STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175304	A. BUILDING _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PRESBYTERIAN MANOR	2300 INDUSTRIAL ROAD EMPORIA, KS 66801

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00142847. The 2567 was electronically sent to the facility on 08/08/19.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		

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

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by:
The facility reported a census of 48 residents with 16 selected for review . Based on observation, interview and record review, the facility failed to review and revise the care plan for one of the 16 residents reviewed resident (R) (R23), with appropriate interventions following 10 falls.

Findings included:

- R23's signed "Physician Order Sheet" (POS), dated 06/20/19, documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behaviors, severe, persistent asthma (disorder of narrowed airways that cause wheezing and shortness of breath) with exacerbation (worsening), hypertension (elevated blood pressure), and osteoarthritis (degenerative changes in joints characterized by pain and swelling) of the right knee.

The admission "Minimum Data Set (MDS)," dated 12/14/18, recorded the resident with a Brief Interview for Mental Status (BIMS) of seven, indicating severely impaired cognition. There were no behaviors or rejection of care. Wandering occurred one to three days in the look back period. He required limited assistance with activities of daily living, was unsteady and was only able to stabilize with staff assistance. There was no impairment to range of motion and used a cane or walker for mobility. He had a history of falls on admission and two or more falls since the last assessment of which none resulted in fractures.

The "Cognitive Loss/Dementia Care Area

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Assessment (CAA)," dated 12/14/19, documented the resident was a new admission on the memory care unit. He had some word finding difficulty, but was able to make his needs known and engage in conversation.

The "Falls CAA," dated 12/14/19, documented staff assisted him with activities of daily living, strengthening and increased mobility. The resident had difficulty waking due to pain in his right knee, causing an abnormal gait. He also has dementia and was forgetful and had confusion at times. He ambulated using a cane.

The quarterly "MDS," dated 06/10/19, recorded the resident with a BIMS of 5, indicating severely impaired cognition. His inattention fluctuates and the resident wanders 1-3 days on the look back period. He needs extensive assistance with bed mobility, transfers, locomotion, dressing, toileting and personal hygiene. He is unsteady on his feet and could only stabilize with human assistance. He used a walker and was incontinent of bowel and bladder. He had two or more falls with injury since the last assessment.

The resident's cognition care plan, dated 06/18/19, directed staff that the resident had a BIMS score of five, indicating severely impaired cognition, had word finding difficulty and did best with yes/no questions. The resident often had confusion and disorientation with episodes of delusions that included agitation.

The resident's activities of daily living care plan, dated 06/18/19, directed staff the resident needed assistance with grooming, repositioning, and used a cane for ambulation. The resident did not use a call light related to his impaired cognition.

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F 657	Continued From page 3	F 657		

Staff were to approach him in a calm manner as the resident's frustration increased due to delusions which increased his risk for falls. His patterns of behavior increased in the evening.

The resident's fall care plan, dated 06/18/19, included the following dated interventions

12/09/18, place the resident on the "Fall Leaf Program" (When staff walk by the resident's door staff would look in on him).

12/16/18, use a bolster on the outside of the bed.

12/27/18, check on the resident frequently, as he does not use a call light and ambulates with a cane with limited assistance of one staff member.

12/28/18, provide stand by assistance when staff observes the resident ambulating.

01/10/19, do not lay clothes out for the next day, as the resident thinks he has to get up at night.

01/24/19, provide a urinal.

02/1/19, AM cares between 8-9 AM.

02/5/19, do not leave him awake and unattended in the bedroom.

02/13/19, reposition him in bed so the hall lights do not shine on his face.

03/23/19, assure "staff are following the care plan intervention, dated 12/28/18, and provide stand by assistance when he is ambulating by himself."

04/3/19, the "resident continues to stand

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F 657	Continued From page 4	F 657		

independently even though he is unsafe to do so."

04/8/19 , the "resident continues to stand independently even though he is unsafe to do so."

04/29/19, the "resident continues to stand independently even though he is unsafe to do so."

04/30/19, the "resident continues to stand independently even though he is unsafe to do so."

06/12/19, the "resident continues to attempt actions beyond his ability. He most likely will continue to fall due to his poor cognition."

06/23/19, the "resident continues to attempt actions beyond his ability. He most likely will continue to fall due to his poor cognition."

07/19/19, the "resident continues to attempt actions beyond his ability."

The care plan lacked development of appropriate fall prevention strategies after each fall.

The "Fall Risk", dated 12/14/18, score was 16, which put him at high risk for falls and indicated the resident had a history of falls.

"Progress Notes" revealed the following:

04/04/19 at 12:38 AM, resident yelling out for help. Nurse and CNA (certified nursing aide) found the resident on the floor leaning against a chair in front of the night stand at the foot of the bed. He was wearing only one non-skid sock and had an abrasion on left buttock from carpet burn. Resident said he hit his head on the chair.

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04/08/19 at 03:49 PM, resident witnessed falling by RN (registered nurse) after attempting to stand and losing his balance.

04/29/19 at 09:59 PM, nurse alerted to resident falling in the hallway. Resident noted on bottom. Staff reports resident was walking out of room backwards, stumbled, fell to his bottom, and hit his head. No abrasion or skin issue to head.

04/30/19 at 01:10 PM, informed from a medication aide the resident was on the floor. Upon assessment found a small amount of blood from the left side of his forehead. Staff applied pressure to the area, and a hematoma (collection of blood outside a blood vessel when the blood vessel becomes injured) observed to left forehead.

The "Physician Communication Sheet", dated 04/30/19, informed the physician of this resident's fall, hitting the left side of his forehead and received a hematoma.

06/12/19 at 6:31 PM, resident talking to CNA behind nurses desk, door opened up and resident lost balance. Nurse slowed down the resident's fall and used arms to protect resident's head. Resident on floor on left side. No new skin occurrences.

06/23/19 at 03:31 PM, nurse informed resident was on the floor. Observed the resident sitting on the floor inbetween the bed and the bathroom. The resident was barefoot. Wet spot in front of the resident suspected to be urine. Resident had an abrasion to the right ring finger.

06/29/19 at 02:09 AM, notified by CNA the

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resident fell. Entered room to find him sitting against his bed railing facing the bathroom and holding himself up with his left arm. The nurse asked him what he was doing, and he said, "trying to get out." Noted a left upper arm skin tear. Denied pain.

07/20/19 at 04:42 AM, nurse informed she was needed in the resident's room. Upon arrival the nurse found the resident gripping on to the front of the wheelchair, with his left hand wedged between the wheelchair and the door, kneeling with his left knee on the floor. The resident complained of right knee pain.

7/29/19 at 05:59 PM, the resident was found on the floor in his room, laying on his left side along the door. He was bleeding from his forehead and left shoulder. The abrasion for his forehead measured 3 cm (centimeters) by 1.5 cm. A skin tear to his shoulder had jagged edges and measured 2 cm by 2 cm . The resident stated, "they threw me around like a kitten, I hit my head on the door, I did not know why I was up."

The "Physician Communication Sheet", dated 07/29/19, informed the physician the resident fell at 11:25 AM. There was an abrasion to the left side of his forehead measuring 3 cm by 1.5 cm. There was a skin tear to the top of his left shoulder measuring 2 cm by 2 cm with jagged edges.

07/30/19 at 08:40 PM, the resident was found on the floor bleeding from his head. The nurse aide held pressure to stop the bleeding. The resident did not speak. The facility called Emergency Medical Services immediately.

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On 07/30/19 at 09:12 PM, the facility received a phone order from the primary care physician to send the resident to the emergency room per ambulance.

07/31/19 at 02:54 AM, documented staff received a call from the nurse at the hospital who stated the resident received four staples to a head laceration. The resident would be returning back to the facility.

Review of the available "Fall Investigation Reports" for the above documented falls, lacked a root cause analysis for the falls or appropriate interventions to prevent the resident from repeated falls.

On 07/31/19 at 07:26 AM, observation upon entering the resident's room revealed a blood stain on the carpet approximately 12 inches x 4 inches from the fall the previous night when he hit his head on the floor. . A cut to the back of the resident's head showed four staples. The resident transferred with assistance of two staff and use of a gait belt to his wheelchair then was taken to the bathroom.

On 07/31/19 at 11:00 PM, observation revealed the resident sat in a recliner on the day hall with the night charge nurse sitting beside him.

On 7/31/19 at 11:05 PM, Licensed Nurse G reported the resident was on a one to one since his fall with injury. When the resident had a fall, staff updated the care plan. Sometimes all it took to update a care plan was to change one word, like if the care plan said to "use reminders to use the call light." She would change the intervention to "keep using reminders to use the call light" and

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F 657	Continued From page 8 the care plan would be considered updated. On 07/31/19 at 02:41 PM, with Administrative Nurse D reported with or without injury there may or may not be new interventions put in place. This resident continued to stand independently even though it was unsafe to do so. I would consider using "the resident continued to stand independently even though he was unsafe to do so" as an updated intervention as it was reiterating that the resident needed continued monitoring. The facility policy for falls, dated 03/26/19, documented staff would review fall interventions from the reference sheet for ideas as to which interventions to implement and then document the new intervention in the care plan. The Quality Assurance nurse would review fall interventions documented in the resident's care plan and would update as needed. The facility failed to review and revise the resident's care plan with appropriate interventions following 10 falls, in 4 months.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		

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The facility reported a census of 48 residents with 16 selected for review, including two residents reviewed for accidents. Based on observation, interview and record review, the facility failed to ensure the two residents reviewed remained free of accidents including resident (R) R23 who experienced 10 falls without appropriate interventions put into place and with the last fall, on 07/30/19, resulting in a head injury which required four staples and R39 who experienced a fall without appropriate interventions in place.

Findings included:

- R23's signed "Physician Order Sheet" (POS), dated 06/20/19, documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behaviors, severe, persistent asthma (disorder of narrowed airways that cause wheezing and shortness of breath) with exacerbation (worsening), hypertension (elevated blood pressure), and osteoarthritis (degenerative changes in joints characterized by pain and swelling).

The admission "Minimum Data Set (MDS), dated 12/14/18, recorded the resident with a Brief Interview for Mental Status (BIMS) of seven, indicating severely impaired cognition. There were no behaviors or rejection of care. Wandering occurred one to three days in the look back period. He required limited assistance with activities of daily living, unsteady on his feet and was only able to stabilize with staff assistance. He had no impairment to his range of motion, and used a cane or walker for mobility. He had a history of falls on admission and two or more falls since the last assessment of which none resulted

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in fractures.

The "Cognitive Loss/Dementia Care Area Assessment (CAA), dated 12/14/19, documented the resident was a new admission on the memory care unit. He had some word finding difficulty, but could make his needs known and engage in conversation.

The "Falls CAA", dated 12/14/19, documented for staff to provide assistance with activities of daily living, strengthening and increased mobility. The resident had difficulty walking due to pain in his right knee, causing an abnormal gait. He also had dementia, was forgetful, and had confusion at times. He ambulated using a cane.

The quarterly "MDS", dated 06/10/19, recorded the resident with a BIMS of five, indicating severely impaired cognition. His inattention fluctuated and he wandered one to three days on the look back period. He required extensive assistance with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. He was unsteady on his feet and could only stabilize with human assistance. He used a walker and was incontinent of bowel and bladder. He had two or more more falls with injury since the last assessment.

The resident's cognition care plan, dated 06/18/19, directed staff that the resident had a BIMS score of five, indicating severely impaired cognition, had word finding difficulty and did best with yes/no questions. The resident often had confusion and disorientation with episodes of delusions that included agitation.

The resident's activities of daily living care plan,

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dated 06/18/19, directed staff the resident needed assistance with grooming, repositioning, and used a cane for ambulation. The resident did not use a call light due to his impaired cognition. Staff were to approach in a calm manner as the resident's frustration increased due to delusions which increased his risk for falls. His patterns of behavior increased in the evening.

The resident's fall care plan, dated 06/18/19, included the following dated interventions;

12/9/18, place the resident on the "Falling Leaf Program" (When staff walk by the resident's door staff would look in on him).

12/16/18, use a bolster on the outside of the bed.

12/27/18, check on the resident frequently, as he does not use a call light and ambulates with a cane with one staff, limited assistance of one staff member.

12/28/18, provide stand by assistance when staff observes the resident ambulating.

01/10/19, do not lay clothes out for the next day, as the resident thinks he has to get up at night.

01/24/19, provide a urinal.

02/1/19, AM cares between 8-9 AM.

02/5/19, do not leave him awake and unattended in the bedroom.

02/13/19, reposition him in bed so the hall lights do not shine on his face

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03/23/19, assure "staff are following the care plan intervention dated 12/28/18, and provide stand by assistance when he is ambulating by himself."

04/3/19, "the resident continues to stand independently even though he is unsafe to do so."

04/8/19 , "the resident continues to stand independently even though he is unsafe to do so."

04/29/19, "the resident continues to stand independently even though he is unsafe to do so."

04/30/19, "the resident continues to stand independently even though he is unsafe to do so."

06/12/19," the resident continues to attempt actions beyond his ability. He most likely will continue to fall due to his poor cognition."

06/23/19, "the resident continues to attempt actions beyond his ability. He most likely will continue to fall due to his poor cognition."

07/19/19, "the resident continues to attempt actions beyond his ability."

The "Fall Risk", dated 12/14/18, score was 16, which put him at high risk for falls and indicated the resident had a history of falls.

The care plan lacked development of appropriate fall prevention strategies after each fall.

"Progress Notes" revealed the following:

04/04/19 at 12:38 AM, resident yelling out for help. Nurse and CNA (certified nursing aide) found the resident on the floor leaning against a

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F 689	Continued From page 13	F 689		

chair in front of the night stand at the foot of the bed. He was wearing only one non-skid sock and had an abrasion on left buttock from carpet burn. Resident said he hit his head on the chair.

04/08/19 at 03:49 PM, resident witnessed falling by RN (registered nurse) after attempting to stand and losing his balance.

04/29/19 at 09:59 PM, nurse alerted to resident falling in the hallway. Resident noted on bottom. Staff reports resident was walking out of room backwards, stumbled, fell to his bottom and hit his head. No abrasion or skin issue to head.

04/30/19 at 01:10 PM, informed from a medication aide the resident was on the floor. Upon assessment found a small amount of blood from the left side of his forehead. Staff applied pressure to the area, and a hematoma (collection of blood outside a blood vessel when the blood vessel becomes injured) observed to left forehead.

The "Physician Communication Sheet", dated 04/30/19, informed the physician of this resident's fall, hitting the left side of his forehead and received a hematoma.

06/12/19 at 6:31 PM, resident talking to CNA behind nurses desk, door opened up and resident lost balance. Nurse slowed down the resident's fall and used arms to protect resident's head. Resident on floor on left side. No new skin occurrences.

06/23/19 at 03:31 PM, nurse informed resident was on the floor. Observed the resident sitting on the floor inbetween the bed and the bathroom.

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The resident was barefoot. Wet spot in front of the resident suspected to be urine. Resident had an abrasion to the right ring finger.

06/29/19 at 02:09 AM, notified by CNA the resident fell. Entered room to find him sitting against his bed railing facing the bathroom and holding himself up with his left arm. The nurse asked him what he was doing, and he said, "trying to get out." Noted a left upper arm skin tear. Denies pain.

07/20/19 at 04:42 AM, nurse informed she was needed in the resident's room. Upon arrival the nurse found the resident gripping on to the front of the wheelchair, with his left hand wedged between the wheelchair and door, and kneeling with his left knee on the floor. The resident complained of right knee pain.

7/29/19 at 05:59 PM, the resident was found on the floor in his room, laying on his left side along the door. He was bleeding from his forehead and left shoulder. The abrasion for his forehead measured 3 cm (centimeters) by 1.5 cm. A skin tear to his shoulder had jagged edges and measured 2 cm by 2 cm . The resident stated, "they threw me around like a kitten, I hit my head on the door, I did not know why I was up."

The "Physician Communication Sheet", dated 07/29/19, informed the physician the resident fell at 11:25 AM. There was an abrasion to the left side of his forehead measuring 3 cm by 1.5 cm. There was a skin tear to the top of his left shoulder measuring 2 cm by 2 cm with jagged edges.

07/30/19 at 08:40 PM, the resident was found on

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the floor bleeding from his head. The nurse aide held pressure to stop the bleeding. The resident did not speak. The facility called Emergency Medical Services immediately.

On 07/30/19 at 09:12 PM, the facility received a phone order from the primary care physician to send the resident to the emergency room per ambulance.

07/31/19 at 02:54 AM, documented staff received a call from the nurse at the hospital who stated the resident received four staples to his head laceration. The resident would return back to the facility.

Review of the available "Fall Investigation Reports" for the above documented falls, lacked a root cause analysis for the falls or appropriate interventions to prevent the resident from repeated falls.

On 07/31/19 at 7:26 AM, observation upon entering the resident's room revealed a blood stain on the carpet approximately 12 inches x 4 inches from the fall the previous night when he hit his head on the floor. A cut to the back of the resident's head showed four staples. The resident transferred with assistance of two staff and use of a gait belt to his wheelchair then was taken to the bathroom.

On 07/31/19 at 11:00 PM, observation revealed the resident sat in a recliner on the day hall with the night charge nurse sitting beside him.

On 7/31/19 at 11:05 PM, Licensed Nurse G reported the resident was on a one to one since his fall with injury. When the resident had a fall,

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the staff updated the care plan.. Sometimes all it took to update a care plan was to change one word, like if the care plan said to "use reminders to use the call light." She would change the intervention to "keep using reminders to use the call light" and it would be considered updated.

On 07/31/19 at 2:41 PM, with Administrative Nurse D, reported with or without injury there may or may not be new interventions put in place. This resident continued to stand independently even though it was unsafe to do so. I would consider using "the resident continued to stand independently even though he was unsafe to do so" as an updated intervention as it was reiterating that the resident needed continued monitoring.

The facility policy for falls, dated 03/26/19, documented staff would review fall interventions from the reference sheet for ideas as to which interventions to implement and then document the new intervention in the care plan. The Quality Assurance nurse would review fall interventions documented in the resident's care plan and would update as needed.

The facility failed to determine the root cause and then develop and implement appropriate interventions for cognitively confused R23 following 10 falls in 4 months to prevent further falls, with the last fall resulting in the resident receiving a head laceration which required an emergency room visit and four staples in his head.

- R 39's signed "Physician's Order Sheet" dated 07/17/19, documented R39 with diagnoses of

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vascular dementia without behaviors, other abnormalities of heart, long term use of aspirin, cellulitus, anxiety disorder, pain, insomnia, local edema, unspecified hearing loss, and hypertension.

The annual "Minimum Data Set" (MDS), dated 04/10/19, recorded the resident with a BIMS (Brief Interview for Mental Status) of six, indicating severely impaired cognition, fluctuating inattention, and no behaviors or rejection of care. Wandering occurred one to three days during the look back period. He required extensive assistance with dressing, personal hygiene, and limited assistance with bed mobility, toileting and supervision with transfers, ambulation and locomotion. His balance was steady at all times with no impairment with range of motion. There was one fall with minor injury on 07/02/18.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 04-10-19, documented the resident's BIMS score was six (severely impaired cognition). He had difficulty with word finding and completing sentences. He was able to answer simple questions and engage in brief conversations. He was frequently confused and had night time wandering issues. Staff were able to redirect.

The "ADL Functional/Rehabilitation Potential CAA," dated 04/19/19, documented to provide nursing support to complete activities of daily living. He wandered into other residents rooms often at night and was usually easily redirected back to his room by staff.

The "Falls CAA," dated 04/10/19, documented to provide the safest environment that was free of

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falls. He had a history of falls, but not recently. His most recent fall risk score was 10, which made him a high fall risk. The most recent BIMS score was six, indicating severely impaired cognition. Sometimes when the resident was unsettled, safety would be a concern.

The quarterly "MDS", dated 07/08/19, documented the resident with a BIMS of seven, indicating severely impaired cognition. He required limited assistance with bed mobility, dressing, toileting, and personal hygiene and supervision with transfers, ambulation and locomotion. There were no falls prior to admission, one non injury fall, and one fall with minor injury since admission.

The plan of care, last reviewed 07/17/19, revealed the following interventions related to falls:

1/17/19, bed in lowest position.

03/19/19, frequent reminders not to bend or reach out for objects.

05/11/19, continuous visibility for safety.

07/18/19, bolster pillow while in bed.

07/30/19, "Falling Leaf Program." (When staff walk by the resident's door staff would look in on him).

A "Progress Note," dated 07/13/19 at 01:35 AM, a Certified Nurse Aide (CNA) notified the Licensed Nurse (LN)the resident was on the floor. Resident was lying on his right side with right arm under him, legs bent slightly with right foot resting

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against the bottom of the recliner with his head against the other recliner. Call light was not going off. While performing ROM (range of motion) he would not allow the LN to move his lower left extremity. He rated his pain as a 10 out of 10 on the pain scale. The LN notified the physician and called EMS (Emergency Medical Services) who transported the resident to the hospital. At 05:38 AM, hospital staff notified the LN the resident transferred to another hospital due to a left hip fracture.

The "Fall Investigation Report," evidenced staff would put a bolster pillow in place in the resident's bed upon his return to the facility for safety.

A "Physician's Note," dated 07/16/19", instructed staff the resident would be readmitted back to the facility and staff were to place a bed alarm for the resident related to his falls.

A progress note, on 07/17/19 no time documented, evidenced facility staff notified the physician that they did not utilize bed alarms however made changes to the resident's care plan to place a bolster pillow in the resident's bed to prevent the resident from rolling out of bed.

A progress note, on 07/17/19 at 6:39 AM, documented the resident was found on the floor. When the nurse entered the room, the resident was on his knees and bending over against the bed. He had a hard time following direction when staff tried to get him off the floor.

The care plan for falls, dated 07/18/19, instructed staff the resident was to use a bolster pillow for safety.

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On 07/31/19 at 8:08 AM, Certified Nurse Aid (CNA) staff M and N transferred the resident from the recliner to a wheelchair with use of a gait belt. Staff took the resident to the bathroom and again transferred him with use of a gait belt. Direct care staff N, confirmed staff placed the bolster pillow in the resident's bed after he rolled out of bed on 7-17-19.

On 07/31/19 at 2:05 PM, Licensed Nurse (LN) H confirmed staff placed the bolster pillow in the resident's bed after he rolled out of bed on 07/17/19, and the bolster pillow was not put in place when the resident returned to the facility.

On 07/31/19 at 2:41 PM, Administrative Nurse D, confirmed staff should have placed the bolster pillow in place when the resident returned to the facility after hospitalization for the hip fracture. (As planned in the "Fall Investigation Report," dated 07/13/19).

The facility policy for "Falls," dated 03/26/19, documented staff would review fall interventions from the reference sheet for ideas as to which interventions to implement and then document the new intervention in the care plan. The Quality Assurance nurse would review fall interventions documented in the resident's care plan and would update as needed.

The facility failed to implement appropriate, planned (07/13/19 "Fall Investigation Report") interventions following the resident's return from the hospital to prevent further falls.