STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265797	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridge Crest Nursing Center	706 South Mitchell Warrensburg, MO 64093

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 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** Based on interview, and record review, the facility failed to provide oversight and put appropriate interventions in place for one sampled resident (Resident #1) who fell twice on 12/27/24 and sustained head lacerations and then fell again on 1/3/25; failed to ensure fall investigations were completed to include root-cause analysis (RCA-a collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems) and interventions that were put in place for three sampled residents (Resident #1, Resident #6, and Resident #7); failed to complete neurological checks for one sampled resident (Resident #6) after an un-witnessed fall, and failed to update the care plans for three sampled residents (Resident #1, Resident #6, and Resident #7) to include the interventions that were put in to place after the falls occurred out of seven sampled residents. The facility census was 47 residents. Review of the facility's policy titled Falls and Fall Risk, Managing dated March 2018 showed: -A fall was defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force. -An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught himself/herself. -A fall without injury was still a fall. -Unless there was evidence suggesting otherwise, when a resident was found on the floor, a fall would be considered to have occurred. -The staff, with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. -If a systematic evaluation of a resident's fall risk identified several possible interventions, the staff may choose to prioritize interventions. -In conjunction with the consultant pharmacist and nursing staff, the attending physician would identify and adjust medications that may be associated with an increased risk of falling or indicate why those medications could not be tapered or stopped, even if for a trial period. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-If falls were to continue to occur despite initial interventions, staff would implement additional or different interventions, or indicate why the current approach remains relevant. -If underlying causes could not be readily identified or corrected, staff would try various interventions, based on assessment of the nature or category of falling, until was reduced or stopped, or until the reason for continuation of the falling was identified as unavoidable. -In conjunction with the attending physician, staff would identify and implement relevant interventions to try to minimize serious consequences of falling. -The staff would monitor and document each resident's response to interventions intended to reduce falling of the risks of falling. -If interventions were successful in preventing falling, staff would continue the interventions or reconsider whether the measures were still needed if a problem that required the intervention had resolved. -If the resident continued to fall, the staff would re-evaluate the situation and whether it was appropriate to continue or change current interventions. -The staff and/or physician would document the basis for conclusions that specific risk factors existed that would continue to present a risk for falling or injury due to falls. Review of the facility's policy titled Neurological Assessment dated October 2023 showed routine neurological assessments were conducted to evaluate the resident for small changes over time that may be indicative of a neurological injury. 1. Review of Resident #1's admission Record showed the resident was admitted to the facility on [DATE] with the following diagnoses: - Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, mostly affecting middle-aged and elderly people) with Dyskinesia (abnormality or impairment of voluntary movement). -Unspecified Convulsions (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders). -Traumatic Brain Hemorrhage (an escape of blood from a ruptured blood vessel) of Left Cerebrum (the largest part of the brain that is divided into two hemispheres) with Loss of Consciousness of Unspecified Duration. -Muscle Wasting and Atrophy (thinning of muscle mass). -Old Myocardial Infarction (heart attack- a blockage of blood flow to the heart muscle). -Difficulty in Walking. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 11/13/24 showed: -The resident was cognitively intact. -The resident had no Range-of-Motion (ROM) impairment. -The resident had not used any mobility devices. -The resident was independent with all care. -The resident had not had any falls since admission. Review of the resident's Fall Risk Evaluation completed on 12/23/24 at 6:07 P.M. showed: -The resident had one to two falls in the past three months. -The resident was ambulatory and continent. -The resident had predisposing diseases including Parkinson's Disease and seizures, which increased his/her fall risk. -The resident did not take any predisposing medications that would increase his/her risk for falls. -There were no clinical suggestions noted. Review of the resident's care plan dated 12/25/24 showed: -The resident had an Activities of Daily Living (ADLs) self-care performance deficit related to multiple health diagnoses with the resident being able to transfer independently. -The resident had Parkinson's Disease affecting mobility and staff were to monitor for risk of falls. -The resident had an actual fall with no injury on 8/31/24 with the following interventions: --Continue interventions on the at-risk plan. --Ensure all medications were ordered from pharmacy in a timely manner. --For no apparent acute injury, staff were to determine and address causative factors of the fall. --Monitor/document/report Pro re Nata (PRN- as needed) for 72 hours to medical director for signs and symptoms of pain, bruises, change in mental status, and new onset of confusion, sleepiness, inability to maintain posture, or agitation. --Neurological Checks per facility policy. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	--Pharmacy consult to evaluate medications. --Provide activities that promote exercise and strength building where possible. -All interventions for falls were placed in the resident's care plan after this initial fall only. -The resident's fall care plan was not updated upon re-admission or after each fall to include any new interventions that were put in place. Review of the resident's incident note dated 12/27/24 at 5:00 A.M. that Licensed Practical Nurse (LPN) B completed showed: -The nurse had been called into the resident's room and found the resident lying to the side of his/her fall mat. -Blood was coming from the back of the resident's head due to a laceration. -The nurse applied a pressure dressing. -Emergency services were called. -The resident stated that he/she was attempting to get his/her walker so he/she could go downstairs. -The resident was transferred to a gurney and was awake and alert upon leaving the facility to go to the local hospital. Review of the resident's Incident Audit Report dated 12/27/24 at 5:00 A.M. showed: -The resident had an un-witnessed fall. -The resident had been found on the floor next to his/her fall mat. -The resident was laying on his/her left side with his/her head propped up by his/her left arm. -The resident was awake and was apologizing for falling. -The resident was bleeding from laceration to the occipital region of skull. -The depth of the laceration was unable to be determined. -A pressure dressing had been applied. -The resident stated I was trying to get to my walker to go downstairs. I'm sorry. -The action that was taken at the time was applying the pressure bandage. -The resident was normally wheelchair bound. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The predisposing physiological factors included: --Confusion. --Gait imbalance. --Impaired memory. --Incontinence. --Recent change in condition. --Weakness/fainting. -No RCA was determined for this fall. -No interventions post-fall were documented. Review of the resident's emergency room (ER) Documentation dated 12/27/24 at 7:07 A.M. showed: -The resident was sent to the ER after a fall. -The resident was trying to test his/her ambulation. -The resident complained of right hip pain. -The resident had a two-inch laceration to the left back side of his/her head. -The resident had a laceration repair that required two staples. Review of the resident's Fall Risk Evaluation dated 12/27/24 at 1:05 P.M. showed: -The resident had three or more falls in the last three months. -The resident had intermittent confusion. -The resident was ambulatory and continent. -The resident did not have any predisposing diseases. -The resident had a recent change in condition. -The resident had a balance problem while standing. -The resident had a balance problem while walking. -The resident had decreased muscular coordination. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The resident required the use of assistive devices. -The resident took one to two predisposing medications including anti-seizure medication that would increase the resident's risk for falls. -There were no clinical suggestions noted. Review of the resident's incident note dated 12/27/24 at 4:13 P.M. completed by LPN A showed: -The nurse was called into the resident's room by the speech therapist. -The resident was on the floor behind his/her door. -The resident was on his/her stomach with blood on the floor from the resident's head. -The resident was awake and alert. -There was no reported further injury aside from the previous laceration from the fall that morning. -The resident was assessed and assisted up with two staff members and was placed in his/her wheelchair. -The nurse applied a pressure dressing to the resident's head to get the bleeding to stop. -Once the bleeding had stopped, the nurse had attempted to clean the resident's head and hair. -No new laceration noted. -The dressing had been placed on laceration along with rolled gauze. NOTE: There was no investigation or Incident Audit Report completed for this fall. Review of the resident's Transfer to Hospital Summary dated 12/27/24 at 7:30 P.M. completed by LPN B showed: -The nurse had approached the resident's room to greet the resident. -The resident was noted to be laying in bed with his/her pillow saturated in blood. -The resident had an abdominal (ABD) pad (a specialized medical dressing designed to manage and protect moderate to heavily exuding wounds) wrapped with Kerlix (a white gauze dressing/bandage) as a pressure dressing to his/her head. -The pressure dressing was completely saturated with blood. -The nurse alerted the day shift nurse of the finding and alerted the medical director. (continued on next page)

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	265797	A. Building B. Wing	01/24/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-New orders were given to send the resident to the emergency department (ED) for evaluation and treatment due to excessive bleeding. -The nurse assisted the resident into a sitting position and removed the saturated dressing. -The nurse assessed the resident's head and found a new laceration. -The nurse cleansed the wound. Applied a new ABD pad and secured the pad with Kerlix and Coban (a self-adhering bandage). -The resident was then transported to the local hospital by Emergency Medical Services (EMS). Review of the resident's ED-Physician Note dated 12/28/24 at 12:10 A.M. showed: -The resident had been seen in the ED for a fall and that the resident had hit the back of his/her head. -The resident had a four centimeter (cm) curved scalp laceration in his/her superior (top) occipital region with a small amount of oozing blood. -The resident received four staples to this area. -The resident's staples from the previous fall were still intact. Review of the resident's Health Status Note dated 12/28/24 at 1:00 A.M. completed by LPN B showed: -He/She had been notified by the local hospital's ED at 12:18 A.M. that the resident was discharging back to the facility. -The resident had another set of staples placed in order to close the new laceration to the resident's skull. -The resident arrived back to the facility at 1:00 A.M. -The resident was transferred to bed from the EMS gurney. -The nurse educated the resident on the importance of using the call light when in need of assistance. -The resident stated, I think I learned my lesson. -The nurse acknowledged the new orders. Review of a note in the resident's electronic medical record (EMR) dated 12/30/24 at 9:48 A.M. showed: -A bike helmet was brought in for the resident to wear when out of bed. (continued on next page)

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	265797	A. Building B. Wing	01/24/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The resident was able to put on and take off the helmet independently. Review of the resident's admission MDS dated [DATE] showed: -The resident had moderately impaired cognition. -The resident had a fall in the last 2-6 months prior to admission. -The resident had two falls since admission. -The resident had one fall with no injury. -The resident had one fall with injury (except major) which included skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains, or any fall-related injury that causes the resident to complain of pain. -The resident used a wheelchair as a mobility device. -The resident was able to sit to stand (the ability to safely come to a standing position from sitting in a chair or on the side of the bed) with partial/moderate assistance (helper does less than half the effort). Review of the resident's Transfer to Hospital Summary dated 1/3/25 at 8:15 P.M. showed: -The resident was noted to be on the floor to the right side of his/her bed. -The resident's body was on the fall mat, but the resident's head was pressed up against the wall. -Blood was noted on the resident's right side of head and forehead. -A pressure bandage was applied, and the resident was sent to the local ED for evaluation and treatment. -The resident returned to the facility with no new orders around 2:30 A.M. -The resident was started on fall follow-up monitoring. -No specific injury was noted. NOTE: There was no investigation or Incident Report Audit completed for this fall. Review of the resident's hospital records dated 1/4/25 at 2:42 A.M. showed: -The resident had received a Computerized Tomography (CT) Scan of the head and spine with no acute findings. -The resident had an abrasion to his/her left posterior (back) scalp. (continued on next page)

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	265797	A. Building B. Wing	01/24/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The abrasion had stopped bleeding. -The resident showed no signs of distress and was discharged back to the facility. 2. Review of Resident #6's admission Record showed he/she admitted to the facility with the following diagnoses: -Vascular Dementia (a general term describing problems with reasoning, planning, judgement, memory, and other thought processes caused by brain damage from impaired blood flow to the brain). -Epilepsy (a disorder in which nerve cell activity in the brain is disrupted, causing seizures). -Cerebral Infarction (ischemic stroke- occurs as a result of disrupted blood flow to the brain). -Muscle Weakness. -Unspecified Lack of Coordination. -Difficulty in Walking. Review of the resident's quarterly MDS dated [DATE] showed: -The resident was cognitively intact. -The resident used a walker. -The resident was able to move independently. -The resident had not had any falls since admission. Review of the resident's Incident Audit Report dated 12/30/24 at 2:30 P.M. showed: -The resident had an un-witnessed fall. -The nurse had been alerted by a Certified Nurses Aide (CNA) that the resident was found on the floor. -The CNA had recently assisted the resident into bed. -The resident was found sitting on the floor between the legs of the chair with his/her arms above his/her head. -The resident stated that he/she had pain in his/her left arm, but there were no visible injuries. -Resident was assisted up by the nurse and two CNAs and into his/her wheelchair. -The resident had stated that he/she wanted to get up and then fell. (continued on next page)

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	265797	A. Building B. Wing	01/24/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The immediate actions that were taken: --Resident was assisted to his/her recliner. --The resident's bed was adjusted for better clearance of the resident's wheelchair. --The resident was educated to use his/her call light when feeling weak. -The report did not include the RCA of the fall. -NOTE: No neurochecks were completed for a resident who was moderately cognitively impaired. Review of the resident's undated care plan showed: -The resident was at risk for falls with a goal for the resident to be free from falls with the following interventions: --Assist resident with ambulation and transfers. --Determine the resident's ability to transfer. --Evaluate fall risk upon admission and PRN. --If fall occurs, notify provider. --If fall occurs, initiate frequent neurological assessments and bleeding evaluation per facility protocol. --If resident was a fall risk, initiate fall risk precautions. NOTE: The resident did not have an updated care plan related to any actual falls or any fall interventions that were put into place. A copy of the resident's Neurological Assessments for this fall were requested and not received at the time of exit. 3. Review of Resident #7's admission Record showed he/she admitted to the facility with the following diagnoses: -Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses. -Muscle Weakness. -Difficulty in Walking. -Unspecified Lack of Coordination. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's undated care plan showed: -The resident had an ADL self-performance deficit related to a recent hospitalization and the resident was able to independently transfer using his/her walker. -The resident was at moderate risk for falls related to a history of falls prior to admission with a goal that the resident would be free from falls with the following interventions: -Anticipate and meet the resident's needs. --Ensure call light was within reach. --Educate resident/family/caregivers about safety reminders and what to do if a fall were to occur. --Follow facility fall protocol. --Review information on past falls and attempt to determine cause of falls. NOTE: The resident did not have an updated care plan related to any actual falls or interventions that were put into place after falls occurred. Review of the resident's admission MDS dated [DATE] showed: -The resident had moderately impaired cognition. -The resident used a walker and a wheelchair. - The resident was able to go from sitting to standing with partial/moderate assistance. -The resident needed partial/moderate assistance to walk ten feet. -The resident was dependent (helper does all of the effort and the resident does none of the effort to complete the activity) when wheeling more than 150 feet in his/her wheelchair. -The resident had a fall two to six months prior to admission to the facility. Review of the resident's Incident Audit Report dated 1/8/25 at 4:05 P.M. showed: -The resident had a witnessed fall. -The resident was witnessed by a Certified Medication Technician (CMT) standing at his/her closet hanging up a coat. -The resident lost his/her balance and landed on his/her buttock. -The CMT assisted the resident to a lying position with a pillow underneath his/her head. -The resident was assessed by the charge nurse and no injuries were noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The resident denied any pain. -The resident was assisted by two staff members onto his/her feet. -The staff assisted the resident into a chair. -The resident had not used his/her wheelchair and walker that were in her room and had not called for assistance. -There were no documented fall interventions that the facility put in place after the fall occurred. Review of the resident's Incident Audit Report dated 1/17/25 at 9:39 P.M. showed: -The resident had an un-witnessed fall. -A nursing aide (NA) had found the resident on the floor in his/her bathroom. -The resident stated that he/she had tried to take himself/herself to the bathroom and fell. -The resident had stated that he/she hit his/her head on the door frame. -The resident had scrapes to his/her knees, but they were not bleeding. -There was no noticeable injury to the resident's head. -The resident was assisted up and onto the toilet without difficulty. -The resident had pain to his/her head. -The resident became emotional and was upset about not being able to do his/her own things. -He/She did not want to have to ask the nurses for assistance. -The resident was educated on the importance of using his/her call light. -The report did not include the RCA of the fall. 4. During an interview on 1/24/25 at 11:15 A.M. the Director of Nursing (DON) said: -There was only one incident report for all of Resident #1's falls. -The nurses had only been doing progress notes for his/her other falls. -He/She was unaware the fall investigations were not completed. During an interview on 1/24/25 at 2:24 P.M. CNA A said: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-CNAs were responsible for getting the nurse if they witnessed a fall or if they found a resident on the ground. -The CNAs could assist in getting the vital signs of the resident and helping the resident up if indicated. -All care staff could help perform the Neurological Assessments, but the nurses were the ones that completed the assessment and placed the findings in the resident's chart. -Resident #1 refused to use his/her call light and would get up without staff assistance, causing the falls. -Resident #1 had fall mats on both sides of his/her bed, but that was the only fall intervention that was put in place that he/she could think of. -Resident #6's falls normally occurred during the night. -Resident #6 had difficulty in asking for help but seemed to be getting better. -He/She remembered that Resident #7 had fallen in the bathroom, and that the resident did not like using his/her call light. -The fall intervention for Resident #6 and Resident #7 was education related to call light use. -He/She thought if a resident fell, then neurological assessments were mandated to be completed. -The neurological assessments were done for 48 hours in total. -Nurses were responsible for completing the fall investigations and updating the care plan. -The Administrator was responsible for ensuring the completion of the fall investigations. During an interview on 1/24/25 at 2:32 P.M. LPN A said: -He/She had been in the building during one of Resident #1's falls, his/her second fall on 12/27/24. -Resident #1 had told LPN A that he/she was trying to get up to go to the bathroom. -Resident #1 would also acknowledge that he/she had not used the call light. -When he/she assessed Resident #1, he/she could not tell where the resident was bleeding from, so he/she had applied a pressure dressing to the resident's head. -He/she was unaware the resident had a second injury to the head. -He/she did not put any interventions in place after the second fall. (continued on next page)

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	265797	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridge Crest Nursing Center	706 South Mitchell Warrensburg, MO 64093

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 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She thought neurological assessments were completed for un-witnessed falls. -The CNAs could get the vital signs for the neurological assessments, but the nurses were responsible for all other parts of the assessment and would document the results in the resident's medical record. -The facility was not responsible for completing the neurological assessments if the resident was sent to the ER and had a CT scan done with negative findings. -He/She had only worked at the facility for a month. -He/She was unsure of the facility's policy related neurological assessments. -There should have been neurological assessments completed for Resident #6's fall. -He/She was unsure who completed the fall investigations. -He/She thought there was a form that the nurses could fill out after a fall occurred, but she was unsure of the facility's policy related to fall investigations. -He/She expected the CNAs or other floor staff to report all falls to the charge nurse. -He/She was unsure of the fall interventions that were in place for Resident #1, Resident #6, and Resident #7. -He/She confirmed the issues with the fall investigations for Resident #1, Resident #6, and Resident #7 as they did not show RCA or specific interventions that were put in place. -The nurses were not responsible for any part of the care planning process. -Care plans needed to be updated after every fall that occurred. -He/She was unsure why Resident #1, Resident #6 and Resident #7 did not have updated care plans. -Usually care plans would show the date of each fall and the intervention(s) that were put in place. During an interview on 1/24/25 at 3:05 P.M. the DON said: -He/She was not present for any of Resident #1's falls. -The DON was responsible for completing all fall investigations. -The fall investigations were usually completed in the risk management meetings. -He/She had been informed that there was no place to put the RCA on the fall investigations and that there needed to be a progress note that included RCA and the intervention that was put into place after each fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She confirmed that an RCA was not completed for Resident #1's fall investigation. -Resident #1 had a bike helmet that was brought in to protect his/her head when out of bed. -Resident #1 also had the following interventions in place: --Fall mats. --His/her bed was moved. --Frequent checks, meaning the resident was checked on every 15-20 minutes. --This was not documented anywhere but remembers this being in place for the resident as standard fall precautions. -Resident #6's intervention was education related to call light usage. -Resident #7's intervention was for him/her to use his/her wheelchair for mobility. -The description of action part of the Incident Audit Report could count as the intervention that was put in place after the fall. -He/She expected the floor nurses to complete the RCA and put interventions in place for each resident fall. -Social Services was responsible for all aspects of the care plan but had been informed since becoming the DON that he/she could also help with care plans. -The care plan did not need to be updated after each fall. -The care plan only needed to be updated if a new intervention was put into place after a fall occurred. -The nurses were responsible for completing the neurological assessments. -Neurological assessments were completed after un-witnessed falls. -The staff did not have to complete neurological assessments when residents came back from the hospital post-fall unless there was a noted head injury. -The DON ensures completion of the neurological assessments. -Neurological assessments should have been completed after Resident #6's fall. During a phone interview on 1/27/24 at 5:44 P.M. Physician A said: -He/She had been notified after each resident's falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Resident #1 could ambulate on his/her own and had no mobility restrictions. -He/She thought that Resident #'1 falls were unavoidable, however he/she was unaware that the facility had not been completing thorough fall investigations and were not putting interventions in place after each fall. -Neurological assessments did not need to be completed for residents who were sent out post-fall. -He/She expected staff to complete neurological assessments every hour after a fall and he/she would come in the next day to review them. -He/She was really involved in the resident post-fall care. -He/She was unsure of specific interventions that were put into place for residents post-fall. -He/She was unaware that Resident #1 had a bike helmet as part of the resident's fall interventions. -Anytime a new fall intervention was put into place the staff needed to inform him/her, to be able to approve of the intervention. -The facility needed to complete thorough investigations of each fall including the root cause of the fall. -He/She would review medications and do anything needed to mitigate fall occurrences. -Falls and fall intervention needed to be care planned and updated as needed. MO00248468