STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555517	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kern Valley Healthcare District Dp Snf	6412 Laurel Ave Lake Isabella, CA 93240

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) was able to exercise the right to refuse physician ordered meal consistency. This failure resulted in Resident 2's rights to make decisions on her care to be violated and had the potential for not meeting Resident 2's nutritional needs .Findings: During a review of Resident 2's Order Summary Report, (OSR) dated 10/15/25, the OSR indicated Resident 2's diet order was NAS (No Added Salt) diet pureed texture (foods are smooth, lump-free, and uniformly blended, resembling pudding or paste, used for people with chewing/swallowing difficulties), regular/thin consistency, no straws . During a review of Resident 2's care plan with the focus on non compliance with following recommendations related to diet/drinking fluids, initiated 10/16/25. The care plan indicated a few of the interventions were to Educate risk and benefits and possible outcomes of recommendations as needed .Observe for s/s of aspiration during routine care . residents right to refused recommendations to be respected. During a review of Resident 2's Minimum Data Set, (MDS - an assessment tool) dated 10/22/25, the MDS indicated, Resident 2's BIMS (Brief Interview for Mental Status with a range of 0-15) score was 15 (a score of 13 to 15 suggests the resident is cognitively intact). During a review of Resident 2's Video Swallow Evaluation, (VSE) dated 12/11/25, the VSE indicated, Your Recommended Diet Texture Food texture: Minced & Moist (ground / minced, can smash with a fork, 1/4 inch pieces, moist and sticks together) Liquid Texture thin liquid by cup only, in chin tuck position (position involves gently gliding your chin straight back, as if making a double chin, without tilting your head up or down, to align your head over your shoulders, to assist with swallowing) or nectar thick (mildly thick like fruit syrup, coats the back of a spoon) During a review of Resident 2's OSR, dated 10/15/25, the OSR dated 12/11/25, indicated, NAS . diet Pureed Texture, Nectar/Mildly thick consistency . During a review of Resident 2's IDT Notes, dated 12/12/25, the IDT indicated, NP [nurse practitioner] discussed current diet order for Puree texture and nectar thickened liquids. Resident is noncompliant with these orders; she often eats food that family brings her, that is not within ordered diet and she always refuses thickened liquids, she will only drink thin liquids. NP clearly stated all possible risks associated with non-compliance of diet; up to and including death. NP states current dx [diagnosis] of pneumonia is likely caused by aspiration. NP states that res [Resident 2] chances of aspirating are very probable, if she continues to be non-compliant with diet. NP states that [Resident 2] stated, I don't care if this is what kills me. During a review of Resident 2's NN, dated 12/16/25, the NN indicated, [Resident 2] wanted to participate in Christmas hot chocolate bar and treats. Resident is on an ordered Pureed diet with nectar thick liquids per provider after video swallow evaluation. [DON] verified via phone with provider to see if resident could participate. It was stated that, she can participate but her hot chocolate and treats must meet the order dietary requirements of texture. [DON] and [Charge Nurse] went to activity room and explained what provider said. [Resident 2] stated I am going back to my room. I don't want any if I can't have it the way I (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: 555517	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Kern Valley Healthcare District Dp Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 6412 Laurel Ave Lake Isabella, CA 93240	

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	want it. During a concurrent observation and interview, on 12/17/25 at 12:37 p.m. with Resident 2, in Resident 2's room. Resident 2's untouched lunch tray was sitting on her bedside table, there were seven types of pureed meats, potatoes, soups and desserts. Resident 2 stated I was in the hospital for Pneumonia and that is why the facility wants me to eat the mashed food, she stated I do not eat it, she stated she will eat the deserts. Resident 2 stated she told PN that she has gotten pneumonia almost every year but he did not change the diet. Resident 2 stated she has asked to speak to her previous medical doctor in hopes that he will change her diet order. Resident 2 stated she does not ask for alternate meal or textures she stated, I am stubborn and want it my way I will probably end up leaving, I love it here every everyone is nice, but if I die from eat food I like I am ok with that. Resident 2 stated the facility must bring the food, but they know I won't eat it. During an interview on 12/17/25 at 3:23 p.m. with Director of Nursing (DON), DON stated the facility does not have waivers for residents who refuse therapeutic diets. DON stated the facility does not offer minced moist texture. During a review of the facility's policy and procedure (P&P) titled, Patient Rights and Responsibilities, approval date 11/03, the P&P indicated, As a patient of [facility name], you have the right to: .5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedures as you may need in order to give informed consent to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment, or non-treatment and the risk involved in each . 3. The patient is responsible for his actions if he/she refuses treatment or does not follow the physician's instructions.

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F 0580 Level of Harm - Minimal harm or potential for actual harm 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. Based on interview and record review, the facility failed to notify one of three sampled residents (Resident 4) family members when Resident 4 had a fall incident. This failure had the potential for Resident 4's family member to be unaware of Resident 4's fall. Findings:During a review of Resident 4's admission Record, (AR) dated 12/22/25, the AR indicated Resident 4's first emergency contact was his daughter and second emergency contact was his son. During a review of Resident 4's Minimum Data Set, (MDS - an assessment tool) dated 10/21/25, the MDS indicated, Resident 4's BIMS (Brief Interview for Mental Status-standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 4 (a score of 0-7 suggests the resident has severely impaired cognition).During a concurrent interview and record review, on 12/17/25 at 3:08 p.m. with the Director of Nursing (DON), Resident 4's Nursing Note, (NN) dated 12/1/25 at 6:04 a.m. was reviewed. The NN indicated Resident 4 was found on bathroom floor, nurse practitioner and DON were notified. DON reviewed Resident 4's progress notes and there was no documentation of Resident 4's family was notified of the fall incident.During a concurrent interview and record review, on 12/17/25 at 3:23 p.m. with DON, Resident 4's TRIPS Form Forms (Tracking Record for Improving Patient Safety - facility developed fall protocol packet), dated 12/1/25 was reviewed. DON stated there was no documentation on TRIPS Form Resident 4's family was notified, the section where family notification indicated, NA (not applicable) is documented. DON stated she does not know what NA means.During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, approval date 9/2/15, the P&P indicated, Licensed staff shall promptly notify the resident, his or her attending physician, and family/ representative of changes in the resident's medical/mental condition and/or status . A. The Care Manager/Charge Nurse will notify the residents' Attending Physician or On-Call Physician and Director of Nursing Services when there has been: 1. An accident or incident involving the resident; . B. Unless otherwise instructed by the resident , the Care Manager/Charge Nurser will notify the resident's family or representative . when: 1. The resident is involved in any accident .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to provide care and services for one of three sampled residents (Resident 1) when Charge Nurse intentionally neglected to document, report, and assess Resident 1 after a fall incident. This failure had the potential for delay in care, Resident 1 feeling neglected, and injury.Findings:During a review of Resident 1's Minimum Data Set, (MDS - an assessment tool) dated 10/1/25, the MDS indicated Resident 1's BIMS (Brief Interview for Mental Status) score was 11 (a score of 8 to 12 indicates moderately impaired cognition). The MDS indicated Resident 1 had impairments to both upper extremities (shoulders, elbows, wrists, hands) and lower extremities (hips, knees, ankles, feet) of her body and Resident 1 was dependent (helper does all the effort) for chair/bed to chair transfers (the ability to transfer to and from bed to a chair or wheelchair).During a review of Resident 1's Behavior Note, (BN) dated 12/2/25 at 2:08 p.m. the BN indicated, Charge RN [Registered Nurse] found resident attempting to get out of bed to go play a game with her boys. She also stated, I have to get that doggie. Resident placed back in bed; Charge RN sat with resident for 30 min and was able to calm resident. signed by Charge Nurse.During a review of Resident 1's BN, dated 12/2/25 at 3:11 p.m. the BN indicated, Resident found on the floor sitting and naked and playing a game with my boys. RN attempted to reorient resident to surroundings and she stated, I am going to eat your toes!. Resident was not aggressive or agitated but very confused and remains hallucinations of people and objects. Resident was dressed and place in Geri-Chair (a specialized, reclining, mobile chair on wheels designed for mobility-impaired individuals) and Placed out by the nursing station to keep observing signed by Charge Nurse.During a review of Resident 1's Nursing Note, (NN) dated 12/2/25 at 7:08 p.m. the NN indicated, Late Entry . CNAs approached me this evening to let me know that resident was found on the floor, naked and hallucinating earlier in the day. Resident was dressed and assisted into the Geri Chair. I notified [Director of Nursing (DON)] via phone call, [Resident 1's physician] . and left a message for resident ‘s son, . I completed the unwitnessed fall documentation, skin assessment, and vitals. A new bruise was noted on resident's right forearm. No other injuries noted. Signed by Licensed Vocational Nurse (LVN) 2.During a review of Resident 1's Neuro (neurological checks- is a group of questions and tests to check for disorders of the spinal cord and brain) /Vital Sign Flow Sheet, (NVSFS) dated 12/2/25, the NVSFS indicated the first set of neuro checks were completed at 6:30 p.m. on 12/2/25 (approximately 3 hours and 15 minutes after first fall).During a review of Resident 1's NN, dated 12/5/25 at 6:45 p.m. the NN indicated, On 12/4/25 at 1300 I was called into meeting with [CNO Chief Nursing Officer] and [CEO -Chief Executive Officer] regarding resident being found sitting on floor next to bed. Charge RN did not report this as a fall to supervisor due to resident denied falling out of bed 2 times. Resident was assessed at time of incident and found to have no injury and denied any pain or discomfort and neuro status unchanged. During meeting I was instructed to fill out full fall report following protocol. When I arrived, this am [sic] . I finished all required paperwork and documentation per protocol. Signed by Charge Nurse.During a review of Resident 1's care plan (a comprehensive, personalized document that outlines the specific needs of an individual requiring care, detailing the type of support, how it will be provided, and the goals of the care) with the focus on Potential for neglect related to unwitnessed falls, initiated 12/5/25. The care plan indicated a few of the interventions were All Necessary documents will be filled out. and Staff will report any unwitnessed falls.During a review of Resident 1's NN, dated 12/2/25 at 3:11 p.m. the NN indicated, Late Entry: regarding fall of resident. Charge RN came into room and found resident calmly sitting on floor next to bed unclothed and playing a game with my boys, I asked resident if she fell from bed 2 times (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and resident denied falling both times. Resident was assessed and no injury noted. Resident was lifted into Geri-Chair and placed out by the nursing station for better observance. Resident was also asked if she had pain or discomfort anywhere and she denied both. Charge nurse did not report this as a fall to supervisor, nor was a fall form completed at the time due to Charge RN did not believe resident had actually fallen.During an interview on 12/17/25 at 11:56 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 12/2/25 she was walking down the hall when she saw Charge Nurse, CNA 2 and CNA 3 in Resident 1's room. Resident 1 was on the floor. CNA 1 stated the Charge Nurse told us to help her lift Resident 1 up and put Resident 1 into the Geri- chair. CNA 1 stated Charge RN did not assess Resident 1 before or after moving Resident 1 to the chair. CNA 1 stated Charge Nurse did not ask Resident 1 any questions. CNA 1 stated Resident 1 is totally dependent for care she could not climb to the floor and sit down. CNA 1 stated the Charge Nurse told her, CNA 2, and CNA 3 Not to say anything. CNA 1 stated she felt uncomfortable with Charge Nurse telling her not to say anything. CNA 1 stated, I think [Charge Nurse] was just trying to avoid the charting but what if something happened. I think because [Charge Nurse] failed to assess [Resident 1] afterward it was a form of neglect.During an interview on 12/17/25 at 3:10 p.m. with CNA 2, CNA 2 stated she was walking down the hall and saw the Charge Nurse CNA 1, and CNA 3 in Resident 1's room. CNA 2 stated Charge Nurse asked us to help put Resident 1 into the Geri-chair. CNA 1 stated Charge Nurse stated that this was the second time she found Resident 1 on the ground. CNA 2 stated she did not witness Charge Nurse conduct an assessment or ask Resident 1 any questions. CNA 1 stated Resident 1 could not bear weight and would not have been able to get out of bed and sit Indian style on her own. CNA 2 stated, [Charge Nurse] looked at all three of us and said don't say a word about this to anyone. CNA 2 stated she had given Resident 1 a shower earlier that day and Resident 1 did not have any skin issues. CNA 2 stated she believed the Charge Nurse did not want to do the paperwork. CNA 2 stated she reported to Social Services (SS) because it felt like it was medical neglect.During an interview on 1/13/26 at 3:50 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was made aware of Resident 1's fall by SS approximately 5:30 p.m. on 12/2/25. LVN 2 stated SS informed her that a few CNAs came to her and reported Resident 1 had a fall and it was not reported. LVN 2 stated the CNAs reported they were walking by and saw the Charge Nurse picking up Resident 1 and trying to put her back in bed, the CNAs helped put Resident I back in bed. LVN 2 stated the Charge Nurse told the CNAs Don't say anything this is the second time it has happened. LVN 2 stated she called the DON and was instructed to treat the fall like it had just happened. LVN 2 stated Resident 1 cannot bear weight and would not be able to get out of bed on her own. LVN 2 stated when she assessed Resident 1, Resident 1 did have a new bruise to her right arm below her elbow.During an interview on 1/14/26 at 3:01p.m. with CNA 3, CNA 3 stated on 12/2/25 she was the one who found Resident 1 on the ground at bedside, she stated Resident 1 was on floor without her nightgown on. CNA 3 stated she reported the fall to the Charge Nurse. CNA 2 stated the Charge Nurse came into Resident 1's room and two other CNAs were walking by and came into help. CNA 3 stated we put Resident 1's gown back on her and assisted her to the Geri-Chair. CNA 3 stated she did not witness Chare Nurse asking Resident 1 any questions or take any vital signs. CNA 3 stated the Charge Nurse did say to us (CNA 1, CNA 2, and CNA 3) not to say anything about the fall.During an interview on 1/15/26 at 3:12 p.m. with Charge Nurse, Charge nurse stated she has worked full time at the facility since January of 2025. Charge Nurses stated Resident 1 has dementia (memory loss) and was restless that day. Charge Nurse stated CNA 3 informed her Resident 1 was on the floor sitting crossed legged and without a gown on. Charge Nurse stated she and CNA 3 went into the room. Charge Nurse stated CNA 1 and CNA 2 came into Resident 1's room and assisted Resident 1 up into (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Geri-Chair. Charge Nurse stated she did not complete vital signs or neurological checks for Resident 1's fall. Charge Nurse confirmed the BN dated 12/2/25 at 3:11 p.m. documentation did not indicate an assessment was completed. Charge Nurse stated she did not document the Resident 1's NN, dated 12/2/25 at 3:11 p.m. late entry until a couple of days after Resident 1's fall. Charge Nurse stated she received training on the facility's TRIPS Forms (Tracking Record for Improving Patient Safety - facility developed fall protocol packet), for falls, make progress notes, care plan, notifying provider and family, DON, initiate neuro-check (neurological check-tests that a healthcare provider uses to see how well your nervous system is working) for unwitnessed falls. Charge Nurse stated, I did say to them I am not reporting this as a fall, but you guys can do whatever you want.During a review of the facility's P&P titled, Abuse Prevention Program, approval date 12/7/16, the P&P indicated, Each resident will be free from abuse, neglect (the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress) . Components Of The Resident Protection Program . B. Training . D. Identification.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, interview, and record review, the facility failed to implement a care plan for one of three sampled residents' (Resident 1) fall precaution. This failure had the potential to result injury for Resident 1.Findings:During a review of Resident 1's care plan (a comprehensive, personalized document that outlines the specific needs of an individual requiring care, detailing the type of support, how it will be provided, and the goals of the care) with the focus on The Resident has had an actual fall, initiated 12/13/25. The care plan indicated one of the interventions was Fall mats to both sides of bed when resident is in bed.During a concurrent observation, interview, and record review, on 12/17/25 at 1:52 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 1's room. Resident 1 was in her bed with one fall mat at bedside. Resident 1's care plan with the focus on The Resident has had an actual fall, initiated 12/13/25, was reviewed. LVN 1 confirmed Resident 1 was care planned to have fall mats on both sides of the bed. LVN 1 stated Resident 1 had one fall mat at bedside.During a review of the facility's policy and procedure (P&P) titled, Fall Prevention, approval date 11/4/09, the P&P indicated, All patients/residents admitted to [facility name] are considered at risk for falls due to acuity of illness, medication, and unfamiliar environment. Therefore, the patients/resident will be assessed and the care plan will incorporate goals and interventions to provide the optimal safe environment for the patient /resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to follow the facility's policy and procedure (P&P) titled, Neurological Evaluation [Neuro check- is a group of questions and tests to check for disorder of the spinal cord and brain], for one of three sampled residents (Resident 1) when Resident 1 had an unwitnessed fall. This failure had the potential for a delay in treatment and care for Resident 1, and had the potential for Resident 1 to suffer adverse health outcomes.Findings:During a review of Resident 1's Behavior Note, (BN) dated 12/2/25 at 3:11 p.m. the BN indicated, Resident [1] found on the floor sitting and naked and playing a game with my boys. RN [Registered Nurse] attempted to reorient resident to surroundings and she stated, I am going to eat your toes!. Resident was not aggressive or agitated but very confused and remains hallucinations of people and objects. Resident was dressed and place in Geri-Chair [a specialized, reclining, mobile chair on wheels designed for elderly or mobility-impaired] and Placed out by the nursing station to keep observing signed by Charge Nurse. During a review of Resident 1's Nursing Note, (NN) dated 12/2/25 at 7:08 p.m. the NN indicated, Late Entry . CNAs approached me this evening to let me know that resident was found on the floor, naked and hallucinating earlier in the day. Resident was dressed and assisted into the Geri Chair. I notified [Director of Nursing (DON)] via phone call, [Resident 1's physician] . and left a message for resident ‘s son, . I completed the unwitnessed fall documentation, skin assessment, and vitals. A new bruise was noted on resident's right forearm. No other injuries noted. Signed by Licensed Vocational Nurse (LVN) 2. During a review of Resident 1's Neuro/Vital Sign Flow Sheet, (NVSFS) dated 12/2/25, the NVSFS indicated the first set of neuro-checks were completed at 6:30 p.m. on 12/2/25 (approximately 3 hours and 15 minutes after first fall). During a review of Resident 1's NN, dated 12/5/25 at 6:45 p.m. the NN indicated, On 12/4/25 at 1300 I was called into meeting with [CNO Chief Nursing Officer] and [CEO -Chief Executive Officer] regarding resident being found sitting on floor next to bed. Charge RN did not report this as a fall to supervisor due to resident denied falling out of bed 2 times. Resident was assessed at time of incident and found to have no injury and denied any pain or discomfort and neuro status unchanged. During meeting I was instructed to fill out full fall report following protocol. When I arrived, this am [sic] . I finished all required paperwork and documentation per protocol. Signed by Charge Nurse. During a review of Resident 1's NN, dated 12/2/25 at 3:11 p.m. the NN indicated, Late Entry: regarding fall of resident. Charge RN came into room and found resident calmly sitting on floor next to bed unclothed and playing a game with my boys, I asked resident if she fell from bed 2 times and resident denied falling both times. Resident was assessed and no injury noted. Resident was lifted into Geri-Chair and placed out by the nursing station for better observance. Resident was also asked if she had pain or discomfort anywhere and she denied both. Charge nurse did not report this as a fall to supervisor, nor was a fall form completed at the time due to Charge RN did not believe resident had actually fallen. During an interview on 1/13/26 at 3:50 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was made aware of Resident 1's fall by SS approximately 5:30 p.m. on 12/2/25. LVN 2 stated SS informed her that a few CNAs came to her and reported Resident 1 had a fall and it was not reported. LVN 2 stated the CNAs reported they were walking by and saw the Charge Nurse picking up Resident 1 and trying to put her back in bed, the CNAs helped put Resident I back in bed. LVN 2 stated the Charge Nurse told the CNAs, Don't say anything this is the second time it has happened. LVN 2 stated she called the DON and was instructed to treat the fall like it had just happened. LVN 2 stated Resident first set of Neurological checks were completed at 6:30 p.m. on 12/2/25 (approximately 3 hours and 15 minutes after Resident 1's unwitnessed fall). LVN 2 stated when she assessed Resident 1, Resident 1 did have a new bruise to her (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right arm below her elbow. During an interview on 1/15/26 at 3:12 p.m. with Charge Nurse, Charge Nurse stated she did not complete vital signs or neurological checks or do a full assessment for Resident 1's fall. Charge Nurse confirmed the BN dated 12/2/25 at 3:11 p.m. documentation did not indicate an assessment was completed. Charge Nurse stated she did not document Resident 1's NN, dated 12/2/25 at 3:11 p.m. Late entry until a couple of days after Resident 1's fall. During a review of the facility's policy and procedure (P&P) titled, Neurological Evaluation, approved 2/22/16, the P&P indicated, A. In the event that a resident has a witnessed or unwitnessed fall and it is suspected/known or unwitnessed that the resident has bumped/hit his/her head, neurological evaluations are initiated and continued for 72 hours . B. Assure resident safety and complete a full assessment . Do not move resident until assessment has been completed and resident is found safe to move. Obtain a full set of vital signs. Assess pain location, intensity (pain scale), duration and type of pain felt. Document findings. C. Once resident safety has been assured notify resident's physician, family member or legal representative and fall coordinator. D. Place resident on alert charting for 72 hours. Document fall assessment, . and created and/or update fall . care plan . Complete an IDT meeting for appropriate interventions specific to resident and document meeting findings. E. The nurse completes the Neurological Evaluation Log according to the following time frames: 1. Every 15 minutes for the first hour. 2. Every 30 minutes for the 2nd hour after fall. 3. Every 1 hour for the next 3rd and 4th hour after fall.