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	IL6009369	A. BUILDING: _____ B. WING _____	05/27/2022

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TAYLORVILLE CARE CENTER	600 SOUTH HOUSTON TAYLORVILLE, IL 62568

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210 b)5) 300.1210 c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to investigate falls and implement progressive interventions to prevent additional falls for 5 of 13 residents (R11, R26 R41, R52, R60) reviewed for falls in the sample 36. This failure resulted in R26 and R60 sustaining fractured hips and requiring hospitalization. Findings include: 1. On 5/26/22 at 2:15 PM, V32, Certified Nurse's Assistant (CNA), and V27, CNA, attempted to transfer R26 out of her wheelchair (w/c) to bed to	S9999		

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perform catheter care. R26 was sitting in her w/c, slumped over at her waist, and refused to get out of her chair despite several attempts and encouragement from CNAs. V32 stated R26 is usually agreeable to laying down after supper and they provide catheter care at that time. V32 stated they will reapproach R26 again in a little bit to see if she is agreeable to getting out of her chair.

R26's Face Sheet documents her diagnoses to include Type 2 Diabetes Mellitus, Hypertension, Insomnia, Major Depressive Disorder, History of Falling, Unspecified Dementia Without Behavioral Disturbance, Difficulty in Walking, Not Elsewhere Classified, Unsteadiness on Feet, Other Abnormalities of Gait and Mobility, and Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites.

R26's Minimum Data Set (MDS), dated 3/31/22, documents she is severely cognitively impaired and requires extensive assist with bed mobility and transfers. The MDS documents she is dependent for locomotion on and off the unit.

R26's Fall Risk Evaluation, dated 5/17/22, documents a score of 13, indicating she is at increased risk of falls.

R26's Care Plan dated 4/3/20 documents: "I am at risk for falls related to previous fall, cognition, unsteadiness." The care plan lists the following falls: 10/04/21 Fall from recliner attempting self-transfer; 12/13/2021 slide from chair; Fall 1/17/22; Fall 1/27/22, Fall 3/1/22; Fall 3/28/22; Fall 5/8/22 fall from w/c.

R26's Un-Witnessed Fall Report, dated 10/4/21 at 7:15 AM, documents: "This writer was outside of

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resident's door. Heard a loud noise, resident yelling for help. Upon entering the room noted resident laying on her left side with her head up against the nightstand. Recliner was tipped forward. Small amount of blood on the floor. Resident unable to give description. Resident assisted back to the recliner after PROM (Passive Range of Motion) completed. Area above left brow cleansed with soap and water. Steri-strips applied over approximately 0.5 cm (centimeter) superficial laceration. Neuro checks started."

R26's Care Plan was updated on 10/4/21 with new intervention: Therapy to screen to establish transfer status.

R26's Unwitnessed Fall Report dated 12/13/21 at 8:00 PM documents: "CNA came to nurses' station to let nurse know that resident slipped out of her w/c onto the floor. When writer approached resident's room, resident was laying on her right side, legs out in front of her, wheelchair behind her against the bathroom door and resident was in front of her bed. When writer asked resident what happened she stated, "I don't know." Resident denied any pain, denied hitting her head at all. Writer, CNA and gait belt assisted resident back into her w/c. Resident then received a shower and writer checked resident body for any marks. Resident has no marks on her from fall. Vitals were obtained and resident is on fall neuros due to fall being unwitnessed. Resident was wearing non-slip socks."

R26's Care Plan did not have any progressive interventions added following this fall on 12/13/21.

R26's Unwitnessed Fall Report, dated 1/17/22 at 8:00 PM, documents, "Writer called to resident's

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S9999	Continued From page 4 room. Resident was noted to be lying on her left side on bathroom floor with feet near the toilet, walker near the sink. Resident yelling out, no injury noted at time of assessment. Resident assisted to sitting position with no c/o (complaint of) injury, assisted to standing with 3 staff assist. Resident able to walk back to her recliner at this time without difficulty. Resident unable to give a description." R26's Care Plan did not include any progressive interventions added following this fall on 1/17/22. R26's Unwitnessed Fall Report, dated 1/27/22 at 5:15 PM, documents, "Writer was called down to resident room, resident was laying on the floor on her right side, head towards the wall, feet towards her recliner. When asked resident what happened she stated, 'I don't know.' Writer asked resident about any pain, she stated 'my back'. Performed ROM (range of motion) on all extremities. No c/o pain voiced at this time. Resident rolled over to her back, assisted to a sitting position, and then to a standing position and then into her wheelchair with assistance of 2 staff members and a gait belt. Writer did a full assessment, no new areas noted. Started resident on neuros. Denies hitting her head. Called POA (Power of Attorney) and faxed MD (Medical Doctor). " Under "Resident Description" the report documents, "Resident has been complaining of pain in her back for weeks according to POA." There were no progressive interventions added to R26's Care Plan following this fall 1/27/22. R26's Witnessed Fall Report, dated 3/1/22 at 8:09 AM, documents, "Was called to room per CNA who witnessed fall. Noted (R26) on floor in	S9999		

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S9999	Continued From page 5 door frame of bathroom facing her bed. CNA reported that while she was taking another resident to her room, she noted (R26) in a semi-standing position in front of the toilet. She attempted to get to her but before she could, (R26) fell to ground landing on her buttock and then rolled to right side. Resident description, "I was trying to go pee and I just fell." (R26) was assessed for injury. ROM checked and within normal limits. Vital signs were taken. (R26) was assisted off floor by 3 staff members and placed on toilet. There were no progressive interventions added to R26's Care Plan after this fall on 3/1/22. R26's Unwitnessed Fall Report dated 3/28/22 at 8:30 PM documents, "Writer was coming up the hall when writer heard a crash followed by a yell for help. When writer arrived to nurses' station, resident was noted to be on the floor lying on her right arm. She denies any pain, no injury noted upon assessment. She was wearing non-skid socks and states that she was trying to 'get up and go'. Had been toileted 1 hour prior to incident. Lighting was appropriate for situation. Resident was assessed, no injury or pain reported on assessment." A new intervention was added to R26's Care Plan following this fall: "Monitor me for needs when in halls or at nurses' station." R26's Serious Injury Incident Report, dated 5/8/22 at 4:30 AM, documents, "There were no witnesses to the incident. Administrator originally indicated resident was not capable of communication, however, resident can communicate but resident is not a good historian. On 5/8/22 at approximately 4:30 AM CNA entered	S9999		

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S9999	Continued From page 6 (R26's) room to find her on the floor with her arm under her head, on her left side at the foot of her bed. (R26) was assessed at the time of the incident, but not found to have injuries and denied pain. On 5/10/22 resident reported pain and physician notified and x-rays ordered. (X-ray company) notified and results were received on the morning of 5/11/22 indicating a femoral neck fracture. Physician ordered (R26) to be sent to (hospital) to be evaluated by orthopedic physician. Surgery was performed on 5/17/22. Investigation into the fall on 5/9/22 by the IDT (Interdisciplinary Team) revealed the CNA had just gotten (R26) up and put her into her w/c and left her sitting in her room. Resident often wheels herself around in her w/c, and it appeared resident wheeled herself beside her bed, as her w/c was found close to her bed. Staff believe resident was attempting to put herself back in bed, due to the early morning hour. IDT determined resident should be allowed to sleep in if desired. ADON (Assistant Director of Nursing) interviewed (R26) before she was transferred to the hospital and (R26) did not have any recollection of any incident, or that she was even hurt at the time, and wondered why she was being sent out. Review of the circumstances did not indicate neglect or abuse and fall interventions will be reviewed when resident returns from the facility and therapy will evaluate (R26) for treatment and education. Initial report had a typo in the dates of complaints of pain, as medical reflects no pain reported until 5/10/22 when the physician was called." A new intervention was added to R26's Care Plan on 5/10/22: "I am not to be gotten up before 5:00 AM," but the care plan was not updated with R26 having sustained a hip fracture and surgery to repair it.	S9999		

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S9999	Continued From page 7 2. On 5/27/22 at 9:05 AM, V17, CNA, and V22, CNA, transferred R52 from her w/c to her bed. R52 was noted to have a quarter sized dry scab to her left forehead. After she was in bed, a skin check was performed and R52 had bruises to her right hip and buttock. V17 stated the scab, and the bruises were from when R52 fell a couple of weeks ago and had to be sent to the hospital because she had a brain bleed. V17 stated R52 had fallen out of bed. V17 stated R52 cannot turn herself in bed but sometimes she does scoot herself. V17 stated they usually have a floor mat on the floor if someone falls out of bed, and they keep the bed in the lowest position when the resident is in it. She stated they have not put a floor mat down for R52 yet; she stated she got R52 up this morning and there was not a floor mat on the floor. After R52's care was completed, V17 put a wedge cushion under R52's right side, with R52 facing the left side of the bed, which was facing open door. The right side of the bed was against the wall. The wedge cushion would have prevented R52 from scooting against the wall but would not have impeded R52 to scoot to the left and out of bed. R52's Face Sheet documents her diagnoses to include Traumatic Subdural Hemorrhage Without Loss of Consciousness (5/10/22), Major Depressive Disorder, Hypoxemia, Unspecified Dementia with Behavioral Disturbance, Anxiety Disorder, History of Falling, Muscle Wasting and Atrophy, Muscle Weakness, and Other Abnormalities of Gait and Mobility. R52's MDS, dated 5/2/22, documents she is severely cognitively impaired and requires extensive assist of 2 staff to transfer and for bed mobility.	S9999		

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S9999	Continued From page 8 R52's Care Plan, dated 12/14/18, documents: "I am at risk for falls r/t (related to) decreased mobility, weakness, anxiety, cognitive loss, secondary to depression, dementia, muscle weakness. Fall from bed 5/9- laceration to head and to hospital with subdural hematoma" There was no updated intervention after R52's fall on 5/9/22. The first intervention after R52's fall on 5/9/22 was initiated on 5/23/22 as "wedge pillow in bed to decrease ability to roll out of bed." R52's "Serious Injury Report," dated 5/9/22 at 5:00 AM, documents, "(R52) was noted to be on floor by nurse at 5:00 AM when walking down B Hall. (R52 was on the floor laying on her left side with her hand above her head, with head facing toward the floor. R52 appeared to have fallen out of bed. R52's head was bleeding. Ambulance was called and (R52) was transferred to (local hospital), then transferred from there to another hospital for treatment and observation. Investigation into fall was initiated. Staff caring for resident were interviewed. CNAs had completed the 4:00 AM bed checks on B Hall at approximately 4:45 AM with R52 being the last resident checked on B Hall. Prior to leaving the room, the caregivers had positioned her on her right side, facing the wall, and she was well positioned when they left the room. Resident is known to be mobile in bed and CNA described her as "quite the wiggle worm". Resident has a low bed. All caregivers (nurses and CNAs) believe R52 wiggled herself to the edge of the bed and on the floor. Upon return to the facility, R52 was evaluated by therapy and a positioning cushion was implemented in hopes of helping resident position self in bed. This intervention is being monitored by staff.	S9999		

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S9999	Continued From page 9 R52's hospital records include a CT report, dated 5/9/22 at 5:36 AM, which documents, under "Impression": "1. New right-sided epidural hematoma overlying the lateral right frontal lobe." R52's Physician Progress Note, dated 5/21/22, documents: Reason for visit: Follow up. The progress note documents, "She (R52) recently had that bad fall and had a bleed that initially was thought to be an epidural hematoma but I think in Springfield (2nd hospital) they determined it more likely was subdural." On 5/26/22 at 12:41 PM, R52's Care Plan was reviewed with V4, Minimum Data Set/Care Plan Coordinator (MDS/CPC). V4 stated she has not gotten around to updating R52's care plan since she returned from the hospital. 3. On 5/24/22 at 11:20 AM, R60 was standing up in front of his wheelchair (w/c). V4, MDS/CPC, was coming up the hall and directed R60 to sit back down and then propelled him in his w/c to the dining room for lunch. R60's call light was on at the time he was observed standing up. The MDS nurse offered him toileting, but he declined. On 5/24/22 at 1:20 PM, V24, R60's wife, reported R60 fell in January (1/18/22) and broke his hip and stated he also had a fall this past Sunday (5/22/22) and was sent to the emergency room (ER), but did not have any injuries other than a few scabs. R60's Face Sheet documents he was initially admitted to the facility on 10/22/21 with the diagnoses of Fracture of Unspecified Part of Neck of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing (10/22/21), History of Falling (10/22/21), Other Abnormalities	S9999		

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S9999	Continued From page 10 of Gait and Mobility, Parkinson's Disease, Unspecified Dementia Without Behavioral Disturbance, and Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites. The Face Sheet included an additional diagnosis, dated 1/28/22, of Periprosthetic Fracture Around Other Internal Prosthetic Joint, Initial Encounter. R60's MDS, dated 5/6/22, documents R60 is severely cognitively impaired with both long and short term memory problems. Per the MDS, R60 requires extensive assist from 2 staff for transfers (care plan documents he needs 1 assist) and limited assist with walking. R60's Fall Risk Evaluation, dated 5/9/22, documents a score of 20, indicating he is at risk of falls. R60's Witnessed Fall Report, dated 1/12/22 at 11:15 AM, documents, "CNA reported that resident 'went to his knees during care.' Abrasion to left knuckles noted and band aid applied." Resident description, 'He is unable to give description. He stated he hit his head, but CNA reports she saw the incident and he didn't hit his head." R60's Care Plan, dated 10/25/21, was not updated with a progressive intervention after this fall. R60's Unwitnessed Fall Report, dated 1/18/22 at 11:05 PM, documents, "Writer was sitting at nurses' station when a loud crash was heard down the hallway. Resident had gotten up by himself and walked to hallway when he lost his balance and fell landing on his right side. Fall was not witnessed and hallway dark at time of occurrence. Resident had not been incontinent of	S9999		

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urine or bowel and denied need for either. Writer noted that right wrist has open laceration and resident yelling out in pain while writer was assessing site. Resident also grabbing at hips and grimacing. EMS (Emergency Medical Service) notified of need for transport. Spouse, MD (Medical Doctor), on call nurse and ER (emergency room) nurse all notified of fall and given report of incident. Resident unable to give description." Under "Other Info" the report documents: "Resident has been getting up frequently without assistance and has had increased behaviors lately."

R60's Progress Note, dated 1/19/2022 at 4:08 AM, documents, "Writer called and spoke with (nurse) at (hospital's) ER whom reports that resident will be admitted shortly, and that resident has a right femur fracture requiring surgical intervention. Resident will be admitted once room becomes available. POA (Power of Attorney) at bedside."

R60's Hospital Records include his "Hospitalist History and Physical (H&P)," dated 1/19/22 at 4:32 AM, which documents, "Impression: Right periprosthetic hip fracture: Acute impacted radial head fracture, and Fall." The H&P report further documented, "At the time of my evaluation, patient's wife reported that patient has fallen multiple times in the last 5 days." Besides R60's falls on 1/12/22 and 1/18/22, no other falls were documented in his progress notes and no other fall reports for January 2022 were provided by the facility.

R60's Care Plan, dated 10/25/21, included an intervention dated 1/18/22, "I am becoming more mobile, assist me with ambulation, give frequent reminders to wait for assist before walking on my

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S9999	Continued From page 12	S9999		

own." There were no additional progressive interventions put in place after R60 was readmitted from the hospital on 1/28/22."

R60's Witnessed Fall Report, dated 2/26/22 at 8:30 AM, documents, "Resident fell in dining room at 8:30 AM. Fall was witnessed by two CNAs. Resident could move all extremities. Resident unable to give a description. No injuries observed at the time of incident."

R60's Care Plan was not updated with any progressive interventions following his fall on 2/26/22.

R60's Progress Note, dated 4/20/2022 at 3:09 PM, documents, "Nursing Note Text: Resident was sitting in wheelchair at nurses' station, resident stood up, writer could not get to resident quick enough and resident lost balance and went down on his knees. no injuries noted. writer assessed resident. ROM (range of motion) WNL(within normal limits). resident did not hit his head. resident was assisted back into his wheelchair, and he asked to go to bed. CNA took resident to room to lay down. POA (Power of Attorney) and MD (Medical Doctor) notified of witnessed fall."

The facility failed to provide a "Witnessed Fall Report" for his fall on 4/20/22 indicating this fall had been investigated. R60's Care Plan was not updated with progressive interventions after this fall.

R60's Witnessed Fall Report, dated 5/22/22 at 5:37 PM, documents, "Writer was sitting at nurses' station and resident was sitting in w/c and stood up and before I could get to him, he fell to the floor, landing on his right side. He did not hit

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	IL6009369	A. BUILDING: _____ B. WING _____	05/27/2022

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S9999	Continued From page 13	S9999		

his head. Examined for injuries and resident has skin tears to right elbow and two skin tears on his right lower arm. Swelling to outer right wrist noted. Skin tear to left shin. Resident unable to give description. Examined for injuries and skin tears noted to right elbow and two on right wrist. Skin tear to left shin and raised area on right wrist. Moves lower legs and left arm. Notified (MD) at 3:45 PM and made doctor aware of fall and sending to hospital ER for evaluation. Notified ambulance at 3:50 PM. Notified POA at 3:55 PM. Ambulance here and transported resident per stretcher to hospital."

R60's Care Plan was updated on 5/23/22 with the new intervention: obtain labs and urinalysis/ culture & sensitivity (ua/c&s) per MD order and report to MD results. No lab results could be found on R60's EMR (Electronic Medical Record) regarding labs and ua/c&s ordered following his fall on 5/22/22.

On 5/26/22 at 2:40 PM, V3, Assistant Director of Nursing, stated, "When we did the initial fall huddle for (R60), we discussed doing his labs, but the physician stated he thought they had probably done all that stuff in the hospital when he was sent to the emergency room. We also talked to his wife who is usually here every day, and she had not been in to see him on the day he fell, and she thought him trying to get up might have been a behavior." V3 stated the labs were not done, and they just forgot to go in and update R60's care plan to take the labs off and add that staff are to keep his walker closer to him and encourage him to go to more activities. "His wife brought in a new game she thinks he might like, so we are trying to get him to join in games." V3 stated she later checked with the hospital, and they had only done x-rays when he was seen in

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S9999	Continued From page 14 the ER on 5/22/22 but no labs or ua were done. On 5/26/22 at 12:41 PM, V4 stated she had not done much with R26's Care Plan since she came back after being hospitalized for her hip fracture. V4 stated, "I only have two hands. I spend a lot of time on the floor working. When I added some interventions on 1/4/22, I added a lot of new things then so I may not have added anymore." V4 stated she usually hears about falls in morning meeting and tries to update care plans then. V4 stated she does not look at the fall reports before she updates the care plan because she usually hears about the fall before she sees the reports. She stated with the new fall program she is supposed to add something new when a fall occurs. R26's, R52's and R60's fall care plans were reviewed and V4 acknowledged that she did not update their care plans after every fall with progressive interventions. V4 stated, "You can only do so much." 4. R11's May 2022 Physician Order Sheet (POS) documents R11 has a diagnosis of pain in left hip, orthostatic hypotension, repeated falls, secondary Parkinsonism, multi-system degeneration of the autonomic nervous system, unsteadiness on feet, difficulty in walking, lack of coordination, muscle weakness, other abnormalities of gait and mobility, muscle wasting and atrophy, fatigue, and need for assistance with personal care. R11's MDS, dated March 8, 2022, documents R11 is cognitively intact, independent with bed mobility, transfer, and personal hygiene, requires supervision and setup with dressing, and requires setup with eating and toileting. R11's Fall Risk Assessment, dated 11/13/2021, documents R11 is at risk for falls.	S9999		

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S9999	Continued From page 15 R11's Care Plan with initiation date of 9/1/2021 documents, "The resident has had an actual fall with minor injury r/t (related to) poor balance with Parkinson's diagnosis. The resident will have no serious injuries due to falls by next review. Target date 6/8/22." R11's Unwitnessed Incident Report, dated 12/17/22 at 3:06 PM, documents, "Staff called writer to room stating they found (R11) on the floor. Writer entered room and noted that he was sitting by bed upright Indian style. Walker was across room by his chair. Resident description: (R11) stated he was coming back from his closet and his right foot 'froze' up. At that point he felt a little dizzy and immediately went down on his right knee. In the process of going down, he sheared his right flank/rib area on the foot board of the bed causing a large abrasion. There is a small abrasion to his right forehead, but he is not certain what he hit his head on." R11's Care Plan documents R11 had a fall on 12/17/2022 with no injury. No new intervention was documented following the 12/17/2022 fall. R11 had a subsequent fall on 1/1/2022. R11's Unwitnessed Incident Report, dated 1/1/2022, documents, "CNA came to get writer and stated that resident would like to see nurse and stated that he fell, as well. CNA stated that when she answered his call light resident was sitting in recliner. When writer approached resident room, he was sitting in his recliner. When writer asked resident what happened he stated that he had fallen and hit his head. Writer did not feel any bumps or see any marks on head. Writer did notice a bruise to the back left shoulder. Resident description: I was trying to go	S9999		

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S9999	Continued From page 16 to the bathroom. I lost my balance and fell and hit my head." R11's Care Plan documents fall on 1/1/2022 with bruise to left shoulder. No new intervention was documented until 1/18/2022. 5. R41's May 2022 POS documents R41 has a diagnosis of Parkinson's disease, anemia, and dementia in other diseases classified elsewhere without behavioral disturbance. R41's MDS, dated 4/22/2022, documents R41 is cognitively intact, requires extensive assistance from two or more persons for bed mobility, transfer, dressing and toileting, requires extensive assistance with one person for personal hygiene, and requires setup for eating. R41's Fall Risk Assessment dated 1/14/2022 documents R41 is at risk for falls. R41's Care Plan with initiation date of 1/27/2022 documents, "I am at risk for falls related to decreased mobility, weakness, cognitive loss secondary to Parkinson's dementia, anemia. I will remain free from injury related to fall through next review. Target date 7/28/2022." R41's Unwitnessed Fall Incident Report for 2/4/22 at 2:45 PM documents, "Resident was found lying next to his bed face down with his head against his recliner. His slippers were next to him but had not been on. His catheter bag was lying next to him, and his glasses were next to him with one side broken. Resident Description: Resident stated he was trying to stand up to go (urinate) and fell forward and hit his head on the floor." R41's Care Plan documents R41 had a fall on	S9999		

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S9999	Continued From page 17 2/4/2022 with resulting hematoma and laceration. No intervention documented following 2/4/2022 fall. R41 fell again on 2/15/2022 causing abrasion and skin tear. R41's Unwitnessed Fall Incident Report for 2/15/2022 at 10:30 AM documents, "Resident was noted on floor in his room. Resident description: Resident states that he was trying to put his basin back in his top drawer of his dresser. He lost his balance and fell backwards." R41's Care Plan was not updated with a new intervention after 2/4/2022 and 2/15/2022 falls until 2/21/2022. On 5/27/2022 at 9:07 AM, V3, Assistant Director of Nursing (ADON), stated, "I expect a new intervention following each fall. Once the team decides on the intervention, it is documented in the care plan." The Facility's Falls Prevention Management Policy and Procedure, dated 3/15/2018, documents, "It is the policy of (the facility) to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The Fall Prevention Program includes the following components: Immediate change in interventions that were unsuccessful. Care plan incorporates interventions are changed with each fall, as appropriate." (A)	S9999		

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