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	555737	A. BUILDING _____ B. WING _____	C 03/14/2023

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SERENTO CASA	1740 S SAN DIMAS AVE SAN DIMAS, CA 91773

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health (CDPH) during the investigation of one complaint and one Facility Reported Incident (FRI). Complaint: CA00821560 FRI: CA00824671 Representing the Department: HFEN 41511 The inspection was limited to the one complaint and one FRI investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were written as a result of complaint CA00821560 and entity reported incident CA00824671.	F 000	Disclaimer: The following plan of correction is completed in accordance with State and Federals laws. It is not an admission to the alleged findings shown in the statement of deficiencies.	
F 656 SS=H	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656	The resident who 's requirement was not met per review of clinical record during this investigation is no longer an active resident. The facility initiated a QAPI on 3/23/23 regarding completion of resident -centered comprehensive care plan with participation of the medical director, Don, DSD, MDS and medical records director. Medical records/ designee reviewed and audited all active residents on 3/23/23 for completion of comprehensive plan of care. No other residents were found with incomplete nor not updated comprehensive plan of care.	3/30/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/30/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Revised: Administrator 4/10/23

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F 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a resident-centered comprehensive care plan to prevent a fall for one of two sampled residents (Resident 1), who had blindness on both eyes (visual impairment/unable to see) and a history of falls by failing to: Ensure the Interdisciplinary Team (IDT, a team of health care professionals who work together to	F 656	All IDT members and nursing staff were inserviced by DSD and DON on 03/23, 3/24, & 3/30 timely initiating, formulating and completion of resident-centered plan of care per policy and procedure. Audits will be conducted 5 x a week starting 3/24/23 by medical records director /designee and will be discussed in stand-up meeting under 3n of the DON and Administrator. On 3/24/23, MDS/Designee provide a calendar to the DIT members, DON, Administrator and medical records for a scheduled review of resident centered comprehensive plan of care. Timely completion of resident on 3/24/23 resident centered comprehensive care plan will be reported 5 x a week in stand up meeting and to the monthly QA committee. Record of audit completion will be provided to the DON and Administrator weekly. the DON and Administrator weekly.The facility initiated a QAPI on 3/22/23 regarding IDT meetings on falls with participation of the medical director, Don, DSD, MDS, DOR and medical records director. Medical records director/designee has completed an audit on 03/23/2023 on all active residents with falls Audits were reviewed and submitted to the DON and Administrator; no other active residents were found to be deficient by this practice. Medical records director/ designee has reviewed all residents with recent falls for completion of IDT meeting and updated plan of care by 03/27/2023 All IDT meetings for post falls will be completed and discussed in stand-up meeting for review and revision of plan of care if indicated. Record of such meetings will reflect in each resident's clinical record. All IDT members and nursing staff were inserviced by DSD and DON on 03/23/2023, Regarding: Falls, managing fall risks, IDT meetings for falls and timely completion and revision of resident-centered plan of care per policy and procedure to address changes needed to meet resident's needs	

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F 656	Continued From page 2 establish plans of care for the residents) met and updated Resident 1's Fall Care Plan as indicated in the facility's policy and procedure, titled "Falls - Assessing Falls and Their Causes," after Resident 1 fell on 12/26/2023, 1/6/2023, and 1/13/2023. As a result, Resident 1 sustained multiple falls (12/26/2023, 1/6/2023, 1/13/2023, and 1/15/2023,) in the facility and was hospitalized due to injuries sustained from the falls. On 1/15/2023, the facility transferred Resident 1 to General Acute Care Hospital (GACH) 1's Emergency Department (ED) due to head trauma (damage to the scalp, skull, or brain caused by injury) and cephalohematoma (an accumulation of blood under the scalp) Cross reference F689 Findings: A review of Resident 1's Admission Record (face sheet) indicated the facility admitted Resident 1 on 12/21/2022 with diagnoses that included unsteadiness on feet, muscle weakness, blindness on both eyes, and a history of falling at home. A review of Resident 1's Physician Progress Notes, dated 12/22/2022, at 9:01 PM, indicated Resident 1 had a fall with head injury from the previous admission (10/25/2022). The note indicated Resident 1 lost 80 percent of her eyesight. A review of Resident 1's Falls Care Plan, initiated on 12/22/2022, indicated Resident 1 was at high risk for falls related to unsteady (unable to	F 656	All incidents of falls and completed IDT meetings will be reported and discussed in the monthly QA committee and QAPI members for review and evaluation.	

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F 656	Continued From page 3	F 656		

stabilize without staff assistance) gait (walk), decreased mobility (ability to move), and activity intolerance. The goal was for Resident 1 to not sustain serious injury. The nursing interventions included to anticipate Resident 1's needs and provide prompt response to all requests for assistance, provide appropriate footwear when walking, ensure the call light was within reach and encouragement for Resident 1 to use it.

A review of Resident 1's Care Conference (IDT meeting note), dated 12/23/2022, indicated Resident 1 had unsteady gait and remained a fall risk due to visual impairment. There was no indication that the IDT discussed falls and interventions to prevent falls due to unsteady gait and visual impairment.

A review of Resident 1's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 12/27/2022, indicated Resident 1 had severe impaired cognition (ability to think and process information). The MDS indicated Resident 1 had impaired vision. Resident 1 required extensive physical assistance during toilet use and limited physical assistance from one person when walking in the room. The MDS indicated Resident 1 was not steady when moving from seated to standing position and when walking with a walker.

A review of Resident 1's Morse Fall Risk Assessments (MRS, the Morse Fall Scale is a rapid and simple method of assessing a patient's likelihood of falling), dated 12/26/2022, indicated the Resident 1 was at high risk for falls due to a history of falling, use of walker, weakness when walking, and overestimating or forgets her limits. Resident 1 scored 80 points (a score of 45 or

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F 656	Continued From page 4 higher means high risk for falls). A review of Resident 1's Progress Note - Change in Condition, dated 12/26/2022, timed at 4:15 PM, indicated Resident 1 experienced an unwitnessed fall and was found sitting on the floor next to the resident's walker. The note indicated Resident 1 required frequent visual monitoring due to periods of confusion and forgetfulness. Resident 1 required encouragement to use the call light, and prompt anticipation to attend to the resident's needs. A review of Resident 1's Situation Background Assessment and Recommendation (SBAR, communication record between members of the health care team) Communication Form, dated 1/6/2023, untimed, indicated Resident 1 sustained a fall. The form indicated Resident 1 had activity intolerance but overestimated her own limits. Resident 1 did not use the walker and used furniture to hold on while walking. Resident 1 was unable to walk more steps to the bathroom and decided to sit down slowly on the floor. Resident 1 complained of lower back pain (not rated). The form indicated Resident 1 required more assistance (not indicted type of assistance) with activities of daily living (ADL, activities related to personal care such dressing, eating and personal hygiene). A review of Resident 1's Actual Fall Care Plan, initiated on 1/6/23, indicated Resident 1 had an actual fall related to an unsteady gait, poor balance, and activity intolerance. The goal was for Resident 1 to resume usual activities. Nursing interventions included to monitor Resident 1 for changes in mental status and to determine and address causative factor of the fall.	F 656		

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F 656	Continued From page 5 A review of Resident 1's SBAR Communication Form, dated 1/13/2023, timed at 12:03 AM, indicated Resident 1 was found lying on the floor, on her right side, next to the resident's bed and walker. Resident 1 reported that she slid off her bed and lost balance when trying to get up to go to the bathroom. Resident 1 complained of body pain (unrated). Licensed Vocational Nurse 2 (LVN 2) notified Resident 1's Physician (MD 1, Doctor of Medicine), MD 1 ordered STAT (rush/immediate) X-rays (image study of the bones and soft tissue) of the right shoulder and hip to rule out fractures (breaking). The X-ray results were negative for fractures. A review of Resident 1's SBAR Communication Form, dated 1/15/2023, timed at 11:44 PM, indicated Resident 1 was found sitting on the floor with bleeding on the left ring finger, hematoma (a collection of blood outside of the vessels, a bad bruise) on the back of the head, and bruising on both buttocks. Resident 1 was sent out to the hospital via ambulance (911, phone number to call for emergency services). A review of Resident 1's GACH 1's Emergency Documentation, dated 1/16/2023, timed at 12:22 AM, indicated Resident 1 was admitted from the facility after sustaining a fall with a cephalhematoma to the left occiput (back of the head or skull). Resident 1 stated, she was walking with her walker and had a fall. The documentation indicated Resident 1 had several falls in the past, was on blood thinner medication, and had an obvious head injury. The Computed Tomography (CT, medical imaging used to obtain detailed internal images of the body) result was negative for a brain bleed. The diagnoses	F 656		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 656	Continued From page 6 included head injury and cephalohematoma. A review of Resident 1's Nurse Progress Notes, dated 1/16/2023, at 10:02 AM, indicated Resident 1 returned to the facility from GACH 1 after sustaining a fall. The note indicated Resident 1 was stable with diagnosis of cephalohematoma on the left parietal (forming part of the top and side of the head) area. The note indicated Resident 1's skin was intact, had multiple bruises on the lower back, and multiple discolorations on both legs. A review of Resident 1's Admission Discharge Census List, dated 2/6/2023, indicated Resident 1 was discharged from the facility at 8:40 PM. During an interview on 2/8/2022, at 8:50 AM, the Director of Nursing (DON) stated the IDT did not meet after Resident 1's falls due to staff focused on direct resident care (hands on, face-to-face contact with residents for the purpose of diagnosis, treatment, and monitoring). The DON stated the fall care plan had to be updated after each fall and stated care plans were a guide for nurses (in general) to follow. The DON stated care plans had to be specific, detailed, and not be generalized due to every resident being unique. During a concurrent interview on 2/8/2023, at 9:06 AM, with the DON and a review of Resident 1's Fall Care Plans, dated 12/22/2022, 1/6/2023, and the IDT meeting note, dated 12/23/2022, the DON stated Resident 1 was admitted to the facility with a history of multiple falls and was legally blind (20/200 visual acuity, a person can see at 20 feet, what a person with 20/20 vision sees at 200 feet). The DON stated Resident 1's Fall Care Plan and IDT note did not include	F 656		

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F 656	Continued From page 7	F 656		

interventions to prevent recurrent falls. The DON stated the IDT did not meet after Resident 1 fell on 12/26/2023, 1/6/2023, and 1/13/2023. The DON stated the IDT had to meet after every fall to discuss and find the root cause of the falls. The DON stated if the IDT met and addressed the falls, future falls could have been prevented for Resident 1. The DON stated Resident 1's Actual Fall Care Plan, created on 1/6/2023, did not include person-centered interventions to address the root cause of the fall.

A review of the facility's policy and procedure, titled, "Care Planning - Interdisciplinary Team," revised 3/2022, indicated the IDT is responsible for the development of resident care plans. Comprehensive, person-centered care plans are based on resident assessments and developed by the IDT.

A review of the facility's policy and procedure, titled, "Care Plan, Comprehensive Person-Centered," revised 3/2022, indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The policy indicated assessments of residents are ongoing and care plans are revised as information about the resident's condition changes. The IDT reviews and updates the care plan when there has been a significant change in the resident's condition.

A review of the facility's policy and procedure, titled, "Falls - Managing Fall Risk," dated 10/1/2022, indicated fall risk factors included: cognitive impairment, lower extremity (legs) weakness, and visual deficits.

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F 656	Continued From page 8 A review of the facility's policy and procedure, titled, "Falls - Assessing Falls and Their Causes," dated 10/01/2022, indicated the purpose of the policy was to provide guidelines for assessing a resident after a fall and to assist the staff in identifying causes of the falls.	F 656		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services to prevent avoidable accidents for two of two sampled residents (Resident 1 and Resident 2), who were assessed at high risk for falls. This deficient practice resulted in Residents 1 and 2 sustained multiples falls and had the potential for Resident 1 and 2 to sustain serious injury and harm. Cross Reference: F656 Findings: a. A review of Resident 1's Admission Record (face sheet) indicated the facility admitted Resident 1 on 12/21/2022 with diagnoses that	F 689	A. Resident 1 was assessed by a license nurse on 2/26/23 and showed no signs and symptoms of change in condition. IDT review was done on 2/15/23 and discussed risks with responsible party. Resident 1 expired 2/26/23. Resident 2 was assisted by the license nurse immediately on 2/7/23 to ensure call light was within reach. Resident 2 was also assessed by a license nurse on 2/7/23 with no signs and symptoms of change in condition. Resident was referred to RNA on 3/13/22 for strengthening exercises both upper and lower extremities. Fall Risk Assessment was done on 3/24/23. IDT Care Conference was done on 3/24/23 and Care Plan was updated. B. Starting 3/24/23, care Plans updated for residents with recent fall incident. All residents high risk for fall were audited by Medical Records starting on 3/23/23 and completed 4/7/23 to ensure IDT reviews were done. There were no other residents found to have similar findings. DSD made rounds on 2/7/23 to ensure that all call lights were within reach and no other residents were found to have similar findings. DSD provided an in-service to Nursing staff and IDT regarding Fall Risk Protocol on 3/2/23,3/7/23,3/22/23,3/24/23.	04/07/23

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F 689	Continued From page 9 included unsteadiness on feet, muscle weakness, blindness on both eyes, and a history of falling at home. A review of Resident 1's Falls Care Plan, initiated on 12/22/2022, indicated Resident 1 was at high risk for falls related to unsteady (unable to stabilize without staff assistance) gait (walk), decreased mobility (ability to move), and activity intolerance. The goal was for Resident 1 to not sustain serious injury. The nursing interventions included to anticipate Resident 1's needs and provide prompt response to all requests for assistance, provide appropriate footwear when walking, ensure the call light was within reach and encouragement for Resident 1 to use it. A review of Resident 1's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 12/27/2022, indicated Resident 1 had severe impaired cognition (ability to think and process information). The MDS indicated Resident 1 had impaired vision. Resident 1 required extensive physical assistance during toilet use and limited physical assistance from one person when walking in the room. The MDS indicated Resident 1 was not steady when moving from seated to standing position and when walking with a walker. A review of Resident 1's Fall Risk Assessments, dated 12/26/2022, indicated the Resident 1 was at high risk for falls due to a history of falling, use of walker, weakness when walking, and overestimating or forgets her limits. Resident 1 scored 80 points (a score of 45 or higher means high risk for falls). A review of Resident 1's Progress Note - Change	F 689	C. On 3/2/23, The Fall Risk Protocol is now made available at the nurses station for reference. On 3/2/23, A list of residents High Risk for Fall are also made available at the nurses station and updated weekly by the IDT as needed. Charge Nurses are initiating huddles q shift with the CNAs and ensuring to remind them of the the updated list of high risk residents are at the nurses stations to alert staff and remind them of Fall Protocol in place. IDT scheduled Fall review weekly with Medical Records auditing completion of IDT review, Residents High Risk for Fall List update, and Care Plan update as needed weekly and report findings to the DON for further actions as needed. Fall Protocol in-service was done by DSD on 3/2/23 and 3/7/23, 3/22/23 and 3/24/23 for nursing staff and IDT members. Inservice provided to IDT and staff on free of accidents and hazards on 3/23/23, 3/24,23 and 3/30/23. D. Starting 3/24/23, Medical Records audits admissions and Change of Condition for any need for IDT and Care Plan updates weekly and as necessary. IDT will review all incidents Monday to Friday which includes fall episodes and update resident's Care Plan as needed. Starting 3/24/23, DSD/designee will monitor fall protocol compliance weekly and report any negative findings to the DON and/or IDT for review and analysis. DON will analyze progress of the Performance Improvement Plan weekly x 4 weeks, then monthly thereafter and report findings to the QA Committee monthly or as scheduled.	

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F 689	Continued From page 10 in Condition (COC), dated 12/26/2022, timed at 4:15 PM, indicated Resident 1 experienced an unwitnessed fall and was found sitting on the floor next to the resident's walker. A review of Resident 1's Situation Background Assessment and Recommendation (SBAR, communication record between members of the health care team) Communication Form, dated 1/6/2023, untimed, indicated Resident 1 sustained a fall. The form indicated Resident 1 did not use the walker and used furniture to hold on while walking Resident 1 was unable to walk more steps to the bathroom and decided to sit down slowly on the floor. Resident 1 complained of lower back pain (not rated). A review of Resident 1's SBAR Communication Form, dated 1/13/2023, timed at 12:03 AM, indicated Resident 1 was found lying on the floor, on her right side, next to the resident's bed and walker. Resident 1 reported that she slid off her bed and lost balance when trying to get up to go to the bathroom. Resident 1 complained of body pain (unrated). A review of Resident 1's SBAR Communication Form, dated 1/15/2023, timed at 11:44 PM, indicated Resident 1 was found sitting on the floor with bleeding on the left ring finger, hematoma (a collection of blood outside of the vessels, a bad bruise) on the back of the head, and bruising on both buttocks. A review of Resident 1's GACH 1's Emergency Documentation, dated 1/16/2023, timed at 12:22 AM, indicated Resident 1 was admitted from the facility after sustaining a fall with a cephalhematoma to the left occiput (back of the	F 689		

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	555737	A. BUILDING _____ B. WING _____	C 03/14/2023

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F 689	Continued From page 11	F 689		

head or skull). Resident 1 stated, she was walking with her walker and had a fall. The documentation indicated Resident 1 had several falls in the past, was on blood thinner medication, and had an obvious head injury. The Computed Tomography (CT, medical imaging used to obtain detailed internal images of the body) result was negative for a brain bleed.
A review of Resident 1's Nurse Progress Notes, dated 1/16/2023, at 10:02 AM, indicated Resident 1 returned to the facility from GACH 1 after sustaining a fall. The note indicated Resident 1 was stable with diagnosis of cephalohematoma on the left occiput, multiple bruises on the lower back, and multiple discolorations on both legs.

A review of Resident 1's nurses notes dated 1/18/2023 at 11:23 AM, indicated Resident 1 had a fall on 1/17/23, before lunch.

A review of Resident 1's COC dated 1/31/2023 at 2:15 AM, indicated a Certified Nurse Assistant (CNA, unidentified) found Resident 1 on the floor. The note indicated Resident 1 was getting up to go to the bathroom and fell. Resident 1 denied any pain.

A review of Resident 1's Physician Progress Note, dated 2/1/2023 at 8:41 PM, indicated Resident 1 had recent fall with worsening facial bruises. The note indicated the physician sent the resident to the GACH.

A review of Resident 1's nurses note, dated 2/2/2023 at 12:15 AM, indicated the resident returned to the facility, and Resident 1's CT scan of the head was negative.

A review of Resident 1's Admission Discharge

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F 689	Continued From page 12 Census List, dated 2/6/2023, indicated Resident 1 was discharged from the facility at 8:40 PM. During a concurrent interview on 2/8/2023, at 9:06 AM, with the Director of Nursing (DON) and a review of Resident 1's Fall Care Plans, dated 12/22/2022, 1/6/2023, and the IDT meeting note, dated 12/23/2022, the DON stated Resident 1 was admitted to the facility with a history of multiple falls and was legally blind (20/200 visual acuity, a person can see at 20 feet, what a person with 20/20 vision sees at 200 feet). The DON stated Resident 1's Fall Care Plan and IDT note did not include interventions to prevent recurrent falls. The DON stated the IDT did not meet after Resident 1 fell on 12/26/2023, 1/6/2023, and 1/13/2023. The DON stated the IDT had to meet after every fall to discuss and find the root cause of the falls. The DON stated if the IDT met and addressed the falls, future falls could have been prevented for Resident 1. The DON stated Resident 1's Actual Fall Care Plan, created on 1/6/2023, did not include person-centered interventions to address the root cause of the fall. b. A review of Resident 2's admission record indicated the facility admitted Resident on 12/22/2022 with diagnoses that included nontraumatic subdural hematoma (bruise on the brain), injury of the head, and seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain). A review of Resident 2's MDS dated 12/28/2022, indicated the Resident had had cognitive impairment. The MDS indicated the resident required extensive assistance with bed mobility	F 689		

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F 689	Continued From page 13 and transfers. A review of Resident 2's Fall Risk Assessment, dated 12/23/2022, indicated the resident was at high risk for falls. A review of Resident 2's Fall Care Plan, dated 12/23/2022, indicated nursing interventions were to address the risk for falls included call light within reach, appropriate footwear, and provide visual prompts when the resident asks for help. A review of Resident 2's COC, dated 12/24/2023 at 4:32 AM indicated a CNA (unidentified) found Resident 2 on floor. Resident 2 had a small skin tear on the right knee and 1 inch skin tear on the back. Resident denied any pain. A review of Resident 2's Nurses Progress Note, dated 12/29/2022 at 2:10 PM, indicated Resident 2 was found lying on the floor mats. Resident 2 denied any pain and had no injury. A review of Resident 2's Incident Note, dated 1/13/2023 at 6:02 PM, indicated e mattress in kneeling position with both hands-on top of the mattress. The note indicated Resident 2 was looking for his wallet A review of Resident 2's Nurses Progress Note, dated 1/28/2023, at 12:15 PM, indicated Resident 2 was crawling on floor mat toward the bathroom. Patient stated he needed to go to the bathroom. During an observation and concurrent interview with Licensed Vocational Nurse 1 (LVN 1), on 2/7/2023 at 10:10 AM, Resident 2 was in bed with the call light on the floor behind the head of the neighboring bed. The resident stated he was not	F 689		

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F 689	Continued From page 14 able to reach the "buzzer". The resident verbalized having to use the bathroom and stated he could just get up and go on his own since the bathroom was "only 10 feet away." LVN 1 stated resident 2 was impulsive and would get out of bed without asking. LVN 1 acknowledged the resident could not call for help to the restroom if the call light was not within reach. LVN 1 stated the call light needed to be accessible to prevent Resident 2 from getting up alone. A review of the facility's policy and procedure, titled, "Falls - Managing Fall Risk," dated 10/1/2022, indicated fall risk factors included: cognitive impairment, lower extremity (legs) weakness, and visual deficits. A review of the facility's policy and procedure, titled, "Falls - Assessing Falls and Their Causes," dated 10/01/2022, indicated the purpose of the policy was to provide guidelines for assessing a resident after a fall and to assist the staff in identifying causes of the falls.	F 689		