| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055995 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Windsor Convalescent Center of North Long Beach | 260 E Market St<br>Long Beach, CA 90805 |

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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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician for two of three sampled residents on:<br><br>a) 5/22/2025 when Resident 3 was transferred to a general acute care hospital (GACH) for difficulty breathing,<br><br>b) 5/23/2025 when Resident 4 had a new skin redness to the nose area, and<br><br>c) 5/26/2025 when Resident 4 was refusing care, had agitation, and increased confusion.<br><br>This failure had the potential to result in a delay of care for Resident 3 and Resident 4.<br><br>Findings:<br><br>During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - -a chronic lung disease causing difficulty in breathing) and anxiety disorder (persistent and excessive worry that interferes with daily activities).<br><br>During a review of Resident 3 ' s Minimum Data Set (MDS – a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 3 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment and required setup assistance for eating, and moderate assistance (helper does less than half the effort) for toileting, bathing, and dressing.<br><br>During a concurrent interview and record review on 6/5/2025 at 10:16 a.m. with licensed vocational nurse (LVN) 1, Resident 3 ' s medical record was reviewed. LVN 1 stated on 5/22/2025 at 3:40 p.m., Resident 1 called 911 himself due to difficulty breathing and was transported to the GACH by ambulance. LVN 1 stated the physician was not notified of the change of condition or of Resident 3 ' s transfer to the GACH. LVN 1 stated the physician should have been notified of Resident 3 ' s transfer to the GACH.<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 4's admission Record , the admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), schizophrenia (a mental illness that is characterized by disturbances in thought), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).<br><br>During a review of Resident 4 ' s MDS dated [DATE], the MDS indicated Resident 4 had severe cognitive impairment, required supervision for eating, required maximal assistance (Helper does more than half the effort) for toileting and dressing, and was dependent (helper does all the effort) for bathing.<br><br>During a concurrent interview and record review on 6/5/2025 at 10:16 a.m., with LVN 1, Resident 4 ' s medical record was reviewed. LVN 1 stated the Situation-Background-Assessment-Recommendation (SBAR) Communication Form dated 5/23/2025 indicated Resident 4 had a change in skin condition, new redness to the nose. The SBAR form indicated the facility was awaiting a call back (from the physician) for recommendations of the physician. LVN 1 stated the documentation was not clear if the physician was informed. LVN 1 stated there was no follow up with physician or escalation to the medical director on 5/22/2025. LVN 1 reviewed the SBAR Communication form dated 5/26/2025 which indicated Resident 4 had episodes of undressing, refusal of care, and increased confusion. The SBAR form indicated the facility was pending MD (medical doctor/physician) reply for recommendations of the physician. LVN 1 stated there was not a follow up with the physician or medical director on 5/26/2025. LVN 1 stated the physician should be notified for any change of condition, and if unable to reach the physician, the nurse should call again or call the facility ' s medical director. The LVN stated any notification or follow up with the physician is documented in the resident ' s medical record.<br><br>During an interview on 6/5/2024 at 3:04 p.m., with the Director of Nursing (DON), the DON stated if a resident experiences a change of condition or is transferred to a GACH, the physician should be notified. The DON stated, if the nurse is unable to speak to the physician with four hours, the nurse should contact the facility ' s medical director. The DON stated if the physician is not notified of a change of condition of the resident, there is a potential for delay of care.<br><br>During a review of the facility ' s policy and procedure (P&P), titled Change in Condition, Notification of, dated 8/25/2021, the P&P indicated the facility must immediately inform the resident, consult with eh resident ' s physician and/or NP, and notify, consistent with his/her authority, Representative where there is:<br><br>·<br><br>An accident involving the Resident.<br><br>·<br><br>A significant change in the Resident ' s physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications).<br><br>·<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A need to alter treatment significantly (that is, a need to discontinue ro change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br><br>·<br><br>A decision to transfer or discharge the Resident from the Center. |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) was free from physical restraints (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body) by failing to:<br><br>1.Assess Resident 1 for possible causes of behaviors and implement interventions before the application of physical restraints.<br><br>2.Notify the physician of Resident 1 ' s continued agitation and obtain a Physician Order for the use of Physical restraints before applying the restraints.<br><br>3.Develop a care plan to address the need for the implementation of physical restraints.<br><br>4.Attempt to use less restrictive interventions before application of physical restraints on Resident 1.<br><br>5. Ensure Registered Nurses (RN), Certified Nurse Assistants (CNA), and staff were competent in using physical restraints and managing fall risks and challenging behaviors.<br><br>These deficient practices resulted in violation of Resident 1 ' s right to be free from restraints. On 5/30/2025 approximately 2:30 a.m., RN 1 and CNA 1 restrained Resident 1 (using a bed sheet wrapped and tied around Resident 1 ' s legs to restrict his movements) due to a risk of recurrent falls and combative behavior. This practice placed Resident 1 at risks of skin breakdown, injury from attempts to free himself, feelings of helplessness, fear, and humiliation leading to physical, long term emotional, mental decline, and reduced self-worth.<br><br>Findings:<br><br>During a review of Resident 1 ' s admission Record, the admission Record indicated the facility admitted Resident 1 on 5/18/2025, with diagnoses including, cognitive communication deficit (difficulty carrying a conversation), abnormal posture, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and chronic pain syndrome (persistent pain that lasts weeks to years).<br><br>During a review of Resident 1 ' s Minimum Data Set (MDS), a resident assessment tool, dated 5/24/2025, the MDS indicated Resident 1 ' s cognition (ability to make decisions of daily living) was severely impaired. Resident 1needed substantial assistance (helper does more than half the effort to complete the task) with dressing, personal hygiene, oral hygiene, and Resident 1 was dependent (helper does all the effort to complete task) on staff with toileting hygiene, and showering.<br><br>During a review of Resident 1 ' s Order Summary as of 5/30/2025, the Order Summary indicated starting 5/18/2025, Lorazepam Oral Tablet 0.5 MG (medication to treat anxiety), give one tablet by mouth every six hours as needed for anxiety for 14 Days manifested by inability to stay still.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1 ' s Medication Administration record (MAR), 5/2025, the MAR indicated Lorazepam 0.5 milligrams orally were administered on 5/30/2025 at 2:30 a.m. and it was effective.<br><br>During a record review of the facility ' s Interview record of CNA 1 at 5/30/2025 at 8:57 a.m., the record indicated CNA 1 stated on 5/30/2025, Resident 1 was very agitated, was kicking during care, and was not redirectable.<br><br>During a phone interview on 5/30/2025 at 4:45 p.m., with the Certified Nurse Assistant (CNA) 1, CNA 1 stated Registered Nurse (RN)1 tied Resident 1 on the calf and leg area to the bed frame to prevent Resident 1 from falling. CNA 1 stated RN 1 and CNA 1 forgot to remove the restraints.<br><br>During a record review of the facility ' s Interview record of RN 1 at 5/30/2025 at 5:10 p.m., the record indicated RN 1 stated he (RN 1) made a clinical judgement to secure Resident 1 to the bed to prevent him from harming himself as well as the staff. RN1 stated Resident 1 was agitated kicking staff unable to control and manage his behavior so RN 1 and CNA 1 secured his legs wo prevent further harm and for resident safety.<br><br>During a phone interview on 5/30/2025 at 5:30 p.m., with Registered Nurse (RN) 1, RN 1 stated he applied sheets around Resident 1 ' s legs to prevent him from getting out of bed, to prevent him from hitting and kicking staff. RN 1 stated Ativan (medication used to induce calmness and sedation) was administered and was ineffective. The physician was not notified nor Resident 1 ' s responsible party. RN 1 stated there were no orders for the restraints and he forgot to remove the restraints. RN 1 stated it was poor judgement on his part.<br><br>During a review of Resident 1 ' s Change in Condition Evaluation, 5/30/2025 at 11:05 a.m., the evaluation indicated at approximately 10 a.m., Resident 1 was noted lying in bed with wrapped bed sheet around ankles.<br><br>During an interview on 5/30/20025 at 3:55 p.m., with Certified Nurse Assistant (CNA) 2, CNA 2 stated she and the Certified Occupational therapist assistant (COTA) found sheets wrapped around Resident 1 ' s calf and leg area, and she immediately called Licensed Vocational Nurse (LVN) 2 and removed the sheets around extremities.<br><br>During the continued interview on 5/30/2025 at 4 p.m., CNA 2 stated she reported it because the facility does not allow restraints, and we do not tie residents to prevent them from falling.<br><br>During an interview on 6/4/205 at 2:38 p.m., with LVN 2, LVN 2 stated later in the day after morning medication pass, CNA 2 alerted LVN 2 that Resident 1 was restrained. LVN 2 stated sheets were wrapped around Resident ' s legs around the calf area like a roll. The legs were closed together.<br><br>During an interview and record review with the Administrator (ADMIN) on 6/6/2025 at 2:54 p.m., the ADMIN stated RN 1 stated he (RN 1) made a clinical judgement to secure Resident 1 to the bed to prevent him from harming himself as well as the staff. The ADMIN stated RN1 reported Resident 1 was agitated, kicking staff unable to control and manage his behavior so RN 1 and CNA 1 secured his legs to prevent further harm and for resident safety.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 6/6/2025 at 3:10 p.m., with the DON, Resident 1 ' s medical record was reviewed. The DON stated the bedsheet wrapped around Resident ' s legs may be a restraint because it limits the resident ' s movement. The DON stated Resident 1 was not assessed for possible causes of behaviors prior to the application of restraints. The DON stated the physician did not order and was not aware of the restraint. The DON stated there is no care plan for restraint application for this resident. The DON stated less restrictive interventions that could have been used instead of restraint application include activities, redirection, increase monitoring, or 1:1 supervision.<br><br>During a review of facility policies and procedure (P&P), titled, Resident Rights, revised 12/2021, the P&P indicated federal and state laws guarantee certain basic rights to all residents of the facility including the right to be free from physical or chemical restraints not required to treat the residents ' symptom.<br><br>During a review of the facility ' s P&P titled, Use of Restraints, revised 4/2017, the P&P indicated:<br><br>1) Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully.<br><br>2) Restraints shall only be used to treat the resident's medical symptom(s) and never for staff convenience or for the prevention of falls.<br><br>3) When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented.<br><br>4) Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.<br><br>5) The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same way the staff applied it given that resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint.<br><br>6) Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including Tucking sheets so tightly that a bed-bound resident cannot move;<br><br>7) Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to detem1ine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:<br><br>a. Obtain informed consent for Ativan for one of three sampled residents (Resident 3) prior to administration<br><br>b. Monitor and document manifested behaviors for the administration of Ativan and Seroquel for one of three sampled residents (Resident 1).<br><br>These deficiencies have the potential to result in the use of unnecessary medication, or non-therapeutic use of psychotropic medication.<br><br>Findings:<br><br>During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - -a chronic lung disease causing difficulty in breathing) and anxiety disorder (persistent and excessive worry that interferes with aily activities).<br><br>During a review of Resident 3 ' s Minimum Data Set (MDS – a resident assessment tool), dated 5/21/2025, the MDS indicated had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, and required setup assistance for eating, and required moderate assistance (helper does less than half the effort) for toileting, bathing, and dressing.<br><br>During a review of Resident 3 ' s Physician Order Summary, the Order Summary indicated an order for Ativan 0.5 milligrams (MG- a unit of measurement) give one tablet by mouth every six hours as needed for Anxiety manifested by restlessness for 14 days starting 5/20/2025.<br><br>During a review of Resident 3 ' s May 2025 medication administration record (MAR), the MAR indicated Resident 3 received Ativan 0.5 MG on 5/21/2025 at 2:40 a.m.<br><br>During a concurrent interview and record review on 6/6/2025 at 3:10 p.m., with the Director of Nursing (DON), Resident 3 ' s Psychotropic Medication Administration Disclosure (Anti-anxiety) Informed Consent for Ativan 0.5 MG every 6 hours as needed (PRN) for anxiety manifested by (m/b) restlessness, dated 5/22/2025, was reviewed. The DON stated there is no signature from the Resident or Resident Representative indicating that the risk, benefits, and indication for medication was explained to the resident or resident representative. The DON stated an informed consent [NAME] be obtained before giving any psychotropic medication such as Ativan. The DON stated it is the resident ' s right to be informed of which psychotropic medications they are prescribed, and their right to agree or refuse the medication.<br><br>During a review of Resident 1 ' s admission Record, the admission record indicated the facility admitted Resident 1 on 5/18/2025, with diagnoses including, cognitive communication deficit, abnormal posture, bipolar disorder, and chronic pain syndrome.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated Resident 1 ' s cognition was severely impaired. Resident 1 needed substantial assistance (helper does more than half the effort to complete the task) with dressing, personal hygiene, oral hygiene, and Resident 1 was dependent (helper does all the effort to complete task) on staff with toileting hygiene, and showering.<br><br>During a concurrent interview and record review on 6/6/2025 at 2:11 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s May 2025 Medication Administration record (MAR) was reviewed. The MAR indicated:<br><br>a.Ativan 0.5 milligrams orally were administered on 5/30/2025 at 2:30 a.m. and it was effective.<br><br>b.Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet via G-Tube three times a day for bipolar disorder m/b increase agitation, kicking staff, thrashing, getting out of bed unsupervised. Medication was administered 5/18/2025 and discontinued 5/20/2025.<br><br>c.Monitoring for behaviors was not tallied with hashmark as ordered.<br><br>d.Start Date 05/18/2025, Monitor episodes of inability to stay still. tally hashmark every shift for use of Ativan for 14 Days.<br><br>e.Start Date 5/18/2025, Monitor episodes of increased agitation, kicking staff, thrashing, getting out of bed unsupervised. Tally hashmark every shift for use of Seroquel<br><br>LVN 1 stated the MAR should have indicated the number of episodes of the manifested behavior, not a check mark. LVN 1 stated it is important that the manifested behaviors are documented and counted so that the physician can review if the medication is appropriate.<br><br>During a concurrent interview and record review on 6/6/2025 at 3:10 p.m., with the DON, Resident 1 ' s medical record was reviewed. The DON stated it is important to document and tally manifested behaviors to prevent unnecessary medications to residents. The DON stated if behaviors are not being tracked or tallied, there is an increased risk of adverse medication affects and possible over and under dosing which can lead to falls or injuries.<br><br>During a review of the facility ' s policy and procedure (P&P) titled, Psychotropic Medication Use, effective 6/2021, the P&P indicated:<br><br>1) Psychotropic medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to use.<br><br>2) All medications used to treat behaviors must be monitored for efficacy, risks, benefits, harm and adverse consequences. ' s behavior<br><br>3) Facility staff should monitor resident using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medications. Facility staff should monitor triggers, episodes, and symptoms, and the resident ' s response to staff interventions.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4) It is the responsibility of the attending health care practitioner to inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulation. The informed consent will be obtained by the Prescriber prior to initiation of the psychotropic medication.<br><br>5) The facility shall verify informed consent prior to the administration of a psychotropic medication for a resident. |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate a fall risk care plan for one of two sampled residents (Resident 1) when Resident 1 was identified as a fall risk.<br><br>This failure resulted in Resident 1 experiencing a fall on 5/23/2025 and sustaining a skin tear to the right elbow.<br><br>Findings:<br><br>During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hyponatremia [low levels of sodium (salt) in the blood that cause headache, confusion, or seizures] and nontraumatic intracerebral hemorrhage (bleeding in the brain not caused by an injury<br><br>During a review of Resident 1's History and Physical (H&P), dated 5/27/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/24/2025, the MDS indicated Resident 1 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment and required maximal assistance (helper does more than half the effort) for oral hygiene and dressing, and was dependent (helper does all the effort) for toileting and bathing.<br><br>During a concurrent interview and record review on 6/5/2025 at 2:10 p.m. with Minimum Data Set Coordinator (MDSC), Resident 1's medical record was reviewed. The MDSC stated the Nursing Documentation Evaluation conducted by a registered nurse, dated 5/18/2025, indicated Resident 1 had fall risks factors identified which included disorientation/confusion, poor safety judgment, unsteady gait (walking), and received psychotropic (affecting how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medication. The MDSC stated Resident 1 fell on 5/23/2025. The MDSC stated there were no fall interventions ordered, or Risk for Falls care plan initiated prior to Resident 1's fall on 5/23/2025. The MDSC stated Resident 1's Risk for Falls care plan was initiated on 5/24/2025.<br><br>During an interview on 6/6/2025 on 3:10 p.m., with the Director or Nursing (DON), the DON stated baseline care plans should be initiated within 48 hours of admission to the facility. The DON stated Resident 1 should have had a care plan to address the risk for falls. If care plans do not address a resident's risk for falls, the resident can experience an injury from a fall.<br><br>During a review of the facility's policy and procedure (P&P), titled Care Plan - Baseline, dated 8/25/2021, the P&P indicated the baseline care plan is developed within 48 hours of a resident's admission.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055995 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Windsor Convalescent Center of North Long Beach | 260 E Market St<br>Long Beach, CA 90805 |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's policy and procedure (P&P), titled Fall Management, dated 5/26/2021, the P&P indicated patients will be assessed for falls risk, those determined to be at risk will receive appropriate interventions to reduce risk an minimize injury. The facility will develop an individualized plan of care. |