STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000889	A. BUILDING: _____ B. WING _____	R 05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA MORTON GROVE	8425 WAUKEGAN ROAD MORTON GROVE, IL 60053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Initial Comments First certification revisit to survey of 3/31/23 Annual Health Complaint Investigation 2392341/IL157798 2392025 /IL157367 Facility-reported Incident Investigation FRI of 2/14/23/IL157968 FRI of3/13/23/IL157586	{S 000}		
{S9999}	Final Observations Statement of Liscensure Violations: 300.610a) 300.1210a) 300.1210d)3)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and	{S9999}	**Attachment A** **Statement of Licensure Violations**	

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{S9999}	Continued From page 1 the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 Regulations were not met as evidenced by:	{S9999}		

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{S9999}	Continued From page 2 Based on observation, interview, and record review, the facility failed to have interventions that were resident-centered and focused on meeting the resident's individual needs, taking into account cognitive impairment and level of functioning that were effective at preventing falls; the facility also failed to ensure that staff followed their protocol of supervising residents at risk for falls while in the common area (dining room). These failures affected three of three (R17, R18, and R19) residents assessed to be at risk for falls, who were reviewed for accidents and supervision. These failures resulted in R18 having two falls, a day a part, with one resulting in a left forehead injury that required seven stitches to left side of the forehead; R17 acquired a skin tear and was sent to local hospital for evaluation after a fall; and R19 experienced a fall while unsupervised in the dining room. Findings include: R18 is a 71-year-old male admitted to the facility on 12/09/22 with diagnoses that include: metabolic encephalopathy, COVID-19, Bipolar disorder, dementia, depression, aphasia. R18's MDS (Minimum Data Assessment) dated 3/15/23 documents that R18 has a BIMS (Brief Interview for Mental Status) of 99 (indicates resident unable to complete); Section G (Functional Status) documents that R18 requires extensive assistance with one person physical assist for transfers; requires limited assistance of one person physical assist for walking in room and in corridor; and is not steady, but able to stabilize without human assistance during transitions and walking - for surface-to-surface transitions R18 is not steady, only able to stabilize with human assistance.	{S9999}		

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{S9999}	Continued From page 3 R18's care plan includes: o (R18) is at high risk for falls related to Alzheimer's disease, Cognitive impairment, Depression, Impulsivity or poor safety awareness and recent fall. Date Initiated: 5/4/2023 Interventions o Ensure that (R18) is wearing appropriate footwear well-fitting shoes or non-skid socks when ambulating. Date Initiated: 05/04/2023 - Gradually dose reduction of Hydroxyzine to 12.5 mg PO TID. Date Initiated: 05/08/2023 I have periods of forgetfulness. I would like staff to frequently reorient me to my surroundings. Date Inflated: 05/04/2023 ol would like staff to provide me a safe environment: even floors, free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, the bed in low position at night, Side rails as ordered, handrails on walls Date Initiated: 05/04/2023 o Monitor resident for complications from current infection. Date Infated: 05/12/2023 - Psych to review resident's psychotropic medication due to increase behavioral problems. Date Initiated: 05/04/2023 o Remind me to ask for assistance. Reorient me on how to use the call light, if necessary Date initiated: 05/04/2023 o Will check CBC and CMP, collect Urine for UA/CS s/p fall. | Date Initiated: 05/04/2023 During the course of this survey noted that R18	{S9999}		

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{S9999}	Continued From page 4 was walking throughout the unit and wandering in and out of his room and dining room. Staff were noted to re-direct R18; resident continued to wander throughout the unit during this survey. On 5/12/23 at 1:33pm, R18 was observed coming out of his room and walked to the dining room requesting milk. R18 came out of the dining room while drinking milk and spilling milk on the hallway floor. R18 was noted to have small petechial bruises under left and right eye; bruise around left eye appeared to be in healing stages (yellow in color). On 5/13/23 at 10:35am, noted that R18 was walking around the unit in hospital gown and was barefoot. On 5/12/23 at 1:38pm, surveyor stopped V14 (CNA) while in the hall to interview and V14 stated, okay but can we please go back into the dining room because I have residents in there and I have to monitor them at all times. Facility provided final incident report of fall that R18 had on 5/3/23. Incident report documents: "On 05/03/2023, at around 10:45 pm, resident was observed sleeping in his bed. Call light within reach and no signs of any discomfort. At around 11:56pm, Resident was noted lying on his left side on the floor in his room. both legs are extended. Call light was not activated. Resident was able to move all extremities without difficulty. Resident is unable to verbalized what happen. Head to toe assessment completed, resident was noted with a small tear to the left eyebrow with minimal bleeding. Site was cleaned with normal saline, and pressure dressing applied. Bleeding was controlled. Vital signs taken. BP 123/72; PR:	{S9999}		

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{S9999}	Continued From page 5 72; RR: 18; Temperature: 97.2 and O2 sat level: 98% at room air. No facial grimacing noted. No loss of consciousness observed. Dr., PCP was notified with order to send out resident via 911 to expedite transfer. Daughter, POA of Care was notified. Nurse remained with the resident until paramedics arrived and was sent out to (local hospital) for further evaluation and treatment. Based on medical records review and staff interview, resident has a diagnosis of dementia with psychotic disturbance, with poor safety awareness and impaired judgement. He is impulsive and has poor decision-making skills. At the time of the fall, call light was noted at bedside and resident did not ask for help or pressed his call light On 05/04/2023 at around 3:27am, resident returned to the facility with stitches on the left eyebrow. Hospital records reviewed. CT of the head and cervical spine was done at the hospital with no abnormal findings. In addition, resident was diagnosed with Covid 19. Pain management and wound care to follow for suture removal on 05/14/2023." Post fall investigation/RCA (Root Cause Analysis) Investigation form documents the following (not limited to): (completed by V12, LPN / Psychotropic Falls Coordinator) Date of Incident: 5/3/23 Time of Incident: 11:56PM Type of Incident: Unwitnessed Fall with Injury Location of Incident: Resident's room Did incident result in injury: Yes, laceration to left side of the forehead Environmental factors that contributed to the incident: Inappropriate Footwear, No footwear/socks Did Resident go to the Hospital: Yes, Resident was sent to (local hospital) ER via 911 due to laceration to left side of forehead. Resident was	{S9999}		

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{S9999}	Continued From page 6 sent back to facility from (local hospital) via stretcher around 3:27am on 5/4/23 in stable condition. Resident came back with 7 stitches to left side of the forehead. CT of the Cervical spine and head without contrast were done and all came back negative. ROOT CAUSE ANALYSIS: (Analysis of Findings Based on the Investigation) After reviewing the resident's fall and gathering all the information from staff and medical records review, resident was observed by staff at his baseline prior to the fall. Resident paces in the unit back and forth and has been redirected by staff several times to go back to bed. He is ambulatory. At the time of the fall, resident was noted with no footwear. Resident has poor safety awareness, impulsiveness and has impaired decision-making skills related to dementia with psychotic disturbance. Resident has been admitted to the facility since 12/09/2022. No record of fall since admission to the facility. Additionally, resident was diagnosed on 05/07/2023 with COVID-19. These factors increased resident's risk to fall. INTERVENTIONS TO ADDRESS INCIDENT (Please indicate assigned Disciplines to implement interventions): -Ensure that (R18) is wearing appropriate footwear well-fitting shoes or non-skid socks when ambulating. -Psych to review resident's psychotropic medications. -Monitor resident for complications from current infection. R18 has fall risk assessment completed on 5/4/23 with a score of 18 (high risk for falls). Facility provided fall report for R18 dated 5/4/23 14:00 that documents:	{S9999}		

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{S9999}	Continued From page 7 Incident Location: Resident's Room Nursing Description: Prior to incident around 1:30pm resident was observed in the dining room sitting and eating snacks. at 2:00pm resident was observed on the floor in another resident's room. Patient was sitting down on the floor next to the bed. Patients upper back and head was leaning against the bed ... Immediate Action Taken Description: Head to toe assessment was done. no visible injuries noted at this time. Resident able to move all extremities with no pain or discomfort. Vital sign checked BP 135/76, Temp 97.8,HR 77, Respiration 18 and Oxygen 96% room air. Resident was transferred back to bed using total mechanical lift with 3 staff assist. Resident family made aware - (family member) refused to send resident to the hospital and refused the x ray that was ordered by NP who was present at the time of the fall. PO verbalized x ray is not needed at this time. NP made aware with order to continue to monitor resident ... No Injuries observed at time of incident. Nursing Progress Notes for R18 include the following documentation: 5/4/202314:49 - Note Text: Spoke to patients daughter in regard to patients fall this afternoon. Daughter was notified that patient was found sitting on the floor in another patients room. Notified daughter that patient was seen by NP who ordered x-ray of bilateral hips. Daughter stated she was declining the x-ray and did not think it was necessary. NP notified of refusal. Will continue to monitor patient. Interview with V12 (LPN / Psychotropic Falls Coordinator) on 5/13/23 at 11:13AM stated that R18 had two falls recently. The first fall was at night on 5/3/23. At this time, V15 (Social	{S9999}		

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{S9999}	Continued From page 8 Services) joined the interview and stated that she was actually the one who found the resident after the fall on 5/4. He has a behavior of swinging his legs around the bed. He is not exit seeking; he just wanders into rooms. We have done 1:1 if he is aggressive. We have petitioned him out three or four times. That's his baseline. Post fall investigation/RCA (Root Cause Analysis) Investigaton form documents the following (not limited to): (completed by V12, LPN / Psychotropic Falls Coordinator) Date of Incident: 5/4/23 Time of Incident: 2:00PM Type of Incident: Unwitnessed Fall without Injury Location of Incident: Other Resident's room Did incident result in injury: No Environmental factors that contributed to the incident: Resident tripped on the blanket Did Resident go to the Hospital: No ROOT CAUSE ANALYSIS: (Analysis of Findings Based on the Investigation) - Based on staff interviews and clinical record review, resident observed sitting on the floor on 05/04/2023 at 2:00 pm resident's room. Resident tripped on the blanket when he was attempting to get up from bed unassisted. Resident did not call for assistance. Resident has Dementia with psychotic disturbance and impaired cognition per social services assessment for BIMS. On 05/07/2023 resident was tested + for COVID 19. COVID 19 causes increase confusion, weakness and fatigue which might have contributed further to him from falling. INTERVENTIONS TO ADDRESS INCIDENT (Please indicate assigned Disciplines to implement interventions): Check CBC/CMP and UA CS s/p fall. Psych to review psychotropic medication due to	{S9999}		

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{S9999}	Continued From page 9 increase behavioral problem. - Gradually dose reduction of Hydroxyzine to 12.5 mg PO TID. R17 is a 78-year-old male admitted to the facility on 10/25/20 with diagnoses that include: aftercare following joint replacement surgery, displaced fracture of base of neck of unspecified femur, Parkinson's disease, and Alzheimer's disease. R17's MDS (Minimum Data Assessment) dated 3/14/23 documents that R17 has a BIMS (Brief Interview for Mental Status) of 99 (indicates resident unable to complete); Section G (Functional Status) documents that R17 requires extensive assistance with 2+ persons physical assist for transfers and has impairment to lower extremities. R17's current care plan documents that R17 is a high risk for falls related to poor safety awareness related to Alzheimer's disease, Cognitive impairment, Fatigue, weakness, Seizure disorder, Use of Hypnotics, non-compliance with using his walker when ambulating, history of falls, and recent fall. Date Initiated: 2/8/22 Interventions (include): -Bed in lowest position and floor mat next to bed for safety. Date Initiated: 3/28/23 -I would like staff to provide me a safe environment: even floors, free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls. Date Initiated: 2/8/22 -Psych to review medication due to impulsive beahvior. Date Initiated: 4/26/23	{S9999}		

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{S9999}	Continued From page 10 Current care plan for R17 also includes focus: o NON-COMPLIANCE: WALKER Pursuant to resident rights, R17 prefers to NOT USE any assisted devices while ambulating around the unit. He continues to walk around the unit without a walker despite staff re-direction. Date Initiated: 03/10/2023 Interventions: o Educate the resident and family about safety precaution. Date Initiated: 03/10/2023 o Ensure that the IDT is educated regarding the resident's preference. Date Initiated: 03/10/2023 Facility provided fall incident report for R17, which documents the following: (completed by V13, LPN) Nursing Description: Prior to the incident around 8:30 PM the resident was in bed sleeping comfortably. at approximately 8:40 PM While the CNA is doing her routine rounds. CNA alerted the writer that the resident was on the floor. writer immediately attended the call and observed the resident lying in his left side position on the floor by the wall next to his bed. The bed was at its lowest position. Resident awake, oriented and verbally responsive. Resident Description: resident unable to specify the location of pain due to cognitive impairment but verbalizes " My brain hurts" Immediate Action Taken Description: Head to toe, body assessment done. The resident sustained a superficial skin tear at his elbow and scant bleeding observed. The wound site was cleansed with normal saline and pressure applied to the site, bleeding stopped.	{S9999}		

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{S9999}	Continued From page 11 Steri strips applied. resident screams in pain. scheduled pain medication was given. Neurocheck Initiated, ROM of extremities, all within residents normal limits. Resident was able to move all extremities without difficulty. Vitals signs showed as follows: BP 123/86 P 70 T 97.8 SPo2 97% via room air. 911 called, staff stayed with the resident until paramedics arrived and transported the resident to (local hospital) for evaluation and treatment. NP notified of the occurrence of fall, ADON and SN supervisor were both notified. Sister made aware of the Hospital transfer R/T a Fall incident. Injuries Observed at Time of Incident - Skin Tear, 18) Left elbow PAINAD: 10 - Breathing - Noisy Laboured Breathing, Negative Vocalization - Loud Moaning or Groaning, Facial Expression - Facial Grimacing, Body Language - Rigid, Fists Clenched ..., Consolability - Unable to console ... Fall Risk Evaluation dated 4/23/23 documents fall risk score of 18 (high risk for falls). Post fall investigation/RCA (Root Cause Analysis) Investigation form documents the following (not limited to): (completed by V12, LPN / Psychotropic Falls Coordinator) Date of Incident: 4/23/23 Time of Incident: 8:40PM Type of Incident: Unwitnessed Fall with Injury Location of Incident: Resident's room Did incident result in injury: skin tear to left elbow Environmental factors that contributed to the incident: Attempting to stand/transfer without assistance Did Resident go to the Hospital: Yes, Resident was sent out via 911 to expedite transfer. Resident claimed that he hit his head and	{S9999}		

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{S9999}	Continued From page 12	{S9999}		

complained of headache. Resident was transferred back to the facility on 4/24/23 after few hours at 430am in stable condition. All imaging test - CT scan and x ray results were negative of injury.
ROOT CAUSE ANALYSIS: (Analysis of Findings Based on the Investigation)
- Per staff interviews and clinical record review, resident is alert and oriented ×1 with poor safety awareness and impulsiveness. Resident was observed lying on the floor on 04/23/2023 @ 8:40 pm. Per staff, resident has tendency to get up from bed despite with unsteady gait and cannot transfer without assistance from staff. Resident has impaired mobility secondary to Parkinson's disease resident and slid down from his bed hitting his head by the wall. Resident did not call for assistance. He has dementia with BIMS score of 3 out of 15 which indicates severe cognitive impairment. Due to his impaired cognitive skills, resident overestimates his physical functions.

INTERVENTIONS TO ADDRESS INCIDENT (Please indicate assigned Disciplines to implement interventions):
Provided a wedge cushion or pillow for positioning, comfort, and body alignment.
Psych to review medication due to impulsive behavior.

R19 is a 54-year-old female admitted to the facility on 2/18/22 with diagnoses that include: epileptic seizures, sepsis, anxiety, neuromuscular dysfunction of bladder, Down Syndrome, and dementia.
R19's MDS (Minimum Data Assessment) dated 2/14/23 documents that R19 has a BIMS (Brief Interview for Mental Status) of 99 (indicates resident unable to complete); Section G (Functional Status) documents that R19 requires

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 13 extensive assistance with one person physical assist for transfers and is not steady, only able to stabilize with human assistance during transitions and walking. R19 uses a wheelchair. R19's current care plan includes (but not limited to) the following focus areas and interventions: o (R19) requires extensive assistance x1 - staff with ADL's bed mobility, transfers, ADL's as dressing, walking. personal hygiene, eating and toileting 2/14/23 Annual: (R19) is a LT care resident, requiring extensive assist x1 staff for transfer to a wheelchair as her primary mode of locomotion. She requires extensive x1 staff support for meals at this time. Functionally Incontinent of B&B: Assisted with toileting and hygiene. Repositioned Q2hours and as needed. Always incontinent of bladder and bowel. Date Initiated: 02/14/2023 Interventions (include): o Provide DME if needed (wheelchair, cane, walker, etc.) Date Initiated: 02/18/2022 o (R19) is high risk for falls related to Cognitive impairment secondary to Developmental delayed. Muscle weakness, Seizure disorder, history of falls and recent fall. Date Initiated: 02/21/2022 Interventions (include): o chair alarm discontinued due to resident has no attempts in getting up from her wheelchair unassisted. Will keep all the other interventions for falls. Date Initiated: 09/27/2022 - Chair alarm to alert staff when resident will attempt to get up from chair unassisted AS so staff can assist resident and prevent falls. Date Initiated: 02/21/2022	{S9999}		

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	IL6000889	A. BUILDING: _____ B. WING _____	R 05/15/2023

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{S9999}	Continued From page 14 o I would like staff to keep furniture in locked position during transfers and nursing care. Date Initiated: 02/21/2022 o I would like staff to provide me a safe environment: even floors, free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls Date Initiated: 02/21/2022 Facility provided fall report for R19 dated 5/7/23 16:00 that documents: Incident Location: Dining Room Nursing Description: During the writer Initial rounds at 3:30pm resident was observed sitting comfortably in her wheelchair inside the dining room, at approximately 4:00 PM. The resident was observed, lying on the dining room floor with the head leaning towards the wall and on top of the wheelchair lock. Alert and awake. Writer immediately attended the resident. Resident Description: Resident Unable to give Description Immediate Action Taken Description: Head to toe and skin assessment was done. No apparent injury noted. Neurocheck initiated. Resident is alert and Oriented to self. disoriented, baseline. ROM to extremities within the resident normal range. No Indication of pain/discomfort observed. VS as follows: T. 97.6 P 73 BP 119/62 SPo2 95% via room air. Ambulance called and sent the resident to (local hospital) for Evaluation and Treatment. DON and ADON were all notified. NP was notified. Sister was notified of the incident and hospital transfer ...No Injuries observed at time of incident. Fall risk evaluation dated 2/20/22 documents score of 15 (high risk for falls); updated fall risk evaluation dated 5/7/23 documents score of 18 (high risk for falls).	{S9999}		

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{S9999}	Continued From page 15 Post fall investigation/RCA (Root Cause Analysis) Investigation form documents the following (not limited to): (completed by V12, LPN / Psychotropic Falls Coordinator) Date of Incident: 5/7/23 Time of Incident: 4:00PM Type of Incident: Unwitnessed Fall without Injury Location of Incident: Dining room Did incident result in injury: No Environmental factors that contributed to the incident: Attempting to stand/transfer without assistance Did Resident go to the Hospital: Yes, Resident was sent to (local hospital) ER via 911 to expedite transfer. Resident was noted with increase weakness. Resident was admitted at (local hospital) with diagnosis of + for COVID 19. ROOT CAUSE ANALYSIS: (Analysis of Findings Based on the Investigation) Per staff interviews and clinical record review, resident was noted lying on the floor. Resident attempted to get up from her wheelchair despite with unsteady gait and balance. Resident has poor safety awareness and cognitive impairment related to dementia and Down Syndrome. In addition, resident was admitted at the hospital because she was tested + for COVID 19 and UTI. Presence of infections increase confusion, fatigue and weakness which have contributed further to this fall. INTERVENTIONS TO ADDRESS INCIDENT (Please indicate assigned Disciplines to implement interventions): PT/OT to evaluate and treat for strengthening, mobility and endurance s/p fall and recent infection. On 5/13/23 at 3:19PM V13 (LPN) was interviewed regarding R19's fall on 5/7/23. V13 stated, I was	{S9999}		

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{S9999}	Continued From page 16	{S9999}		

doing rounds at the start of my shift, and I saw her in the dining room on the corner, right next to her wheelchair by the wall (Wallenius Dining Room). There were other residents in there at this time. There was a staff in there (V16, CNA) but he was by the TV. He did not notice that she was on the floor. I asked him what happened, and he didn't know. I assessed the resident to make sure there was no injury. I asked him to get a pillow so she could lay on it. After I assessed her, we put her back on the WC. She is one or two assist. It depends on if she is having behaviours, but she is total assist. I sent her out. I didn't see any injuries, but I sent her out just in case. No other injuries but I think she was admitted for COVID. Normally, staff are in the dining room. There is usually one or two CNA's in there. Most of the times, nurses give medication by the dining area so that we can keep an eye on the resident's. Some CNAs are in the rooms attending to residents. We have to make sure there is staff in the dining room at all times. There should always be staff because they are demented patients, and you don't know what can happen.

5/13/23 at 3:41PM V16 (CNA) was interviewed and stated, I think I have worked here like seven months. I work everywhere, different units. When I got there it was around 3:30PM (regarding R19's fall on 5/7/23). This woman was on the ground, and I called the nurse. It was the end of the shift and there was no staff in the dining room when I got there and there were residents in the dining room. I think there is supposed to be two staff there. People are running off to leave at the end of their shift and I think that's what happened.

Facility provided Fall Occurrence policy (dated 5/17/22), which reads:

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{S9999}	Continued From page 17 Policy Statement It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. Procedure 1. A Fall Risk Assessment form will be completed by the nurse or the Falls Coordinator upon admission, readmission, quarterly, significant change, and annually. 2. Those identified as high risk for falls will be provided fall interventions. An interim Falls Care Plan may be started but a Falls Care Plan is necessary and required after the State required MDS was done. 3. If a resident had fallen, the resident is automatically considered as high risk for falls. Therefore, the nurse does not have to fill out the Fall Risk Assessment to determine if the resident is high risk for falls or not, after the resident had fallen. 4. An incident report will be completed by the nurse each time a resident falls. 5. The Falls Coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of fall. 6. The nurse may immediately start interventions to address falls in the unit, even prior to the Falls Coordinator's investigation. 7. Ultimately, the Falls Coordinator may change the interventions provided by the nurse if the Falls Coordinator's investigation identifies a more appropriate intervention for the individual fall. 8. The Falls Coordinator will add the intervention in the resident's care plan. 9. The incident may be written in the nurses notes or other parts of the resident's medical record that will remain accessible to any person who has the	{S9999}		

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{S9999}	Continued From page 18 right to access the resident's record. 10. The interventions will be reevaluated and revised as necessary. (B)	{S9999}		