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	146109	A. BUILDING _____ B. WING _____	C 05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	**24588 CHURCH STREET CHENOA, IL 61726**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 225 SS=E	Complaint Investigation #1662477/IL85340 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

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

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F 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report allegations of verbal and physical abuse immediately to the administrator, failed to immediately remove an alleged perpetrator from direct care, failed to investigate abuse allegations, and failed to notify the state agency for two of three residents (R1, R2) reviewed for abuse. This failure had the potential to affect all remaining residents residing on unit #1 and unit #2 (R3 through R85). Findings include: 1. R1's Nursing Notes dated 3/11/16 at 11:25 PM document, "At approximately 4:00 PM, (R1) (complained of) someone covered (R1's) face with hand and tried to kill (R1). (Z2, R1's power of attorney) came in this evening and (R1) told (Z2) . (Z2) asked who was taking care of (R1). (E19 Licensed Practical Nurse) asked (E20 Certified Nurse's Assistant) about complaint and (E20) stated (E20) didn't cover (R1's) mouth, (E20) would not do that. (Z2) was upset with (E20). (E19) spoke with (E1 Administrator) and (E2 Director of Nursing) of allegations." On 5/11/16 at 10:29 AM, E19 stated on 3/11/16 at 4:00 PM, R1 told E19 that E20 had covered R1's mouth and tried to kill R1. E19 stated E19 talked to E2 face to face on 3/11/16. E19 stated E2 then called E1. E19 stated E2 told E19 that they (E1, E2) would take care of it. E19 stated E20 was not removed from duty and worked E20's whole	F 225		

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shift. E19 stated Z2 came in later that evening (3/11/16) and was upset about what R1 was alleging. E19 stated E2 was present and took Z2 to the office to talk to Z2. E19 stated R1 makes frequent comments during cares about staff trying to "hurt her" during cares. E19 stated R1 makes the same comments over and over. E19 stated E19 felt like R1's allegation of someone "covering (R1's) mouth and tried to kill (R1)" was completely different than normal. E19 states E19 knew it needed reported because E19 has never heard R1 say anything like that before.

On 5/10/16 at 2:35 PM, E20 stated E20 remembers the day (3/11/16) that R1 accused E20 of covering R1's mouth and trying to kill R1. E20 stated E19 was aware and Z2 confronted E20 about the allegation. E20 stated E20 has never been suspended and worked the entire shift on 3/11/16.

E20's Employee Time Card report documents E20 punching into work at 1:30 PM, punching out for lunch at 8:00 PM, punching in from lunch at 8:30 PM and punching out from work at 10:00 PM on 3/11/16.

On 5/11/16 at 11:40 AM, E2 stated E2 does not remember the 3/11/16 allegation of abuse. E2 stated if the incident was reported to E2 then E20 would have been removed from the floor. E2 confirmed that E20 worked the entire shift on 3/11/16. E2 confirmed that E20 is still an employee of the facility and is currently working. E2 stated E20 works on the same unit which is unit #2 in the facility when scheduled.

On 5/11/16 at 1:25 PM, E1 stated E1 was unaware R1 alleged "E20 covered R1's mouth

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F 225	Continued From page 3	F 225		

and tried to kill R1" on 3/11/16. E1 stated if E1 was aware E20 would have been sent home immediately pending an investigation. E1 stated the allegation on 3/11/16 should have been reported immediately to the immediate supervisor and then to E1. E1 stated the 3/11/16 allegation was not investigated. E1 stated the 3/11/16 allegation was not reported to the state agency.

2. R2's Physician Order Sheet dated 5/11/16 documents that R1's diagnoses include the following : Alzheimer Disease, Anxiety State, Depressive Disorder and Dementia.

R2's Minimum Data Set dated 3/16/16 documents the following: Moderate cognitive impairment.

R2's Care Plan updated 4/22/16 documents the following: " I (R2) have long and short term memory loss...provide simple redirection when I (R2) am confused. Observe for signs of frustration and anxiety. Provide time for me to respond to each task step. Talk with (R2) in a calm manner.."

R2's "Potential for Abuse and Neglect Assessment" dated 3/8/2016 documents R2 is at high risk for abuse.

The facility's "Preliminary Investigation Re: (regarding) Alleged Verbal Abuse" dated February 17, 2016 documents the following: "The morning of 2/17/16 it was reported by (E10, Housekeeper) that (E10) heard a nurse on neighborhood one yelling at (R2) in (R2's) room. (R2) was yelling at staff that she did not want her room cleaned and swearing at staff. It was

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reported that (E8, Registered Nurse) who (E10) did not know (E8) name was yelling back at (R2). Upon initial investigation the nurse working was (E8). (E8) has been suspended (2/17/16) and is not able to work until the investigation is complete."The same report documents the following staff interviews: E24, Maintenance stated "I was working on neighborhood one, on a light, and heard (E8) yelling and using profanity..." E6, Licensed Practical Nurse stated "(E6) does not remember (E8) calling (R2) any names but (E8's) voice was loud. E4, Certified Nursing Assistant stated "I did not hear (E8) calling (R2) names. I (E4) heard (E8) counting and (E8) left the neighborhood (Unit 1) for a break." E5, Housekeeper stated " (R2) was upset and (E8) was too."

On 5/11/16 at 9:35 am E6, Licensed Practical Nurse stated "...(E8) came in at 12:00pm on 2/16/16. It was soon after that when (E8) was yelling at (R2)."

On 5/11/16 at 12:00 pm, E2, Director of Nursing stated "Staff are suppose to report to the Administrator all allegations of abuse, then report to me. No one reported the allegation that actually occurred on 2/16/16 between (E8) and (R2) until the morning of 2/17/16. It was then reported to (E1) and (E1) let me know as soon as it was reported to him. Nothing was reported on the sixteenth (2/16/16) and should have been reported immediately, as our policy states."

On 5/11/16 at 1:25 pm E1, confirmed that the abuse allegation occurred on 2/16/16, was not reported to E1 until 2/17/16, and E8 continued to work on neighborhood one (unit #1) for the rest of the 2/16/16 shift. E8's Time Sheet dated

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F 225	Continued From page 5 February 2016 documents E8 worked 2/16/16 from 12:00 pm until 10:45 pm. On 5/11/16 at 2:00 pm, E10 stated "(R2) got loud and (E8) responded loud. I think (E8) was trying to talk over (R2). I can't say I did or did not hear (E8) cussing. I was in another room. I think other staff know (R2's) behaviors so everybody was just doing their jobs and were busy. I don't know why they didn't report. I reported the next day to the (E1)Administrator and should have reported it immediately to (E1) that day (2/16/16). The Administrator reminded / re-educated me that I should have reported the incident immediately (2/16/16)." The facility's Abuse policy dated 1/6/15 documents, "Any employee who has knowledge or reason to believe that a resident has been a victim of abuse, by anyone..is under a duty to immediately report such incident or suspicion to his/her immediate supervisor and Administrator..the investigation will begin immediately..do not make the decision yourself about whether an allegation is justified or not. All allegations must be reported. If the allegation is against a (facility) staff member, then that person will be immediately placed on administrative leave pending the investigation...the Administrator and Director of Nursing or their designee will initiate an investigation immediately...the Preliminary Investigation will be faxed immediately and not to exceed within 24 hours to the (state agency)." The facility's Census sheet dated 5/9/16 documents R1, R3, and R5 through R44 reside on unit #2. The Resident Room Assignment Census sheet dated 5/9/16 documents R2, R4,	F 225		

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F 225	Continued From page 6 and R45 through R85 reside on unit #1.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to operationalize their abuse policy by failing to report allegations of verbal and physical abuse immediately to the administrator, failing to immediately remove an alleged perpetrator from direct care, failing to investigate abuse allegations, and failing to notify the state agency for two of three residents (R1, R2) reviewed for abuse. This failure had the potential to affect all remaining residents residing on unit #1 and unit #2 (R3 through R85). Findings include: The facility's Abuse policy dated 1/6/15 documents, "Any employee who has knowledge or reason to believe that a resident has been a victim of abuse, by anyone..is under a duty to immediately report such incident or suspicion to his/her immediate supervisor and Administrator..the investigation will begin immediately..do not make the decision yourself about whether an allegation is justified or not. All allegations must be reported. If the allegation is against a (facility) staff member, then that person	F 226		

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will be immediately placed on administrative leave pending the investigation...the Administrator and Director of Nursing or their designee will initiate an investigation immediately...the Preliminary Investigation will be faxed immediately and not to exceed within 24 hours to the (state agency)."

1. R1's Nursing Notes dated 3/11/16 at 11:25 PM document, "At approximately 4:00 PM, (R1) (complained of) someone covered (R1's) face with hand and tried to kill (R1).

On 5/11/16 at 10:29 AM, E19 stated on 3/11/16 at 4:00 PM, R1 told E19 (Licensed Practical Nurse) that E20 (Certified Nurse's Assistant) had covered R1's mouth and tried to kill R1. E19 stated E19 talked to E2 face to face on 3/11/16. E19 stated E2 then called E1 Administrator. E19 stated E2, Director of Nursing, told E19 that they (E1, E2) would take care of it. E19 stated E20 was not removed from duty and worked E20's whole shift.

E20's Employee Time Card report documents R20 punching into work at 1:30 PM, punching out for lunch at 8:00 PM, punching in from lunch at 8:30 PM and punching out from work at 10:00 PM.

On 5/11/16 at 11:40 AM, E2 stated E2 does not remember the 3/11/16 allegation of abuse. E2 confirmed that E20 worked the entire shift on 3/11/16. E2 stated E20 works on the same unit (Unit #2) in the facility when scheduled.

On 5/11/16 at 1:25 PM, E1 stated E1 was unaware R1 alleged "E20 covered R1's mouth and tried to kill R1" on 3/11/16. E1 stated the

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allegation on 3/11/16 should have been reported immediately to the immediate supervisor and then to E1. E1 stated the 3/11/16 allegation was not investigated. E1 stated the 3/11/16 allegation was not reported to the state agency.

2. The facility's "Preliminary Investigation Re: (regarding) Alleged Verbal Abuse" dated February 17, 2016 documents the following: "The morning of 2/17/16 (alleged verbal abuse occurred on 2/16/16) it was reported by (E10, Housekeeper) that (E10) heard a nurse on neighborhood one yelling at (R2) in (R2's) room. (R2) was yelling at staff that she did not want her room cleaned and swearing at staff. It was reported that (E8, Registered Nurse) who (E10) did not know (E8) name was yelling back at (R2). Upon initial investigation the nurse working was (E8).

On 5/11/16 at 9:35 am E6, Licensed Practical Nurse stated "...(E8) came in at 12:00pm on 2/16/16. It was soon after that when (E8) was yelling at (R2)."

On 5/11/16 at 12:00 pm, E2, Director of Nursing stated "Staff are suppose to report to the Administrator all allegations of abuse, then report to me. No one reported the allegation that actually occurred on 2/16/16 between (E8) and (R2) until the morning of 2/17/16. It was then reported to (E1 Administrator) and (E1) let me know as soon as it was reported to him. Nothing was reported on the sixteenth (2/16/16) and should have been reported immediately, as our policy states."

On 5/11/16 at 1:25 pm E1, confirmed that the abuse allegation occurred on 2/16/16, was not reported to E1 until 2/17/16, and E8 continued to

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F 226	Continued From page 9 work on neighborhood one (Unit #1) for the rest of the 2/16/16 shift. E8's Time Sheet dated February 2016 documents that E8 worked on 2/16/16 from 12:00 pm until 10:45 pm. On 5/11/16 at 2:00 pm, E10 stated "(R2) got loud and (E8) responded loud. I think (E8) was trying to talk over (R2). I can't say I did or did not hear (E8) cussing. I was in another room. I think other staff know (R2's) behaviors so everybody was just doing their jobs and were busy. I don't know why they didn't report. I reported the next day to the (E1)Administrator and should have reported it immediately to (E1) that day (2/16/16). The Administrator reminded / re-educated me that I should have reported the incident immediately (2/16/16)." The facility's "Resident Room Assignments" dated 5/9/16 documents R1, R3, and R5 through R44 reside on unit #2. The same room assignment sheet documents R2, R4, and R45 through R85 reside on unit #1.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		

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Based on observation, interview, and record review the facility failed to manage pain during cares for one of three residents (R1) reviewed for incontinence care in the sample of three.

Findings include:

R1's Pain care plan dated 5/9/16 documents, R1 will occasionally complain of generalized discomfort. R1's goal is to be free of pain 30 minutes after receiving pain medication in the next 90 days. R1's pain intervention directs staff to assess R1 for signs and symptoms of pain. Provide R1 with pain medication as ordered. If R1's medication is no longer effective notify the doctor.

R1's Medication Administration Record (MAR) dated May/2016 documents a 6/20/15 order for APAP 325 mg, two tablets four times a day at 5:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM. R1 has an order to rate R1's pain at 7:00 AM and 4:00 PM.

On 5/10/16 at 10:00 AM, E22 Certified Nurse's Assistant (CNA) and E17 CNA assisted R1 to the toilet with a sit to stand mechanical lift. E17 began to apply the sit to stand belt around R1 and R1 began to say, "make sure it's on right, it hurts me, it hurts me." When R1 was being raised with the lift R1 began to yell, " it hurts, it hurts, please hurry it hurts." After R1 was lowered to the toilet R1 had no more complaints of pain.

On 5/11/16 at 12:05 PM, E14 CNA and E16 CNA transfer R1 from the wheelchair to R1's bed with a full mechanical lift. When R1 was being raised and lowered from the wheelchair to the bed R1 was yelling, "hurry up, I hurt, I hurt, I hurt, ow, ow,

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ow...hurry up." E14 and E16 then began to provide incontinence care to R1. When R1 was rolled from side to side to remove and apply a new incontinence brief R1 was yelling, "you are hurting me, ow, ow, ow, you are hurting my legs, ow, ow, ow." R1 then began to hit E14 yelling, "my legs are killing me...I am so miserable." E14 and E16 pulled up R1's pants and R1 yelled, "I am going to die." After pulling up R1's pants E14 and E16 then used the mechanical lift to move R1 from R1's bed to R1's recliner. During this transfer, R1 yelled, "Ow, ow, ow, it hurts, it hurts, it hurts."

On 5/11/16 at 10:05 AM, E17 stated R1 always yells during cares. R1 will yell, "please don't hurt me" E17 feels that R1 has pain during cares. E17 stated E17 does not know what R1's care plan says in regards to R1 yelling during cares.

On 5/11/16 at 9:30 AM, E14 stated E14 got R1 up this morning for cares. E14 stated R1 was screaming at E14, "you're hurting me, don't pull my arms off." E14 stated E14 thinks the mechanical lifts hurt R1. E14 stated, "I try to make it as fast and painless as possible." E14 stated E14 does not know what to do when R1 acts like that, does not know what R1's care plan says. E14 stated E14 has never been given specific training regarding R1's reactions during cares.

On 5/11/16 at 9:40 AM, E16 stated during cares R1 says cares are painful, will yell during cares that cares hurt. E16 stated E16 is not sure what R1's care plan says regarding R1's reactions to cares.

On 5/11/16 at 12:30 PM, R1 stated, "I hurt all

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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) COMPLETION DATE
F 309	Continued From page 12 over. Those machines hurt me when they lift me. It hurts so bad." On 5/11/16 at 12:40 AM E2 stated, R1's pain assessment should be scheduled at 5:30 AM, 11:30 AM, 4:30 PM, and 8:30 PM instead of 7:00 AM and 4:00 PM. E2 (Director of Nursing)stated the facility is probably not capturing R1's pain. E2 stated E2 has watched R1 transfer and R1 will "holler continuously" during transfers. E2 stated on R1's previous admission, which was couple years ago "we" tried a Fentanyl patch but R1 had a reaction to it. E2 stated R1 will yell and scream every single time R1 is transferred and provided with incontinence cares. E2 stated they have not tried to call the doctor to change R1's pain medications because of R1's age. E2 stated "we" could add more to R1's care plan to elaborate what to do for R1 when R1 is yelling and screaming. The facility's Pain Assessment policy dated 9/14/15 documents, "If the resident displays behaviors which could possibly indicate pain or discomfort, consult with Physician...for residents on scheduled pain medications, document effectiveness routinely and notify MD..if/when change in medication regimen is needed."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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	146109	A. BUILDING _____ B. WING _____	C 05/11/2016

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F 312	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide incontinence care as directed by the plan of care for one of three residents (R1) reviewed for incontinence care in the sample of three. Findings include: R1's Urinary Incontinence Toileting Care Plan dated 5-9-15, documents: R1's goal is to have no complications due to incontinence in the next 90 days. R1 is to be assisted to the toilet before and after meals, activities, upon rising in the morning, and before bed. On 5-10-16 at 9:30 a.m., R1 was wheeling herself down the hallway stating, "I got to go to the bathroom. No one wants to help me. " At this time R1's pants were noticeably wet and bulging and R1 smelled of urine. On 5-10-16 at 9:30 a.m., R1 turned on the call light and stated, "They won't help me because I take too long. I need to go. I am going in my pants." On 5-10-16 at 10:00 AM, E17 Certified Nursing Assistant (CNA) and E22 CNA transferred R1 out of the wheelchair using a mechanical sit to stand lift. At that time, a puddle of urine was noted on R1's wheelchair. R1's wet pants were removed and R1's incontinence brief was saturated with urine. On 5-10-16 at 10:00 AM, E12 (CNA), E15 (CNA), E17, E22, and E23 (CNAs) all verified that they were taking care of R1 on 5-10-16 from 6:00 AM to 10:00 AM, and had not provided R1 with incontinence care or toileting since 6:00 AM, and not after breakfast as directed by R1's plan of care. On 5-11-16 at 2:45 PM, E2 (Director of Nursing) stated, "It is not acceptable if she requested to	F 312		

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F 312	Continued From page 14 go (to the restroom). The Certified Nursing Assistants should follow the incontinence care plan. " The facility's Bowel and Bladder Re-Training policy dated 2-5-16 documents, " Based on the resident's comprehensive assessment, the facility will ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible."	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to identify the root cause and implement post falls targeted interventions for two of three residents (R1, R2) reviewed for falls in the sample of three. Findings include: 1. R1's Nurse's Notes dated 11/2/15 at 10:16 AM documents, "(R1) fell this AM in the restroom. CNA (Certified Nurse's Assistant) was transferring (R1) and (R1's) knees gave out causing (R1) to collapse to the floor.."	F 323		

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F 323	Continued From page 15	F 323		

R1's Incident report dated 11/2/15 documents R1 fell during a transfer. The incident report does not document post fall related interventions.

R1's Fall care plan dated 5/9/16 does not include an intervention related to R1's 11/2/15 fall.

On 5/11/16 at 11:40 AM, E2 Director of Nursing stated, R1's 11/2/15 incident report does not include an intervention for R1's fall. E2 stated fall related interventions were not put into place on R1's care plan. E2 stated the only interventions that have been added to R1's fall care plan since R1's admission (4/2/13) was last night (5/10/16) after R1 fell.

R1's nursing notes dated 5/10/16 at 8:00 PM documents R1 let go of sit to stand lift causing R1 to fall to the floor. R1 changed from a sit to stand lift to a full mechanical lift.

On 5/11/16 at 9:30 AM, E14 Certified Nurse's Assistant stated E14 got R1 up at 6:30 AM this morning. E14 stated E14 used the sit to stand lift. E14 stated E14 transferred R1 from the recliner to the wheel chair. E14 stated E14 found out later after R1's transfer at 6:30 AM that R1's transfer status was changed last night from the sit to stand lift to a full mechanical lift.

On 5/11/16 at 11:40 AM, E2 stated R1 had a fall yesterday (5/10/16) from the sit to stand lift. R1 fell because R1 let go of the sit to stand. R1 was changed from the sit to stand lift to a full mechanical lift last night. The staff were educated last night to use the full mechanical lift. E2 stated E14 should have transferred R1 with the full mechanical lift this morning. E2 stated

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F 323	Continued From page 16 E14 should not have used the sit to stand lift. 2. R2's Physician Order Sheet dated 5/11/16 document that R1's diagnoses include the following : Alzheimer Disease, Anxiety State, Depressive Disorder and Dementia. R2's Minimum Data Set dated 3/16/16 documents the following: Moderate cognitive impairment, extensive two person staff assistance with ambulation / transfers and a history of falls. R2's Fall Risk Assessment dated 4/22/16 documents that R2 is a high risk for falls. Incident Reports dated 3/17/16 at 11:50 am, 3/17/16 at 5:35 pm and 3/21/16 at 4:30 pm document R2 had fallen. R2's incident reports 3/17/16 at 11:50 am documents "(R2) was found on the floor in (R2's) room." R2's incident report 3/17/16 at 5:35 documents "(R2) lost her balance and hit (R2's) head on a chair." R2's incident report dated 3/21/16 at 4:30 pm documents that "(R2) got up from sitting on (R2's) walker and fell, hitting R2's head." These same incident reports show no documentation completed to identify the root cause or targeted prevention interventions for these falls. R2's Care Plan updated 4/22/16 documents the following history of falls: 2/23/16, 2/26/16, 2/29/16, 3/1/16, 3/10/16, 3/25/16 and 4/22/16. The two falls on 3/17/16 and one fall 3/21/16 were not documented on the care plan. There was no documentation completed to indicate targeted, prevention interventions were implemented or that the root cause of the falls that occurred on 3/17/16 and 3/21/16 were	F 323		

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F 323	Continued From page 17 identified. On 5/11/16 at 12:00 pm, E2, Director of Nursing stated "I am not seeing an intervention on the care plan for 3/17/16, either of those falls, and no intervention on 3/21/16. There is no identified root cause so no interventions were implemented....There should have been root causes and interventions for all three of these falls..." The facility policy "Fall Prevention and Management" dated 6/5/2015 documents the following: "The Fall Prevention and Management Program emphasizes fall prevention and management, through identification of resident's risk factors for falls and assists with development of interventions to reduce the incidents of falls....Assessment and Care Plan Following a Fall: Care Plan revisions - interventions to reduce future occurrences...Complete an Incident Report...A Summary of Incident Follow - up will be completed by the Administrator or designee and determination of what may have caused or contributed to the fall..."	F 323		