Nursing Note, dated 1/18/22 at 8:30 PM, documents CNA (Certified Nurse Assistant) observed resident on the floor. Nurse observed right forehead having slight laceration, and knot. Nurse cleansed and applied three steri-strip to lacerated area. Fall risk, POA (power of attorney), and Administration notified. Physician refer to ED for CT (cat scan) head and C-spine clearance. Nurse prepared for ED. Nurse noted to physician the observation of resident's previous laceration. This laceration is not deep, and doesn't continue a blood flow, but it clotted quick. R64's Hospital After Visit Summary, dated 1/18/2022, documents cat scan of cervical spine and cat scan of head, EKG 12 lead, x-ray of left humerus (arm bone) and x-ray of left shoulder all negative for fractures or dislocations. R64's At Risk for Falls Care Plan, dated 8/31/21 with revision on 4/13/22, does not include this fall and has no progressive interventions initiated for this fall on 1/18/22. R64's Nursing Note, dated 2/2/22 at 6:36 PM, documents physician notified that nurse observed resident on the floor by bed with slow blood flow from top of right forehead. Nurse observed small	S9999		

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S9999	Continued From page 5 crescent laceration to top right side forehead. Resident states "I was reaching for my floor mat". Administration and family notified. Neurological observation started. R64's At Risk for Falls Care Plan, dated 8/31/21 with revision on 4/13/22, does not include this fall and has no progressive interventions initiated for this fall on 2/2/22. R64's Nursing Note, dated 2/5/22 at 10:47 AM, documents resident attempted to stand up near the nursing station, and fell hitting head on the floor there is redness noted to top right side of forehead. Resident has no complaint of pain or discomforts. Resident stated that R64 was trying to go to resident's room. Neuro checks initiated. R64's Nursing Note, dated 2/5/22 at 11:00 AM, documents this nurse observed red bruising to resident's left arm physician made aware. R64's Nursing Note, dated 2/5/22 at 12:50 PM, documents new order received from physician to send resident to the ER (emergency room) for evaluation and treatment r/t (related to) fall. EMS (emergency medical services) was called and resident was transferred to local hospital for evaluation and treatment. This nurse gave report to ER nurse regarding resident. R64's Nursing Note, dated 2/5/22 at 4:30 PM, documents resident returned to facility from local hospital ER. No new orders or findings noted. Physician notified of return. R64's At Risk for Falls Care Plan, dated 8/31/21 with revision on 4/13/22, does not include this fall and has no progressive interventions initiated for this fall on 2/5/22.	S9999		

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R64's Nursing Note, dated 2/5/22 at 9:14 PM, documents resident was observed sitting on floor in front of R64's wheelchair. R64 stated R64 did not hit own head, R64 was trying to put self to bed. R64 has no complaint of pain there is still redness on the top of her forehead, and red bruising to the top of left arm but no new skin issues. Resident has had scheduled Ativan and staff put resident to bed after dinner per R64's request. After being put to bed resident was in own room crying so loud R64 could be heard at the nurses' station. R64 stated that R64 was crying because R64 wanted to get into wheelchair. The CNAs got R64 up again into R64's wheelchair and then attempted to put self right back to the bed. This nurse spoke with resident educating R64 to call staff for help, R64 stated that R64 could not wait on staff, but R64 does not want to go back to the hospital. R64 is extremely anxious and cannot pick if resident wants to be in bed or the chair. Every time staff accommodates what R64 is asking resident changes her mind. Physician notified of behaviors and fall. Neuro checks initiated.

R64's At Risk for Falls Care Plan, dated 8/31/21 with revision on 4/13/22, does not include this fall and has no progressive interventions initiated for this second fall on 2/5/22.

R64's Morse Fall Scale, dated 2/22/2022, documents R64 was high risk for falls.

R64's un-witnessed fall report, dated 2/26/22, documents nurse observed resident lying flat on abdomen on side of bed. Wheelchair was forward in front of the window of side of bed. Nurse observes tiny dime size bump to back of head. Ice applied. No complaint of pain. The resident

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S9999	Continued From page 7 stated, "I fell. I hit the back of my head." R64's Nursing Note, dated 2/26/22, documents no nurse's note for this fall. R64's At Risk for Falls Care Plan, dated 8/31/21 with revision on 4/13/22, does not include this fall and has no progressive interventions initiated for this fall on 2/26/22. R64's Nursing Notes, dated 3/9/22 at 6:44 PM, documents walked in after stating resident was on floor upon walking into room. R64 was lying flat next to dresser. Resident had chin laceration cleansed with wound cleanser and place steri strips. Neuro checks are being initiated. LPN of hall notified and to call POA. Physician notified. R64's Nursing Notes, dated 3/9/22 at 7:38 PM, documents resident had a unwitnessed fall, and when questioned on what happened, resident couldn't remember. Laceration steri-stripped. Neurological observations started. Fall report completed. Family contacted, administration, and EMT (emergency medical technician) contacted, and on their way to take resident to the local hospital per physician order. Laceration is deep enough for stitches. Right side cheek, and face observed rosy. Ice applied. R64's Hospital After Visit Summary, dated 3/9/2022, documents reason for visit: head injury. Diagnoses: fall and head injury. Imaging tests: cat scan cervical spine and cat scan of head done. R64's Nursing Note, dated 3/10/22 at 5:07 AM, documents resident return from hospital at 5:00 AM via ambulance was transferred in bed by EMT resident is alert of surroundings, denies pain at present. Head / Spinal CT completed while at	S9999		

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S9999	Continued From page 8 hospital both negative. All extremities WNL physician notified. R64's At Risk for Falls Care Plan, dated 8/31/21 with revision on 4/13/22, does not include this fall and has no progressive interventions initiated for this fall on 3/9/22. R64's Nursing Note, dated 3/24/22 at 7:54 PM, documents around 3:33 PM resident was found lying on ground crying assessed by RN (Registered Nurse) and was found to have bloody mouth and chipped tooth. Resident stated pain to mouth and was worried about finding her chipped tooth. POA called no answer but a voicemail was left. Physician and NP (Nurse Practitioner) notified. Sent to local hospital for further evaluation for unwitnessed fall and bloody gums with chipped tooth. R64's Nursing Note, dated 3/24/22 at 11:00 PM, documents resident returned back to facility from local hospital transported by ambulance per stretcher to room. R64's Hospital Discharge Paperwork, dated 3/24/2022, documents resident states that R64 was trying to transfer on her own out of the chair and fell face forward. Acute mildly displaced fractures of bilateral mandibular coronoid (lower jaw) processes with normal temporomandibular joint (upper jaw bone) alignment. Acute comminuted mildly displaced fractures of the anterior bilateral zygomatic arches (cheek bones.) Bilateral frontal scalp contusions (bruises) and peri-zygomatic/per-maxillary (around cheek bone) subcutaneous and acute displaced fracture of tooth of #8. Chip fracture of tooth #9.	S9999		

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S9999	Continued From page 9 R64's At Risk for Falls Care Plan, dated 8/31/21 with revision on 4/13/22, does not include this fall and has no progressive interventions initiated for this fall on 3/24/22. R64's Nursing Note, dated 3/25/22 at 10:05 AM, documents EMT here with 2 attendants to take resident to the local hospital related to fx (fracture) of jaw. Resident front teeth are loose, and she is complaint of pain in jaw. I called and gave report to local hospital. R64's Nursing Note, dated 3/25/22 at 10:25 AM, documents resident's family informed of resident's current condition after fall and was also informed that resident is being sent to a different local hospital for further evaluation. R64's Nursing Note, dated 3/25/22 at 2:05 PM, documents received report from the local hospital. They are sending her back with Norco (narcotic pain medication) for pain and she will need to F/U (follow up) with ENT (ear/nurse/throat)/Dentist for loose teeth. Resident will remain on clear liquid diet until she sees ENT. I gave ENT F/U appointment to transportation to set up ASAP (as soon as possible). Resident will continue on antibiotics for 7 days. R64's Nursing Note, dated 3/26/22 at 9:18 PM, documents CNA reported to the nurse that resident was on the floor. Nurse observed resident on the floor face down in prone position to floor. Wheelchair was close to resident. Nurse observed wheelchair belt was open, and not sounding off which could have prevented a possible fall. Nurse notified another nurse to contact ambulance regarding possible head trauma. Neurological observation immediately	S9999		

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started. Family, administration, and physician notified. Local hospital was given report that resident will be coming into ED.

On 4/13/2022 at 10:30 AM, R64 was observed sitting in a wheelchair in the hallway. R64 stated, "I fall a lot because I am not steady on my feet but I want to be independent." R64 stated R64 was in the bathroom by herself at the end of March and R64 hit head on the sink and really hurt self bad. R64 stated R64 went to the hospital and the emergency room nurse told resident R64 broke her face.

On 4/13/2022 at 8:25 AM, V2 (Director of Nursing/DON), stated R64 needs extensive assistance with activities of daily living, including toileting and R64 should not toilet by herself because R64 is a very high fall risk and is not stable to transfer herself from wheelchair to the toilet but R64 does it anyway. V2 stated he expects staff to assess and document fall risk assessments and to update the resident's care plan for fall with progressive interventions to prevent future falls.

2. R14's MDS, dated 2/18/2021, documents R14 as severely cognitively impaired, requires extensive assistance with two plus person physical assist with bed mobility, transfers and toilet use. Requires extensive assistance with one person physical assist with locomotion on and off unit, dressing and personal hygiene. Balance during transitions and walking: not steady, only able to stabilize with staff assistance for moving from seated to standing position, walking (with assistance device if used), turning around, moving on and off toilet and surface-to-surface transfer. Mobility devices: walker and wheelchair. Falls: one no injury and one major injury.

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S9999	Continued From page 11 R14's Morse Fall Scale dated 2/24/2021 documents at risk for falls. R14's Care Plan focus the resident has had actual fall with no injury related to unsteady gait. Goal: the resident will resume usual activities without further incident through the review date. Interventions: 4/17/2021 wear gripper socks or shoes. 4/21/2021 hi-lo electric bed. 4/22/2021 hourly safety checks x 30 days (discontinued 4/27/21.) 4/27/2021 30-minute safety checks x 30 days. 4/27/2021 15-minute safety checks x 30 days. 4/27/2021 new order for chest x-ray and UA (urinalysis.) 4/20/2021 staff remained with resident until emergency medical services (EMS) arrival with transport to ED (emergency department.) 5/4/2021 resident returned to facility, placed on 1:1. Continue interventions on the at-risk plan. Resident encouraged to use wheelchair (R14 has severe cognitive impairment per MDS). R14's Care Plan did not have progressive interventions for each fall. R14's Nursing Note, dated 4/17/2021 at 2:06 PM, documents nurse notes resident on floor in bathroom, stated R14 was trying to go back to bed. Unwitnessed. Neurological (neuro) checks started. Resident reports no pain, ROM (range of motion). No open area noted. Will continue to monitor. On 4/14/2022 at 3:00 PM, V2 (DON) stated there was no fall investigation dated 4/17/2021. R14's Nursing Note, dated 4/23/2021 at 12:19 AM, documents this nurse was notified by CNA that resident was on the floor upon investigation resident was sitting on bottom in the middle of the room. Resident stated he was trying to walk to	S9999		

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the restroom and slipped no injuries noted denies any pain or discomfort this shift. Able to move all extremities within normal limits. Family, DON and physician made aware no new orders at this time. Resident educated on the use of the call light and ambulating to the restroom, resident voices understanding (R14 has severe cognitive impairment per MDS). Neurological observation initiated. Will continue to monitor call light and fluids within reach.

On 4/14/2022 at 3:00 PM, V2 stated there was no fall investigation dated 4/23/2021.

R14's Nursing Note, dated 4/27/2021 at 1:54 PM, documents the resident is in bed resting quietly with eyes closed. No signs or symptoms of pain/distress. No injuries noted at this time. The resident is alert to self and situation with frequent confusion. The resident fell in the process of trying to transfer self into the roommate's wheelchair. The resident was transferred to bed, alarm active and bed in lowest position. Physician was notified and ordered 2 view chest x-ray, O2 (oxygen) at 2L (liter) per nasal cannula prn (when needed.) Neuro checks plus frequent vitals initiated.

R14's Nursing Note, dated 4/27/2021 at 9:42 PM documents this nurse was notified by CNA that resident had fallen. Resident was found sitting by bedroom door. R14 stated R14 was trying to go to the bathroom. No injuries noted at this time. Contacted physician.

On 4/14/2022 at 3:00 PM, V2 stated there was no fall investigations dated 4/27/2021.

R14's Nursing Note, dated 4/30/2021 at 6:30 PM, documents nurse called in to (local) hospital

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S9999	Continued From page 13 around 6:30pm to check on status of resident. ED states x-ray shows a left side dislocation. Emergency department strongly believe broken hip awaiting full confirmation from physician. Nurse will F/U & update with any new information. R14's Nursing Note, dated 4/30/2021 at 7:38 PM, documents hospital confirmed resident is getting sutured up at this moment & has a fractured femur & will be admitted, but transferred over to an orthopedic physician for further medical procedures. Nurse asked if ED can fax over x-ray or CT scan to facility. Nurse will F/U with any new changes. On 4/14/2022 at 3:00 PM, V2 (DON) stated there was no fall investigation dated 4/30/2021. R14's Hospital Radiology Report, dated 4/30/2021, documents left hip pain after fall today. Findings: an obliquely orientated, moderately displaced and moderately angulated subtrochanteric (left hip) fracture of the left hip is seen, extending into the intertrochanteric region. A displaced lesser trochanter fragment is noted. R14's Morse Fall Scale, dated 5/4/2021, documents high risk for falls. On 4/13/2022 at 11:00 AM, R13 was observed sitting up in a wheelchair self propelling in his room, he stared and didn't answer any questions regarding falls/injuries. On 4/14/2022 at 10:50 AM, V2 stated there were no 15-minute checks or 1:1 documented for R14 after he had falls in 4/2021. He expected the documentation to be either documented in the resident's Electronic Medical Record (EMR) or scanned from paper documents, either way he	S9999		

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S9999	Continued From page 14 expected the documentation to be available. 3. R28's MDS, dated 1/18/22, documents R28's cognitive skills for daily decision making is moderately impaired. It also documents that R28 transfers with supervision, and no physical help from staff. It further documents her balance, when moving from a seated position to a standing position and when moving on and off of the toilet is not steady but able to stabilize without staff assistance. R28's Morse Fall Scale dated 2/16/22 documents R28 is high risk for falls. R28's Care Plan dated 3/25/22 documents R28 has had actual falls with no injuries. R28's Care Plan further documents R28 had falls on 1/9/22, 1/29/22, 3/2/22. The intervention for the fall of 1/9/22 is reeducate the patient to ask for assistance. The intervention for the fall of 1/29/22 is slippers were removed from the room as they were causing the patient to shuffle and not pick up her feet. The fall of 3/25/22 was not listed on the list of falls in the care plan, but the intervention for this fall is chairs were placed outside the room in the hallway for the patient to sit down, if she becomes tired. The fall of 3/2/22 did not have an intervention listed on the care plan. The falls of 2/18/22, 4/4/22, and 4/11/22 were not listed on the care plan and no interventions were provided. Fall investigations requested for falls but were not provided for each fall. R28's Fall investigation dated 3/25/22, documents "upon investigation it was determined that this resident stood up from the wheelchair without the chair being locked. The resident was educated on the importance of asking for assistance."	S9999		

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R28's Fall Investigation dated 4/4/22, documents "the resident was attempting to get out of wheelchair in the activity room and fell. The resident was informed that it is very unsafe to walk or try to stand up without assistance. The resident verbalized understanding, but further education is needed."

R28's Fall Investigation, dated 4/11/22, documents, "The resident states I was trying to put my shoes on and I slipped off the bed. The resident was asked if she uses her call light for assistance, and she states 'not when I think I can do it by myself.' The Medical Doctor (MD) informed and no new orders obtained." (a fall intervention was not discussed in this fall investigation.)

On 4/15/22 at 10:15 AM, V2 (DON) stated, "At this time, R28 is not redirectable. R28 is not alert and oriented for redirection. We keep R28 in the common area, until we find out the policy as to what we can do for her."

4. The facility's Fall/Incident Log dated 4/12/21 through 4/12/22 documents R40 had falls on 4/8/22 at 2:24 PM and on 11/21/21 at 7:49 PM.

R40's Progress Notes, dated 4/15/22, documents her admission date as 8/13/21 and her diagnoses include Encephalopathy, Unspecified; Unspecified Dementia Without Behavioral Disturbance; Cerebrovascular Disease, Unspecified; Chronic Diastolic (Congestive) Heart Failure; Other Cervical Disc Degeneration, Unspecified Cervical Region; Drug Induced Subacute Dyskinesia; Unspecified Lack of Coordination; Bipolar Disease; Schizoaffective Disorder, Bipolar Type; Unsteadiness on Feet;

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S9999	Continued From page 16 Bilateral Primary Osteoarthritis of Knee; History of Falling; Muscle Weakness (Generalized); Syncope and Collapse. R40's Progress Notes, dated 11/21/2021 at 5:58 PM, documents, "Resident was last seen walking around with another resident trying to assist her with some activity in their room. Resident was found by staff member on the floor. Resident stated that resident hit head on the bedside table and fell to R40's bottom. R40 was able to stand up on her own with minimal assistance. No injuries noted after full body assessment. No pain noted. Resident has stated several times that R40 is alright. DON-ADON-POA-MD made aware." R40's Progress Notes, dated 4/8/2022 at 6:15 AM, documents, "Nurse summoned to A hall by staff, resident on floor sitting on buttock assessment done no injuries noted." It also documents, "denies any pain or discomfort neuro checks protocol follow res (resident) stated to nurse 'I just loss my balance and fell, I am not hurt'." R40's MDS dated 1/29/22 documents she is severely cognitively impaired, ambulates with supervision, is occasionally incontinent of urine and frequently incontinent of bowel, and at the time of this assessment, R40 had had one fall with no injury since the previous assessment. R40's Care Plan dated 2/2/22 documents, "R40 has a hx (history) of falls and remains at risk d/t (due to) dx (diagnosis) of OA (Osteoarthritis) and Cervical disc degeneration with occasional c/o (complaint of) pain to back and knees, and d/t use of psychotropic medications. R40 is up ad lib with slow steady gait, verbal cues needed to	S9999		

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reach destination. R40 is oriented on use of call light with education on use and encouraged to utilize to call staff for assist prn (as needed), with understanding verbalized." The only fall listed for this care plan was dated 1/27/21. R40's falls on 11/21/21 and 4/8/22 were not identified on the care plan. This care plan did not include any progressive interventions to prevent further falls after her falls on 11/21/21 and 4/8/22. Education used as an intervention although R40 has severe cognitive impairment per MDS.

R40's Morse Fall Scale dated 8/13/21 documents her score as 10, indicating she was a low risk for falls at that time. R40 did not have any updated fall risk assessments in her EMR after she fell on 11/21/21 or 4/8/22.

On 4/14/22 at 10:36 AM, V3 (Assistant Director of Nursing/ADON), stated there should be new interventions put in place any time a resident experience a fall. V3 stated V3 and V2 (DON) have just recently started and now they review all falls daily during a morning meeting. R40's current care plan, which was last updated on 1/27/21, was reviewed with V3 and V3 stated the previous DON, V11 (Registered Nurse/RN,) is here now, helping to update the residents' care plans. V3 stated V3 does not know why R40's care plan was not updated after her falls on 4/8/22 or 11/21/21.

On 4/16/22 at 10:15 AM, V2 (DON), stated it is the responsibility of V19 (Care Plan Coordinator/CPC), to put new, progressive interventions in a resident's care plan if they have a fall. V2 stated if a resident falls, the nurse taking care of that resident should assess the resident and the fall and come up with an intervention to prevent further falls. V2 stated the next day, in

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S9999	Continued From page 18 morning meeting, the IDT (Interdisciplinary Team) reviews the resident's fall and the intervention the nurse put into place to see if it's appropriate, and then the CPC updates the resident's care plan with the new intervention or a different intervention, if the intervention from the nurse is not appropriate. V2 stated the facility had not had a CPC for a while, until V19 started a few weeks ago. V2 stated R40's Fall Risk Assessment has not been updated since 8/13/21. The facility's policy, "Fall Prevention Protocol" dated 9/1/05 documents, "Standard: This facility is committed to establishing guidelines and procedures to minimize falls and their effects so as to maximize every resident's well being. It is established that it is impossible to prevent all falls due to their multi-factorial nature, however this standard dictates a mode of action that attempts to identify, assess and implement interventions for each resident at risk and that facilitates an environment that is as safe as possible." Under "II. Facility Response to Resident Falls" the policy further documents, "Assessment/Documentation/Notification: Whenever a resident falls, first provide for the immediate needs of the resident. Before moving the resident assess for any injuries that may require emergency care, treatment, or transfer to an acute care facility. Assess vital signs and attempt to ascertain by communicating with the resident and through observation, the cause of the fall. A narrative summary, written in the nurse's notes, shall follow each fall event and shall include a minimum the following: date and time; brief, objective, factual narrative that describes the details of the incident without assumptions about cause. Avoid phrases such as "appears to be" or "seems to be"; primary cause of incident (if known), including quotes from the	S9999		

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S9999	Continued From page 19 resident, if pertinent; vital signs of resident involved; level of consciousness/emotional state of the resident at the time of the fall; specific descriptions of any injuries, bleeding and/or fractures; any resident reports of pain or discomfort (or lack of reports); assistance or care given in response to the fall; resident's response to this care; notification of the physician and the resident's responsible party. Complete an incident report and forward to the Director of Nursing or designee. Care plans for any resident experiencing a fall event will be updated to reflect the fall, any newly identified risk factors, and interventions designed to prevent reoccurrence. " (A)	S9999		