STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345160	A. BUILDING _____ B. WING _____	C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH CARE CENTER	1011 PORTERS NECK ROAD WILMINGTON, NC 28411

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 11/17/20.. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID # B9WC11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on11/17/2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Two out of 2 allegations were unsubstantiated. Event ID #B9WC11.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		12/12/20

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

Electronically Signed | 12/11/2020

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F 609	Continued From page 1 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practioner interviews and staff interviews, the facility failed to: 1) complete facility reportable incidents for 2 injuries of unknown source to the Health Care Personnel Registry (HCPR) as evidenced by not submitting an initial report and a 5-day investigation report; and 2) failed to report 1 of the 2 injuries of unknown source to the Administrator or the Director of Nursing (DON) for 1 of 3 residents (Resident #3) reviewed for accidents. Findings included: 1. A review of the Abuse Prevention Program Policy and Procedure revised on 03/13/2008 revealed, in part, the definition of types of abuse included injury of unknown source and was defined as when an injury meets both of the following conditions: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and 2) the injury was suspicious because of the extent of the injury or the location of the injury (e.g., the injury was located in an area not generally vulnerable to trauma) or the number of	F 609	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation. 1.) Interventions for affected resident: Resident #3 no longer resides in the facility 2.) Interventions for residents identified as having potential to be affected:	

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F 609	Continued From page 2 injuries observed at one particular point in time or the incidence of injuries over time. The policy states that all reports of resident abuse shall be promptly and thoroughly investigated by facility management. Resident #3 resided in the facility from 04/22/19 through 07/01/20. Diagnosis included Non Alzheimer's dementia. The annual Minimum Data Set (MDS) assessment dated 03/13/20 revealed Resident #3 was severely cognitively impaired. Resident #3 required supervision with one physical staff assistance with walking in her room/corridor. The resident was not steady and only able to stabilize with staff assistance with moving from seated to standing position, and not steady but able to stabilize without staff assistance with walking and turning around. The resident was coded as not having any falls during this assessment period. The resident was not coded as receiving any anticoagulants (blood thinning medication). A nursing note written by Nurse #3 on 01/16/20 revealed the nurse identified a hematoma on the left forehead which was tender to touch and neurological (neuro) checks were initiated. A review of the event report dated 01/16/20 by Nurse #3 revealed the resident was noted to have a left forehead hematoma measuring 1-2" surrounded by swelling. The color of the bruise was documented as purplish/black with swelling and the resident complained of mild pain. A progress note written by the Nurse Practioner (NP) on 01/17/20 revealed the resident was being evaluated due to a hematoma over her left eye.	F 609	On 12/10/2020 an audit of resident events in the last 30 days related to injury was completed. No other injuries of unknown origin were identified that were not reported 3.) Systemic Change On 11/17/2020 nursing staff were trained on the protocol for injuries of unknown origin. The Clinical Coordinator or designee will review resident events for injuries to ensure the documentation is complete and appropriate notifications have been completed 4.) Monitoring of the change to sustain system compliance ongoing: Starting 12/11/2020 the Director of Nursing or Designee will audit resident events with injury weekly for 4 weeks then 1 time per month for 2 months QAPI committee will review the results of the audit monthly for 3 months.	

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The note indicated the resident was ambulatory within the unit and staff did not observe a fall. The note added, due to her advanced dementia, the resident was not able to verbalize her wants. She did not appear to be in pain or discomfort, neuro checks were monitored and intact. The assessment revealed the resident had a periorbital hematoma of the left eye that was noted to be purple with no tenderness and it was unclear how she obtained the hematoma.

An interview was conducted with Nurse #3 via phone on 11/16/20 at 3:50 PM. Nurse #3 reported she no longer worked at the facility and left in May of 2020. Nurse #3 reported on 01/16/20 when she walked into Resident #3 ' s room, she was lying on her bed and appeared to be sleeping. The event report was reviewed with Nurse #3 and she stated it was hard to recollect what she had seen that evening. Nurse #3 stated whatever she had observed, she put in the event report/form because that was the process. Nurse #3 stated she would have reported the event to the Director of Nursing (DON) and notified the physcian. Nurse #3 stated any injury of unknown origin should be reported and she told the DON who was working there at that time. Nurse #3 stated if staff did not observe how the resident sustained an injury or if the resident did not have a fall within the last 24 hours, the facility would conduct an investigation including obtaining statements from all staff to try to establish what happened.

An interview was conducted with the Clinical Care Coordinator (CCC) via phone on 11/17/20 at 11:10 AM. The CCC reported she was not employed at the time of the event on 01/16/20 for Resident #3 and did not know if the injury of

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F 609	Continued From page 4	F 609		

unknown source was reported to the previoius CCC, the previous DON or the Administrator.

An interview was conducted with the DON via phone on 11/17/20 at 2:00 PM. The DON reported she was not employed at the facility at the time of the event on 01/16/20 for Resident #3. The DON reported the current process in place was that if an injury of unknown source was identified, the nurses were to complete an event form, report the event to the CCC and DON and we would investigate how the injury occurred right away and followed the policy to submit an initial report and a 5-day investigation to the HCRP.

An interview was conducted with the NP via phone on 11/17/20 at 2:30 PM. The NP revealed it was unclear how the resident obtained the injury. The NP reported she asked the staff that were working on 01/17/20 what may have happened, but they did not know. The NP stated she believed the process when there was an injury of unknown source was to notify the CCC and the DON so that they could conduct an investigation.

An interview was conducted with the DON via phone on 11/17/20 at 3:45 PM. The DON reported her expectation of her nursing staff, if they identified an injury of unknown source, was to notify the CCC and the DON immediately so that an investigation as to how the injury may have occurred could be conducted. The DON confirmed there was no initial investigation or 5 day investigation completed for the event that was documented on 01/16/20.

2) A nursing note written on 06/22/20 by Nurse #5 revealed staff alerted the nurse to a bruise on

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F 609	Continued From page 5	F 609		

the resident ' s right foot between fourth and fifth toe extending laterally from top of foot. The bruise was noted to be purple in color with mild swelling and noted to be extending approximately 3 inches on top of the foot. The resident had no complaints of pain or signs or symptoms of pain. The note indicated the primary care physician was notified via email.

An interview was attempted with Nurse #5 who no longer worked at this facility via phone on 11/16/20 at 11:00 AM. A message was left for a return call. A second attempt was made to interview Nurse #5 via phone on 11/17/20 at 9:30 AM. A message was left for a returned call.

An interview as conducted with the Clinical Care Coordinator (CCC) via phone on 11/17/20 at 11:10 AM. The CCC stated she was not made aware of the injury of unknown origin to Resident #3 ' s foot on 06/22/20. The CCC confirmed there was no event report completed for this identified injury. The CCC stated if the nurse had completed the event form she (CCC) would have notified the DON and followed up on the injury to establish how it occurred.

An interview was conducted with the Nurse Practioner (NP) via phone on 11/17/20 at 2:30 PM. The NP stated she was made aware of the injury to Resident #3 ' s foot and had evaluated her on 06/25/20. The NP stated this was the first time she had ever evaluated the resident for an injury to her foot. The NP reported there was bruising and mild swelling noted on her foot when she examined the resident. The NP reported she was not aware of how the injury occurred.

An interview was conducted with the Director of

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F 609	Continued From page 6 Nursing (DON) on 11/17/20 at 3:45 PM. The DON reported her expectation of the nursing staff for an injury of unknown source was to complete an event report, notify the physician, family, CCC and DON so that a formal investigation which included the initial report and the 5-day investigation report could be completed. The DON added, she expected a verbal report so that the staff could address the concern right away to establish how the injury occurred.	F 609		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete two quarterly fall risk assessments for 1 of 3 residents (Resident #3) reviewed for accidents who sustained 3 unwitnessed falls with no injury which occurred on 01/28/20, 03/15/20, and 03/16/20, two witnessed falls with no injury which occurred on 04/18/20 and 05/14/20 and one unwitnessed fall with minor injury on 05/24/20. Findings included: Resident #3 resided at the facility from 04/22/19 through 07/01/20. Diagnosis included Non Alzhehimer's dementia. A review of Resident #3 ' s current care plan revealed there was a plan of care in place for at	F 638	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation. 1.) Interventions for affected resident:	12/12/20

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F 638	Continued From page 7 risk for falls. This at risk for falls problem had been originally added to the care plan on 05/23/19. Interventions included: keep call bell within reach, assure floor was free of clutter and no glare, encourage resident to assume a standing position slowly, encourage resident to use environmental devices such as hand grips and hand rails, etc., keep personal items within reach, observe frequently, place in supervised places when out of bed, and provide proper footware. There were no interventions with a date beside them to denote any interventions had been added following 05/23/19. A review of the most recent quarterly fall risk assessment dated 12/29/19 revealed the resident was a high risk for falls with a score of 10. The assessment revealed she was alert and disoriented to person, place and time, had adequate vision, gait and balance were normal, she was ambulatory and incontinent and had no falls in the last 3 months. Diagnoses included dementia and incontinence as the two contributing factors present and to continue with plan of care. A nursing note written by Nurse #3 on 01/28/20 revealed the nurse was notified by staff that Resident #3 was on the floor beside her bed. The resident was sitting on the floor talking to herself and was asked if she was hurt and the resident mumbled "No." The resident was assessed for injury and there were no visible signs of new bruises or skin tears. The resident had range of motion to all extremities with no visible signs of discomfort. The resident was assisted off of the floor and ambulated to the other side of bed with the nurse with no limps noted. The nurse assessed her head for raised	F 638	Resident #3 no longer resides at the facility 2.) Interventions for residents identified as having potential to be affected: Between 11/19/2020 and 11/24/2020 an audit was completed for residents for date of fall risk assessment completion with appropriate corrections as needed 3.) Systemic Change On 12/10/2020 the Director of Nursing completed training with the MDS nurses, Clinical Coordinators and staff nurses regarding timeliness of quarterly fall risk assessments. The MDS schedule will be posted in the Nurse's Team Room. The falls assessment will be completed per the MDS schedule and the completion monitored by the Clinical Coordinator or MDS Coordinator 4.) Monitoring of the change to sustain system compliance ongoing: Starting 12/11/2020 the Director of Nursing or designee will use the MDS schedule to audit fall risk assessments weekly for 4 weeks then will audit one random resident 1 time a week for 2 months.	

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F 638	Continued From page 8	F 638	QAPI committee will review the results of the audit monthly for 3 months.	

areas and the resident was able to move her head up and down and side to side without difficulty.

The annual Minimum Data Set (MDS) assessment dated 03/13/20 revealed Resident #3 was severely cognitively impaired. Resident #3 had no impairments and did not use a mobility device. Resident #3 required supervision with one physical staff assistance with walking in her room/corridor. The resident was not steady and only able to stabilize with staff assistance with moving from seated to standing position The resident was not steady but able to stabilize without staff assistance with walking and turning around. The resident was coded as not having any falls during this assessment period.

A nursing note written by Nurse #1 on 03/15/20 at 5:50 AM revealed the nurse noted the resident to be on the floor beside her bed with a comforter wrapped around her. The resident was found to have no injury and was put back to bed with assistance.

A nursing note written by Nurse #1 on 03/16/20 at 12:37 AM revealed the nurse noted the resident to be on the floor beside her bed. The resident had no injury and was assisted back to bed.

A nursing note written by Nurse #1 on 04/18/20 at 2:43 PM revealed the resident had a witnessed fall in the living room when she had fallen between two chairs. There was no injury.

A nursing note written by Nurse #3 on 05/14/20 at 4:14 PM revealed the resident had a witnessed fall in the living room when she attempted to sit on the reclining chair. The resident had no injury.

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F 638	Continued From page 9	F 638		

A nursing note written by Nurse #3 on 05/24/20 at 2:55 AM revealed the resdient had an unwitnessed fall in the resident ' s room and she was found by staff sitting on the floor beside the bed. The resident ' s forehead was noted to have a laceration and left periorbital swelling noted. The resident complained of pain/discomfort when the nurse was cleansing and dressing her wound. The resident was assisted back to bed. Pressure was applied to the laceration with light bleeding noted. Once bleeding ceased, the laceration was cleansed with normal saline. Steri-strips and a protective dressing were applied.

The quarterly MDS assessment dated 06/06/20 revealed Resident #3 was severely cognitively impaired. Resident #3 required supervision with one physical staff assistance with walking in her room/corridor. Resident #3 had no impairments and did not use a mobility device. The resident was not steady and only able to stabilize with staff assistance with moving from seated to standing position and not steady but able to stabilize without staff assistance with walking and turning around. The resident was coded as having 2 or more falls with no injury and one fall with minor injury during this assessment period.

An interview was conducted with Nurse #1 via phone on 11/16/20 at 3:15 PM. Nurse #1 reported nurses were required to complete fall risk assessments and she believed they were to be done quarterly. Nurse #1 reported the fall risk assessments included information the nurses needed to determine what the resident ' s risk score was by reviewing how many falls the resident may have had during that quarter. Nurse #1 stated Resident #3 had frequent falls and each

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F 638	Continued From page 10	F 638		

time a resident had a fall, a fall event report was completed in the computer. Nurse #1 stated to complete the quarterly fall risk assessments, the nurse would look back on all the fall events that quarter. Nurse #1 could not recall when she last completed a fall risk assessment for Resident #3.

An interview was conducted with Nurse #3 via phone on 11/16/20 at 3:50 PM. Nurse #3 reported the nurses were responsible for completing the quarterly fall risk assessments and a list was provided to the nurses which was kept on the wall at the nurse ' s station. Nurse #3 stated she was not certain when she last completed a fall risk assessment on Resident #3. Nurse #3 stated if the last quarterly fall risk assessment was done in December, 2019, there should have been a fall risk assessment completed in March, 2020 and June, 2020.

An interview was conducted with the Clinical Care Coordinator (CCC) via phone on 11/17/20 at 11:10 AM. The CCC reported the nursing staff were responsible for completing the quarterly assessments which included the fall risk assessments. The CCC stated if the last quarterly fall risk assessment was conducted on 12/19/19, then the next quarterly fall risk assessment would be due on or around 03/19/20 and the following quarterly assessment would be due on or around 06/19/20. The CCC stated she could not provide any quarterly fall risk assessments that were completed since 12/19/19 for Resident #3.

An interview was conducted with the Director of Nursing (DON) on 11/17/20 at 2:00 PM. The DON reported the quarterly fall risk assessments were delegated to the nurses on the long term

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F 638	Continued From page 11 care units and she expected them to be completed each quarter to determine what the fall risk score was for all residents and to ensure the residents had the appropriate plan of care based on the fall risk score.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code a resident ' s fall on the minimum data set (MDS) assessment for 1 of 3 residents (Resident #3) reviewed for accidents. Findings included: Resident #3 was admitted to the facility on 04/22/19. Diagnosis included Non Alzhehimer's dementia. A nursing note written on 01/28/20 revealed the nurse was notified by staff that Resident #3 was on the floor beside her bed. The resident was sitting on the floor talking to herself and was asked if she was hurt and the resident mumbled "No." The resident was assessed for injury and there were no visible signs of new bruises or skin tears. The resident had range of motion to all extremities with no visible signs of discomfort. The resident was assisted off of the floor and ambulated to the other side of bed with the nurse with no limps noted. The nurse assessed her head for raised areas and the resident was able	F 641	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation. 1.) Interventions for affected resident: Resident #3 is no longer resides at the facility. 2.) Interventions for residents identified as	12/12/20

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F 641	Continued From page 12 to move her head up and down and side to side without difficulty. The annual MDS assessment dated 03/13/20 revealed Resident #3 was severely cognitiviey impaired. Resident #3 required supervison with one physical staff assistance with walking in her room/corridor. The resident was not steady and only able to stabilize with staff assistance with turning around, and not steady but able to stabilize with staff assistance with walking. The resident was coded as not having any falls during this assessment period. An interview was conducted with the MDS Nurse via phone on 11/17/20 at 11:03 AM. The MDS nurse stated when compiling information to complete the annual assessments, she would review the nurse ' s notes, any new events, the physician ' s orders and progress notes, speak to nursing staff, and review the medication and treatment administration records. The MDS nurse stated she should have documented Resident #3 had a fall during this annual assessment on 03/13/20 and that it was a data entry error. An interivew was conducted with the Director of Nursing (DON) on 11/17/20 via phone at 11:10 AM. The DON reported her expectation was for the MDS nurse to ensure she entered accurate information from records and staff when completing all MDS assessments. The DON stated the MDS needed to be accurate for resident quality of care.	F 641	having potential to be affected: Between 11/19/2020 and 11/24/2020 an audit was completed for residents to review coding for number of falls on the last MDS and reviewed the chart for accuracy of assessment. Corrections were completed if indicated 3.) Systemic Change On 12/10/2020 the Director of Nursing educated the MDS nurses, Clinical Coordinators and staff nurses regarding accurate coding of falls on the MDS. The falls coding will be verified by the Director of Nursing or designee prior to completion. 4.) Monitoring of the change to sustain system compliance ongoing: Starting 12/11/2020 the Director of Nursing or designee will use MDS calendar to audit 10 completed MDS assessments each month for 3 months to ensure accurate coding of falls. QAPI committee will review the results of the audit monthly for 3 months.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		12/12/20

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F 657	Continued From page 13 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update a comprehensive care plan to reflect unwitnessed and witnessed falls and failed to revise the care plan with new interventions to address the unwitnessed and witnessed falls for 1 of 3 residents (Resident #3) reviewed for accidents. Findings included:	F 657	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal requirements. The Health Care Center	

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F 657	Continued From page 14 Resident #3 resided in the facility from 04/22/19 through 07/01/20. Diagnosis included Non Alzheimer's dementia. The annual Minimum Data Set (MDS) assessment dated 03/13/20 revealed Resident #3 was severely cognitively impaired. Resident #3 required supervision with one physical staff assistance with walking in her room/corridor. The resident was not steady and only able to stabilize with staff assistance with moving from seated to standing position, and not steady but able to stabilize without staff assistance with walking and turning around. The resident was coded as not having any falls during this assessment period. The resident ' s last quarterly MDS assessment dated 06/06/20 indicated the resident continued to have problems with unsteadiness with moving from seated to standing position and she had experienced two falls with no injury and one fall with minor injury during this assessment period. A review of Resident #3 ' s current care plan revealed there was a plan of care in place for at risk for falls. This at risk for falls problem had been originally added to the care plan on 05/23/19. Interventions included: keep call bell within reach, assure floor was free of clutter and no glare, encourage resident to assume a standing position slowly, encourage resident to use environmental devices such as hand grips and hand rails, etc., keep personal items within reach, observe frequently, place in supervised places when out of bed, and provide proper footware. There were no interventions with a date beside them to denote any interventions had been added following 05/23/19. An interview was conducted with the MDS Nurse	F 657	does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation. 1.) Interventions for affected resident: Resident #3 no longer resides at the facility. 2) Interventions for residents identified as having potential to be affected: Between 11/19/2020 and 11/24/2020 a care plan audit was performed to identify and correct all unwitnessed and witnessed fall interventions. All care plans reviewed were updated if indicated. 3.) Systemic Change On 12/10/2020 the Director of Nursing educated the MDS nurses and Clinical Coordinators and nursing staff regarding the timely updating of resident care plans with fall interventions. Care plans will be reviewed by the Clinical Coordinator when a fall event occurs and the Falls Committee will verify accuracy of care plan when reviewing fall events.	

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F 657	Continued From page 15 via phone on 11/17/20 at 2:28 PM regarding how care plans were updated and revised. The MDS nurse stated when she updated the care plan she would not change the problem start date which indicated the date the problem was identified and the category of the problem. The MDS Nurse reported she would update the goal column to reflect any new changes and revise the goal date, and she would also update the approaches column with new interventions and the date the interventions were added to the care plan. A review of the fall history events for Resident #3 revealed Resident #3 had 3 unwitnessed falls with no injury which occurred on 01/28/20, 03/15/20, and 03/16/20, two witnessed falls which occurred on 04/18/20 and 05/14/20 and one unwitnessed fall with minor injury on 05/24/20. A nursing note written by Nurse #3 on 01/28/20 revealed the nurse was notified by staff that Resident #3 was on the floor beside her bed. The resident was sitting on the floor talking to herself and was asked if she was hurt and the resident mumbled "No." The resident was assessed for injury and there were no visible signs of new bruises or skin tears. The resident had range of motion to all extremities with no visible signs of discomfort. The resident was assisted off of the floor and ambulated to the other side of bed with the nurse with no limps noted. The nurse assessed her head for raised areas and the resident was able to move her head up and down and side to side without difficulty. Review of Resident # 3 ' s at risk for falls care plan, last revised on 05/23/19, revealed no notation the care plan was updated following the	F 657	4.) Monitoring of the change to sustain system compliance ongoing: Starting 12/11/2020 the Director of Nursing or designee will use the MDS calendar to audit 10 completed care plans a month for 3 months to ensure resident plans of care include appropriate fall interventions. QAPI committee will review the results of the audit monthly for 3 months.	

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01/28/20 fall.
A nursing note written by Nurse #1 on 03/15/20 at 5:50 AM revealed the nurse noted the resident to be on the floor beside her bed with a comforter wrapped around her. The resident was found to have no injury and was put back to bed with assistance.

A nursing note written by Nurse #1 on 03/16/20 at 12:37 AM revealed the nurse noted the resident to be on the floor beside her bed. The resident had no injury and was assisted back to bed.

A nursing note written by Nurse #1 on 04/18/20 at 2:43 PM revealed the resident had a witnessed fall in the living room when she had fallen between two chairs. There was no injury.

Review of Resident # 3 ' s at risk for falls care plan, last revised on 05/23/19, revealed no notation the care plan was updated following the resident ' s falls on 03/15/20, 03/16/20 or 04/18/20.

An interview was conducted with Nurse #1 via phone on 11/16/20 at 3:15 PM. Nurse #1 reported she was working when Resident #3 had a fall on 03/15/20 and 03/16/20. Nurse #1 stated she could not recall what interventions she put in place on 03/15/20, but believed she had implemented for the resident ' s bed to be in the lowest postion. Nurse #1 was not sure how the resident kept falling out of bed. Nurse #1 added she felt the resident just rolled out and did not seem to be aware she was out of her bed because she was found sleeping both nights on the floor. Nurse #1 stated she remembered not implementing a fall mat because with ambulatory dementia residents the fall mats can cause more

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harm than good because they may trip over them. Nurse #1 reported she was made aware of the witnessed fall on 04/18/20 by the staff. Nurse #1 stated she did not recall implementing an intervention for that fall. Nurse #1 reported if a resident had a fall, the nurses completed a fall event and documented their assessment of the fall and, as part of the protocol, the nurse reported the fall to her supervisor. Nurse #1 reported all falls were reviewed by the Clinical Care Coordinator (CCC) and the Director of Nursing (DON). Nurse #1 stated she believed the DON and CCC updated the care plan with the new interventions. Nurse #1 stated nurses can implement new interventions and then it was reviewed by the management team to determine the best intervention. Nurse #1 added, the management team would let the nurses know what the new intervention was.

A nursing note written by Nurse #3 on 05/14/20 at 4:14 PM revealed the resident had a witnessed fall in the living room when she attempted to sit on the reclining chair. The resident had no injury.

Review of Resident # 3 ' s at risk for falls care plan, last revised on 05/23/19, revealed no notation the care plan was updated following the 05/14/20 fall.

A nursing note written by Nurse #3 on 05/24/20 at 2:55 AM revealed the resdient had an unwitnessed fall in the resident ' s room and she was found by staff sitting on the floor beside the bed. The resident ' s forehead was noted to have a laceration and left periorbital swelling noted. The resident complained of pain/discomfort when the nurse was cleansing and dressing her wound. The resident was assisted back to bed. Pressure

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was applied to the laceration with light bleeding noted. Once bleeding ceased, the laceration was cleansed with normal saline. Steri-strips and a protective dressing were applied.

Review of Resident # 3 ' s at risk for falls care plan, last revised on 05/23/19, revealed no notation the care plan was updated following the 05/24/20 fall.

An interview was conducted with Nurse #3 via phone on 11/16/20 at 3:51 PM. Nurse #3 stated on 05/14/20 when the resident fell she was trying to sit on the reclining chair and it was a witnessed fall with no injury. Nurse #3 reported it was difficult to stop all falls on the dementia unit when residents were ambulatory. The staff do their best to keep an eye on the ambulatory residents to ensure their safety. Nurse #3 stated she did not recall implementing an intervention for the witnessed fall on 05/14/20. Nurse #3 reported when the resident fell on 05/24/20, her bed was in the lowest position, ¼ half rails were up and the comfortor was not on her when she was found on the floor. Nurse #3 reported it was unclear how she fell and, at this time, new interventions were not put in place because the facility was already doing what they could to prevent the falls. Nurse #3 added, she just continued with the current plan of care that was in place prior to the 05/24/20 fall. Nurse #3 stated if a resident had a fall, the nurses were to complete an event to explain the details of the fall. Nurse #3 stated the nurses could implement a new intervention if a resident fell and usually it was reviewed by the CCC and the DON. Nurse #3 stated she believed the MDS nurse or the CCC updated the care plan. Nurse #3 stated any new interventions would be communicated to the nursing staff by the nurse or the CCC.

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An interview was conducted with Nurse #4 via phone on 11/17/20 at 1:20 PM. Nurse #4 reported if a resident had a fall, the fall protocol was to complete an event in the computer system which would ask all the questions regarding the fall such as time, place, environmental conditions, if there was injury, vital signs, etc. The nurse stated she would try to determine how the resident fell and implement an intervention. She stated the CCC would review any falls that occurred. Nurse #4 reported the management team usually updated the care plan with any new interventions and would communicate to the nurses what the intervention was.

An interview was conducted with the Clinical Care Coordinator via phone on 11/17/20 at 2:00 PM. The CCC reported she was unable to find the "working" care plan which was a paper document that was kept at the nurses ' s station for Resident #3. The CCC confirmed she worked with the nursing staff, the MDS Nurse and the DON to determine any new interventions if a resident had a fall. The CCC reported it would get written on the working care plan to reflect any new goals or interventions.

During the interview with the MDS nurse on 11/17/20 at 2:28 PM, the MDS Nurse stated the care plan should be updated as soon as an event occurs. The MDS Nurse reported the working care plans were at the nurse ' s station and updated in hand writing by the MDS Nurse and the CCC. The MDS Nurse stated she worked collaboratively with the CCC and the DON and they would often let her know if something would need to be care planned. The MDS Nurse added, information from the CCC would be

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conveyed to her as soon as they put an intervention or goal in effect. The CCC would email or verbally communicate to the MDS nurse the updated goals and interventions. The MDS Nurse reported she used the working care plan with hand writing to update the care plan in the system annually. It was validated with the MDS Nurse that Resident # 3 ' s annual care plan for at risk for falls had not been updated with the revisions following each of the resident ' s unwitnessed and witnessed falls. The MDS Nurse stated not updating the annual care plan for at risk for falls for Resident #3 was an isolated situation and it got missed in error.

An interview was conducted with the DON on 11/17/20 at 3:20 PM. The DON reported her expectation of the MDS nurse was to ensure the care plans were updated to provide the nursing staff the knowledge of the care and interventions needed to prevent falls.