STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055259	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monrovia Post Acute	1220 E. Huntington Drive Duarte, CA 91010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37662 Based on interview and record review, the facility failed to revise the plan of care and implement new interventions for one of three sampled residents (Resident 1) after Resident 1 first fell on [DATE] at 1:20 AM to prevent Resident 1 from further falls and injuries. This deficient practice placed Resident 1 at risk for further falls and injuries. Cross Reference F689 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 to the facility on [DATE], with diagnoses that included traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain due to injury) without loss of consciousness, Covid-19 (minor to severe respiratory illness caused by a virus and spread from person to person), fall (on)(from) other stairs and steps, and other abnormalities of gait (manner of walking or moving on foot) and mobility (ability to move). During a review of Resident 1's Fall Risk Evaluation, dated 6/7/2024, the Fall Risk Evaluation indicated, Resident 1 was at high risk for falls. During a review of Resident 1's History and Physical Examination (H&P), dated 6/8/2024, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's untitled care plan (CP), initiated on 6/7/2024, and revised on 6/9/2024, the CP indicated, Resident 1 was at high risk for falls due to confusion, gait/balance problems, psychoactive drug (medication that affects behavior, mood, thoughts, or perception) use, unawareness of safety needs, and history of falls. The CP interventions included for staff to anticipate and meet Resident 1's needs, review information on past falls and attempt to determine cause of falls, record possible root causes, and alter/remove any potential causes of falls if possible. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 6/11/2024, the MDS indicated, Resident 1 had severely impaired cognition (ability to think and process information). The MDS indicated, Resident 1 normally used a walker (a device that gives support to maintain balance or stability while walking) and wheelchair. The MDS indicated, Resident 1 required substantial/maximal assistance (helper did more than half the effort and lifted or held trunk or limbs) for toileting hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated, Resident 1 required substantial/maximal assistance for rolling left and right on the bed, lying to sitting on side of the bed, sitting to standing, and walking 10 feet. The MDS indicated, Resident 1 had a fall in the last month prior to admission to the facility. During a review of Resident 1's Physical Therapy (PT- therapy used to preserve, enhance, or restore movement and physical function impaired or threatened by disease, injury, or disability) Discharge Summary (PTDS), dated 6/23/2024, the PTDS indicated, Resident 1 required minimal assistance (assisting person performed 25 percent (%) of the task) for transfers and ambulating 150 feet using a two-wheeled walker. During a review of Resident 1's Situation-Background-Assessment-Recommendation Summary for Providers (SBAR Summary), dated 6/24/2024, timed at 1:34 AM, the SBAR Summary indicated, on 6/24/2024, untimed, CNA 1 found Resident 1 sitting on the floor (in Resident 1's room) in an upright position with her back against the wall and her legs straight out. The SBAR Summary indicated, Resident 1 had no injuries and denied any pain. The SBAR Summary indicated, two staff members (unidentified) assisted Resident 1 back to bed. The SBAR Summary indicated, Resident 1's bed remained in the lowest position. The SBAR Summary indicated, Resident 1's primary care provider recommended neurological checks (assesses level of consciousness, movement, hand grasp, pupil [the black opening in the middle of the colored part of the eye) reaction, speech, and vital signs [measurements of the body's most basic functions]) and frequent visual checks. During a review of Resident 1's Nursing Progress Notes (NPN), dated 6/24/2024, timed at 2:43 AM, the NPN indicated, on 6/24/2024, at 1:20 AM, Resident 1 had an unwitnessed fall in Resident 1's room. The NPN indicated, CNA 1 found Resident 1 sitting on the floor in front of Resident 1's bed with Resident 1's back against the wall and near the window. The NPN indicated, Resident 1 could not say what happened. During a review of the same NPN, dated 6/24/2024, timed at 2:43 AM, the NPN indicated, on 6/24/2024, at 2:15 AM, Resident 1 had a second fall. The NPN indicated, Resident 1's roommate (Resident 3) was calling for help. The NPN indicated, CNA 1 found Resident 1 sitting on the floor in an upright position near Resident 3's bed. The NPN indicated, Resident 1 had laceration (a tear, cut, or gash) on the left part of Resident 1's head and blood on her arm and gown. The NPN indicated, Resident 1 stated Resident 1 fell on something but was unsure of what it was. The NPN indicated, Resident 1 did not complaint of any pain or discomfort. The NPN indicated, LVN 1 called for emergency transport due to head injury. During an interview on 7/19/2024 at 12:15 PM with the Director of Rehabilitation (DOR), the DOR stated Resident 1 was unsteady and used a walker for ambulation. The DOR stated Resident 1 required a lot of cueing (to provide a hint or prompt for an action), but able to follow directions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/19/2024 at 1:07 PM with CNA 1, CNA 1 stated on 6/23/2024, at 11 PM, Resident 1 was very confused and could not sleep. CNA 1 stated on 6/24/2024, unable to recall time, CNA 1 had to sit by Resident 1's room door because Resident 1 kept getting out of bed. CNA 1 stated on 6/24/2024, at around 1:30 AM, CNA 1 found Resident 1 sitting on Resident 1's buttocks on the floor, close to Resident 1's bed. CNA 1 stated on 6/24/2024, after the first fall that occurred at 1:20 AM, unable to recall exact time, CNA 1 was in another resident's room, opposite Resident 1's room, when Resident 1 had a second fall. CNA 1 stated CNA 1 heard a loud sound and before CNA 1 entered Resident 1's room, CNA 1 saw Resident 1 on the floor by Resident 1's room door. CNA 1 stated CNA 1 notified LVN 1. CNA 1 stated LVN 1 did not provide CNA 1 with any specific instructions to increase supervision/monitoring of Resident 1 after Resident 1's first fall (on 6/24/2024 at 1:20 AM). During a follow-up telephone interview on 7/22/2024 at 12:21 PM with CNA 1, CNA 1 stated on 6/23/2024, at 11 PM, CNA 1 found Resident 1 walking unassisted to Resident 1's bathroom. CNA 1 stated CNA 1 assisted Resident 1 to the bathroom then put Resident 1 back to bed. CNA 1 stated a few minutes after, CNA 1 heard Resident 1 getting up from Resident 1's bed. CNA 1 stated CNA 1 asked Resident 1 what Resident 1 needed but Resident 1 did not say anything. CNA 1 stated Resident 1 was confused and CNA 1 redirected Resident 1 back to Resident 1's bed. CNA 1 stated (on 6/24/2024, at 1:20 AM), Resident 1 got up from Resident 1's bed unassisted for the third time and fell . CNA 1 stated CNA 1 was sitting in the hallway monitoring the call lights when Resident 1 fell the first time on 6/24/2024 at 1:20 AM. CNA 1 stated CNA 1 could not see inside Resident 1's room from the hallway where CNA 1 was sitting. CNA 1 stated CNA 1 notified LVN 1 and LVN 1 gave medication to Resident 1. During a review of Resident 1's Medication Administration Record (MAR) for 6/2024, the MAR indicated, no documented evidence that LVN 1 administered medication to Resident 1 from 6/23/2024 to 6/24/2024 during the 11 PM to 7 AM shift. On 7/22/2024 at 10:55 AM and 11:31 AM, attempts were made to contact LVN 1, however LVN 1 did not answer or return the call. During an interview on 7/22/2024 at 2:07 PM with the Director of Nursing (DON), the DON stated (on 6/24/2024), Resident 1 was having increased confusion, agitation, and kept getting out of bed. The DON stated due to Resident 1's agitation and episodes of getting out of bed, the staff (CNA 1 and LVN 1) needed to increase supervision/monitoring of Resident 1 from every two hours to every hour, elevate to every 15 minutes, or have CNA 1 stay with Resident 1 as needed for Resident 1's safety. The DON stated LVN 1 needed to revise Resident 1's care plan and add new interventions after the first fall to help prevent the second fall and injuries. On 7/30/2024 at 8:55 AM, an attempt was made to contact LVN 1, however LVN 1 did not answer or return the call. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Safety and Supervision of Residents, revised 7/2017, the P&P indicated, resident safety, supervision, and assistance to prevent accidents were facility-wide priorities. The P&P indicated, the facility's individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The P&P indicated, the facility analyzed information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The P&P indicated, the care team targeted interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. The P&P indicated, implementing interventions to reduce accident risks and hazards included communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training as necessary, and ensuring that interventions were implemented. The P&P indicated, monitoring the effectiveness of interventions shall include ensuring that interventions were implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed and evaluating the effectiveness of new or revised interventions. The P&P indicated, resident supervision was a core component of the systems approach to safety. The type and frequency of supervision may vary among residents and over time for the same residents. The P&P indicated, for example, resident supervision may need to be increased when there was a change in the resident's condition. During a review of the facility's P&P titled, Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated, based on previous evaluations and current data, the staff identified interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P indicated, if the resident continued to fall, staff re-evaluated the situation and whether it was appropriate to continue or change current interventions. The P&P indicated, if falling recurred despite initial interventions, staff implemented additional or different interventions, or indicate why the current approach remained relevant. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated, care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The P&P indicated, when possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. The P&P indicated, assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions change. The P&P indicated, the facility reviewed and updated the care plan when there had been a significant change in the resident's condition and when the desired outcome was not met.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37662 Based on interview and record review, the facility failed to provide care and services to prevent a fall (move downward, typically rapidly and freely without control, from a higher to a lower level) for one of three sampled residents (Resident 1) as indicated in the facility's policies and procedures (P&P) titled, Safety and Supervision of Residents, and Falls and Fall Risk, Managing, by failing to: 1. Ensure Certified Nursing Assistant 1 and/or Licensed Vocational Nurse 1 provided supervision/monitoring when Resident 1, who was assessed as being high risk for falls, had increased agitation and confusion, repeated episodes of getting out of bed, and ambulating in Resident 1's room unassisted. 2. Ensure LVN 1 revised Resident 1's untitled care plan for falls and implemented new interventions after Resident 1 first fell on [DATE] at 1:20 AM to prevent Resident 1 from further falls and injuries. As a result, on 6/24/2024 at 2:15 AM, after the first fall at 1:20 AM, Resident 1 fell to the floor again. Resident 1 sustained a moderately displaced fracture (bone breaks into two or more pieces and move out of alignment) and mildly impacted fracture (occurs when the broken ends of the bone are jammed together by force of the injury) at the neck of the left subcapital femur (neck of the thigh bone). Resident 1 was transferred and admitted to General Acute Care Hospital (GACH) 2 on 6/24/2024 at 3:08 AM for further evaluation and had a left hip hemiarthroplasty (a type of partial hip replacement surgery that involved replacing half of the hip joint) on 7/1/2024. Cross Reference F657 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 to the facility on [DATE], with diagnoses that included traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain due to injury) without loss of consciousness, Covid-19 (minor to severe respiratory illness caused by a virus and spread from person to person), fall (on)(from) other stairs and steps, and other abnormalities of gait (manner of walking or moving on foot) and mobility (ability to move). During a review of Resident 1's Fall Risk Evaluation, dated 6/7/2024, the Fall Risk Evaluation indicated, Resident 1 was at high risk for falls. During a review of Resident 1's History and Physical Examination (H&P), dated 6/8/2024, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's untitled care plan (CP), initiated on 6/7/2024, and revised on 6/9/2024, the CP indicated, Resident 1 was at high risk for falls due to confusion, gait/balance problems, psychoactive drug (medication that affects behavior, mood, thoughts, or perception) use, unawareness of safety needs, and history of falls. The CP interventions included for staff to anticipate and meet Resident 1's needs, review information on past falls and attempt to determine cause of falls, record possible root causes, and alter/remove any potential causes of falls if possible. During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 6/11/2024, the MDS indicated, Resident 1 had severely impaired cognition (ability to think and process information). The MDS indicated, Resident 1 normally used a walker (a device that gives support to maintain balance or stability while walking) and wheelchair. The MDS indicated, Resident 1 required substantial/maximal assistance (helper did more than half the effort and lifted or held trunk or limbs) for toileting hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated, Resident 1 required substantial/maximal assistance for rolling left and right on the bed, lying to sitting on side of the bed, sitting to standing, and walking 10 feet. The MDS indicated, Resident 1 had a fall in the last month prior to admission to the facility. During a review of Resident 1's Physical Therapy (PT- therapy used to preserve, enhance, or restore movement and physical function impaired or threatened by disease, injury, or disability) Discharge Summary (PTDS), dated 6/23/2024, the PTDS indicated, Resident 1 required minimal assistance (assisting person performed 25 percent (%) of the task) for transfers and ambulating 150 feet using a two-wheeled walker. During a review of Resident 1's Situation-Background-Assessment-Recommendation Summary for Providers (SBAR Summary), dated 6/24/2024, timed at 1:34 AM, the SBAR Summary indicated, on 6/24/2024, untimed, CNA 1 found Resident 1 sitting on the floor (in Resident 1's room) in an upright position with her back against the wall and her legs straight out. The SBAR Summary indicated, Resident 1 had no injuries and denied any pain. The SBAR Summary indicated, two staff members (unidentified) assisted Resident 1 back to bed. The SBAR Summary indicated, Resident 1's bed remained in the lowest position. The SBAR Summary indicated, Resident 1's primary care provider recommended neurological checks (assesses level of consciousness, movement, hand grasp, pupil [the black opening in the middle of the colored part of the eye) reaction, speech, and vital signs [measurements of the body's most basic functions]) and frequent visual checks. During a review of Resident 1's Nursing Progress Notes (NPN), dated 6/24/2024, timed at 2:43 AM, the NPN indicated, on 6/24/2024, at 1:20 AM, Resident 1 had an unwitnessed fall in Resident 1's room. The NPN indicated, CNA 1 found Resident 1 sitting on the floor in front of Resident 1's bed with Resident 1's back against the wall and near the window. The NPN indicated, Resident 1 could not say what happened. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the same NPN, dated 6/24/2024, timed at 2:43 AM, the NPN indicated, on 6/24/2024, at 2:15 AM, Resident 1 had a second fall. The NPN indicated, Resident 1's roommate (Resident 3) was calling for help. The NPN indicated, CNA 1 found Resident 1 sitting on the floor in an upright position near Resident 3's bed. The NPN indicated, Resident 1 had laceration (a tear, cut, or gash) on the left part of Resident 1's head and blood on her arm and gown. The NPN indicated, Resident 1 stated Resident 1 fell on something but was unsure of what it was. The NPN indicated, Resident 1 did not complaint of any pain or discomfort. The NPN indicated, LVN 1 called for emergency transport due to head injury. During a review of Resident 1's GACH 2 Emergency Medicine Report (EMR), dated 6/24/2024, timed at 3:08 AM, the EMR indicated, Resident 1was brought in by ambulance for contusion (injury to the soft tissue often produced by a blunt force such as a kick, fall, or blow) after falling out of the bed. The EMR indicated, Resident 1 complained of six out of 10 pain (0 = no pain and 10 = the worst pain) to her left hip. The EMR indicated, Resident 1 would be admitted to GACH 2 for further care and evaluation. During a review of Resident 1's GACH 2 Hip and Pelvis X-ray (pictures of the inside of the body) Report of Resident 1's left hip, dated 6/24/2024, timed at 4:15 AM, the X-ray Report indicated, Resident 1 had a moderately displaced left femoral subcapital neck fracture. During a review of Resident 1's GACH 2 Computed Tomography Scan (CT scan, medical imaging technique used to obtain detailed internal images of the body) Report of Resident 2's left hip, dated 6/24/2024, timed at 8:47 AM, the CT scan Report indicated, Resident 1 had a moderately displaced fracture and mildly impacted fracture at the neck of the left subcapital femur. During a review of Resident 1's GACH 2 Discharge Summary (DS), dated 7/9/2024, the DS indicated, Resident 1 had a left hip hemiarthroplasty (a type of partial hip replacement surgery that involved replacing half of the hip joint) for femoral neck fracture on 7/1/2024. During an interview on 7/19/2024 at 12:15 PM with the Director of Rehabilitation (DOR), the DOR stated Resident 1 was unsteady and used a walker for ambulation. The DOR stated Resident 1 required a lot of cueing (to provide a hint or prompt for an action), but able to follow directions. During a telephone interview on 7/19/2024 at 1:07 PM with CNA 1, CNA 1 stated on 6/23/2024, at 11 PM, Resident 1 was very confused and could not sleep. CNA 1 stated on 6/24/2024, unable to recall time, CNA 1 had to sit by Resident 1's room door because Resident 1 kept getting out of bed. CNA 1 stated on 6/24/2024, at around 1:30 AM, CNA 1 found Resident 1 sitting on Resident 1's buttocks on the floor, close to Resident 1's bed. CNA 1 stated on 6/24/2024, after the first fall that occurred at 1:20 AM, unable to recall exact time, CNA 1 was in another resident's room, opposite Resident 1's room, when Resident 1 had a second fall. CNA 1 stated CNA 1 heard a loud sound and before CNA 1 entered Resident 1's room, CNA 1 saw Resident 1 on the floor by Resident 1's room door. CNA 1 stated CNA 1 notified LVN 1. CNA 1 stated LVN 1 did not provide CNA 1 with any specific instructions to increase supervision/monitoring of Resident 1 after Resident 1's first fall (on 6/24/2024 at 1:20 AM). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a follow-up telephone interview on 7/22/2024 at 12:21 PM with CNA 1, CNA 1 stated on 6/23/2024, at 11 PM, CNA 1 found Resident 1 walking unassisted to Resident 1's bathroom. CNA 1 stated CNA 1 assisted Resident 1 to the bathroom then put Resident 1 back to bed. CNA 1 stated a few minutes after, CNA 1 heard Resident 1 getting up from Resident 1's bed. CNA 1 stated CNA 1 asked Resident 1 what Resident 1 needed but Resident 1 did not say anything. CNA 1 stated Resident 1 was confused and CNA 1 redirected Resident 1 back to Resident 1's bed. CNA 1 stated (on 6/24/2024, at 1:20 AM), Resident 1 got up from Resident 1's bed unassisted for the third time and fell . CNA 1 stated CNA 1 was sitting in the hallway monitoring the call lights when Resident 1 fell the first time on 6/24/2024 at 1:20 AM. CNA 1 stated CNA 1 could not see inside Resident 1's room from the hallway where CNA 1 was sitting. CNA 1 stated CNA 1 notified LVN 1 and LVN 1 gave medication to Resident 1. During a review of Resident 1's Medication Administration Record (MAR) for 6/2024, the MAR indicated, no documented evidence that LVN 1 administered medication to Resident 1 from 6/23/2024 to 6/24/2024 during the 11 PM to 7 AM shift. On 7/22/2024 at 10:55 AM and 11:31 AM, attempts were made to contact LVN 1, however LVN 1 did not answer or return the call. During an interview on 7/22/2024 at 2:07 PM with the Director of Nursing (DON), the DON stated (on 6/24/2024), Resident 1 was having increased confusion, agitation, and kept getting out of bed. The DON stated due to Resident 1's agitation and episodes of getting out of bed, the staff (CNA 1 and LVN 1) needed to increase supervision/monitoring of Resident 1 from every two hours to every hour, elevate to every 15 minutes, or have CNA 1 stay with Resident 1 as needed for Resident 1's safety. The DON stated LVN 1 needed to revise Resident 1's care plan and add new interventions after the first fall to help prevent the second fall and injuries. The DON stated CNA 1 needed to notify LVN 1 when CNA 1 had to help another resident so LVN 1 could have monitored Resident 1. On 7/30/2024 at 8:55 AM, an attempt was made to contact LVN 1, however LVN 1 did not answer or return the call. During a review of the facility's P&P titled, Safety and Supervision of Residents, revised 7/2017, the P&P indicated, resident safety, supervision, and assistance to prevent accidents were facility-wide priorities. The P&P indicated, the facility's individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The P&P indicated, the facility analyzed information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The P&P indicated, the care team targeted interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. The P&P indicated, implementing interventions to reduce accident risks and hazards included communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training as necessary, and ensuring that interventions were implemented. The P&P indicated, monitoring the effectiveness of interventions shall include ensuring that interventions were implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed and evaluating the effectiveness of new or revised interventions. The P&P indicated, resident supervision was a core component of the systems approach to safety. The type and frequency of supervision may vary among residents and over time for the same residents. The P&P indicated, for example, resident supervision may need to be increased when there was a change in the resident's condition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P&P titled, Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated, based on previous evaluations and current data, the staff identified interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P indicated, if the resident continued to fall, staff re-evaluated the situation and whether it was appropriate to continue or change current interventions. The P&P indicated, if falling recurred despite initial interventions, staff implemented additional or different interventions, or indicate why the current approach remained relevant.