POC accepted
H3BW 38551
10/9/19

PRINTED: 09/27/2019
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555306	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEI-AI SOUTH BAY HEALTHCARE CENTER	15115 S VERMONT AVE GARDENA, CA 90247

(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 The following reflects the findings of the Department of Public Health of a Complaint investigation during an Abbreviated Survey. Complaint number: CA00648151 Representing the Department of Health: Health Facilities Evaluator Nurse: 38551 This inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. There were two deficiencies issued for Complaint number CA00648151	F 000	F689 Free of Accidents Hazards/Supervision/Devices 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice A comprehensive assessment of Resident 1 was conducted when he returned to the facility on July 30, 2019. His care plans were updated on July 30, 2019 to reflect his current risk factors for fall and interventions were developed to address specific risk factors. Similarly, physician's orders were reviewed on July 30, 2019 for the devices or alarms that were to be utilized for Resident 1.	10/27/19
F 689 SS=G	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 follow physician orders, a resident's care plans for use of assistive devices such as bed and wheelchair alarms and floor mats and provide the necessary supervision for one of three sampled residents who had a high risk for falls with injuries (Resident 1). Resident 1 had a history of falls and required	F 689	Resident 1's care plan interventions for fall and injury prevention are communicated with the staff during change-of-shift huddles daily to ensure that interventions are followed through. CNA 1 was provided a one-on-one in-service by the Assistant Director of Nursing (ADON) on July 23/2019 regarding fall prevention and management, specifically about communicating and coordinating with the supervising licensed nurse and assigned CNA whenever helping out with a resident who is not assigned to him.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 9/27/19

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.

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F 689	Continued From page 1 close staff supervision with use of alarms to prevent falls, was not supervised and alarms were not used as prescribed by the physician. This deficient practice resulted in Resident 1 falling three times within seven (7) days. Resident 1 sustained injuries from the falls on 7/22/19 and 7/29/19, and was transferred to a general acute care hospital (GACH) for evaluation and treatment. This deficient practice had the potential to result in further falls and injuries to Resident 1 and other residents with high risk for falls. Findings: A review of Resident 1's Admission Face sheet indicated Resident 1was admitted to the facility on 12/13/18 with a most recent admission on 4/18/19. Resident 1's diagnoses included traumatic brain injury (a disruption in the normal function of the brain caused by a bump or blow to the head), history of falling, generalized muscle weakness, left hemiplegia (paralysis [inability to move] one side of the body) and hemiparesis (weakness of the muscles of the lower face, arm, and leg on the left side of the body), seizure (a sudden, uncontrolled electrical disturbance in the brain that can cause changes in behavior, movements or feelings, and in levels of consciousness) and dementia (decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities). A review of a "Morse Fall Risk Screen," (a fall risk	F 689	2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken The Assistant Director of Nursing (ADON) will review incidents and accidents that occurred within the months of July 2019 to the present month to identify any other residents who may have been affected by the same deficient practice. The review will focus on ensuring that a comprehensive assessment was conducted to identify fall risk factors and that the resident's care plan reflects person-centered interventions to mitigate fall risk. This will be completed by October 7, 2019. If any other resident is identified to be affected by the same deficient practice, the facility will follow its interdisciplinary team process to assess fall risk factors, develop care plan, and communicate interventions for each specific resident with assigned staff.	

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F 689	Continued From page 2 assessment), dated 12/13/18, indicated Resident 1 had a score of 65 (a score of 45 and above means high fall risk). A review of Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated 8/19/19, indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required a one-person physical assist with bed mobility, dressing, eating, toilet use and personal hygiene. The MDS indicated Resident 1 required a two-person physical assist moving to or from a bed, chair and or wheelchair to a standing position. A review of Resident 1's history and physical (H/P) report, dated 7/5/19, indicated Resident 1 could make his needs known, but could not make medical decisions. A review of Resident 1's care plan, dated 7/8/19 indicated Resident 1 had high risk for falls and injury, poor judgement and safety awareness, history of falls and limited mobility. The staff's interventions included to keep Resident 1's personal items, including the call light within reach, bed in low position and to keep the room clutter free. 1.A review of Resident 1's care plan, dated 7/22/19, indicated Resident 1 had an actual fall incident on 7/22/19. The staff's interventions included to transfer Resident 1 to the hospital for evaluation, assess the resident for pain, injury, change in range of motion, mobility and level of consciousness (the state of being awake and aware of one's surroundings), provide first aid for presence of injury and to determine the cause of the fall.	F 689	3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur The DON or ADON will conduct medical record reviews for new admissions daily five times a week and residents post-fall to ensure that the care plan for fall or injury prevention reflects a holistic assessment of every resident and that risk-specific interventions were developed. This will be implemented on October 7, 2019 The licensed nurses were provided an in-service on Fall Prevention and Management, including the facility's Falling Star Program, by the Nurse Consultant on October 2, 2019. The in-service emphasized the importance of conducting a comprehensive assessment to identify fall risk factors, developing risk-specific care plan, communicating interventions with CNAs, and monitoring effectiveness of interventions. The CNAs will be provided an in-service on Fall Prevention and Management by the Nurse Consultant on October 7, 2019. The in-service will focus on the role of CNAs in preventing falls and injuries and about the facility's Falling Star program.	

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F 689	Continued From page 3 A review of a "Situation Background Assessment and Recommendation" ([SBAR] an internal communication form), dated 7/22/19 and timed at 2 p.m., indicated Resident 1 had a fall on 7/22/19 and sustained a skin tear (a wound caused by shear, friction, and/or blunt force resulting in separation of skin layers). A review of the facility's "Transfer Form," dated 7/22/19 and timed at 2:10 p.m., indicated Resident 1 was totally dependent on the staff for bathing, dressing, toileting, transfers and eating. This form indicated Resident 1 who had a high fall risk, had a skin tear on the forehead measuring one by 0.5 centimeters ([cm] unit of measurement). A review of Resident 1's GACH Progress Note dated 7/23/19 indicated Resident 1 was admitted to the GACH on 7/22/19 and discharged on 7/25/19, following a fall in the facility that resulted in Resident 1 sustaining a frontal head hematoma (a collection of blood outside of blood vessels). A review of Resident 1's Physician's orders, dated 7/25/19, indicated Resident 1 should have bilateral (both) half side bed rails up to assist Resident 1 when turning and repositioning in bed. A review of Resident 1's Morse Fall Risk Screen, dated 7/25/19, indicated Resident 1's score was higher at 75, compared to the assessment on 12/2018 of 65. A review of Resident 1's physician's orders, dated 7/26/19, indicated Resident 1 should have a tab alarm (a device that alerts the staff when the	F 689	The facility implemented change-of-shift huddles between the licensed nurse and the CNAs to discuss residents' special needs, including fall prevention measures. This was implemented on September 30, 2019. The ADON will post an updated list of residents in the Falling Star program by the nurse's station weekly to make staff informed of residents who are high risk for falls. This was completed on October 7, 2019. The Department Managers will conduct room rounds once a week to ensure that fall prevention interventions are being implemented according to each resident's care plan. Deficient findings during rounds will be reported to the DON and Administrator during the stand-up meeting for follow-up. This will be implemented on October 18, 2019. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will track and trend data from room rounds and medical record reviews monthly and will report findings to the Quality Assessment and Assurance (QAA) Committee during the QAPI meeting for further recommendations.	

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F 689	Continued From page 4 resident tried to get up unassisted) while in bed to alert the staff. This order also indicated the staff should monitor Resident 1's tab alarm for placement and functioning every shift. The physician order also included for Resident 1 to have a left-sided floor mat placed for fall management every shift. A review of Resident 1's Interdisciplinary Team Conference Record ([IDT] a group of medical professionals that work together towards a common goal for a resident), dated 7/26/19 and timed at 4 p.m., indicated on 7/22/19 at 1:20 p.m., Resident 1 was found on the floor in the room, in a right-side lying position with the wheelchair behind the resident. Resident 1 sustained injuries and was transferred to a GACH on 7/22/19 at 2:25 p.m. and returned to the facility on 7/26/19. The IDT's recommendations included to use a floor mat at Resident 1's bed side, a bed alarm to remind the staff when Resident 1 attempted to get out of bed unassisted and remind the new CNAs not to leave resident with high fall risk in the room while in wheelchair. On 7/30/19 at 2:30 p.m., during an interview, the facility's Director of Nursing (DON) stated Resident 1 was at high risk for falls and had two falls with injuries within four days. The DON stated that on 7/22/19, Resident 1 who had a tendency of trying to grab a wheelchair, had an unwitnessed fall with a small laceration to the forehead and was transferred to a GACH. The DON stated that at the time of the fall, the wheelchair might not have been in Resident 1's reach and there was no wheelchair alarm to alert the staff Resident 1 was attempting to get up unassisted. A review of Resident 1's SBAR form, dated	F 689		

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F 689	Continued From page 5 7/27/19 and timed at 5 p.m., indicated Resident 1 who was readmitted to the facility two days prior (7/25/19), from the hospital was observed with swelling to the left wrist and hand. A review of Resident 1's nurses' progress note, dated 7/27/19 and timed at 3:30 p.m. indicated on 7/27/19, during lunch, Resident 1's family member (FM1) notified a Charge Nurse that Resident 1's left arm was swollen. The note indicated upon assessment, Resident 1's left wrist and left hand were observed to be swollen. The Note indicated Resident 1 did not know what happened to his left hand and that the left wrist was immobilized. According to this noted, Resident 1's physician ordered an x-ray (process on taking pictures of a body part to diagnose broken bones and other disorders) to be done on the resident's left wrist. A review of Resident 1's an untimed SBAR form, dated 7/29/19 indicated Resident 1 had a fall from a wheelchair on 7/29/19, and sustained an abrasion (a skin scraping or wearing away) and laceration (injury to the skin and the soft tissue) to the forehead. A review of Resident 1's nurses' progress note, dated 7/29/19 and timed at 6:38 p.m., indicated on 7/29/19 at 4 p.m., Resident 1 fell on the floor. The note indicated Resident 1 was on the floor in his room with the wheelchair next to him. The note indicated Resident 1 had a reopened frontal head laceration measuring 2.5 cm by 2.1 cm, a left upper eye brow laceration, a 1.2 by 1.5 cm upper facial abrasion, and a 1.6 cm mid-upper lip laceration with bleeding. A review of Resident 1's Physician order, dated	F 689		

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F 689	Continued From page 6 7/29/19 and timed at 3:43 p.m., indicated Resident 1 should have a sensor pad alarm (a device placed on a chair or bed that makes a sound when the resident tries to get out of bed or chair unassisted), while in the wheel chair to alert the staff when the resident attempted to get up unassisted. This order also indicated the staff should to monitor the alarm for placement and functioning every shift. A review of Resident 1's "Verification of Informed Consent for Use of Prolonged Devices," dated 7/29/19, indicated Resident 1 was at risk for falls and was to have a sensor pad alarm while in a wheelchair. A review of an IDT note, dated 7/30/19 and timed at 6:58 p.m., indicated on 7/29/19 at approximately 4 p.m., Resident 1 was found on the floor next to his bed, with the wheelchair on the resident's side. Resident 1 sustained injuries to the frontal head measuring 2.5 cm, a laceration on the left upper eyebrow measuring 2.1 cm, an abrasion on the left upper cheek measuring 1.2 by 1.5 cm, a laceration on the mid upper lip measuring 1.6 cm. This note indicated Resident 1 was observed with minor bleeding from the injured sites. According to this note, Resident 1 fell when a CNA was about to transfer the resident from the wheelchair to the bed.	F 689		
	A review of the GACH "Emergency Documentation," indicated Resident 1 was admitted to the GACH on 7/29/19 and discharged on 7/30/19, following a forehead laceration and bruising to the left cheek. This documentation			

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F 689	Continued From page 7 indicated a staff dropped Resident 1 when moving him from a wheelchair to the bed. According to this documentation, Resident 1 had a left frontal head hematoma (a collection of blood outside of blood vessels) with a superficial laceration and complained of pain to the left elbow and left upper arm. A review of a "Summary of Investigation," dated 7/31/19, indicated Resident 1 had an unwitnessed fall on 7/22/19 at approximately 1:20 p.m., sustained a frontal head laceration with minimal bleeding and was transferred to a GACH. The summary indicated Resident 1 was admitted to the GACH from 7/22/19 to 7/25/19. This report indicated Resident 1 had a high risk for fall and injury due to limited mobility, history of falls, confusion and forgetfulness. On 7/30/19 at 2:30 p.m., during an interview, the DON stated that on 7/29/19, Resident 1 had an unwitnessed fall from a wheelchair after a Certified Nursing Assistant 1 (CNA 1) left the resident in an unlocked wheelchair in his room. The DON stated that CNA 1 was newly hired to the facility and was not aware Resident 1 was a high fall risk. On 7/30/19 at 2:45 p.m., during a concurrent observation and interview, Resident 1 was observed in a reclining position in a wheelchair, in the dining room and with no wheelchair alarm. Resident 1 was observed with two lacerations on the mid forehead and the mid upper lip. The DON stated Resident 1 did not have a chair alarm in place but should have, to prevent falls and injuries to the resident. On 7/30/19 at 2:58 p.m., during an interview, CNA	F 689		

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F 689	Continued From page 8 2 stated that on 7/29/19, CNA 1 left Resident 1 who was very agitated unattended in his room, because CNA 1 did not know how to care for Resident 1 and Resident 1 was not supposed to be left unattended due to a history of falls. On 7/30/19 at 3 p.m., during an interview, CNA 1 stated that on 7/29/19, Resident 1 was assisted in a wheelchair to the room. CNA 1 stated that Resident 1 did not have a wheelchair alarm or a floor mat, as prescribed by the physician on 7/26/19. CNA 1 left Resident 1 in a wheelchair with an unlocked left wheel. CNA 1 stated that thirty minutes later, at approximately 3:30 p.m., Resident 1 was found on the floor. According to CNA 1, Resident 1's fall could have been prevented if Resident 1 was left in the hallway where the staff could supervise the resident. On 7/30/19 at 3:15 p.m., during an interview, the facility's Activities Director (AD) stated Resident 1 who had a history of falls had a tendency of leaning forward while in the wheelchair. The AD stated Resident 1 who had two recent falls from the wheelchair did not have a wheelchair alarm. On 8/1/19 at 1 p.m., during an interview, Licensed Vocational Nurse 1 (LVN 1) stated that Resident 1 was very agitated and had a history of falls and required close supervision. LVN 1 stated on 7/29/19, CNA 1 should not have left Resident 1 in the room unsupervised. LVN 1 stated Resident 1 did not have floor mat or an alarm in place on 7/29/19, when the resident fell. A review of the facility's policy titled "Fall Risk Assessment," with a revised date of 3/2018, indicated the facility would identify and document	F 689		

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F 689	Continued From page 9 resident's risk factors for falls and establish a resident centered fall preventive plan based on relevant assessment information. A review of the facility's policy titled, "Accidents and Incidents, Investigating and Reporting," with a revised date of 7/2017, indicated the facility would comply with current rules and regulations governing accidents and or incidents involving a medical device.	F 689		

California Department of Public Health

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B4835	T22 DIV5 CH3 ART5-72541 Unusual Occurrences Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department. An incident report shall be retained on file by the facility for one year. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshal. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to report two unwitnessed fall incidents to the Department of Health Services (DHS), for one of three sampled residents (Resident 1), who had two falls in four days and sustained lacerations (deep cuts) to the forehead and upper lip. This deficient practice placed Resident 1 and other residents in the facility at risk for neglect. Findings: A review of Resident 1' s Admission Face sheet indicated Resident 1 was admitted to the facility on 12/13/18, with a most recent admission on 4/18/19. Resident 1's diagnoses included traumatic brain injury (a disruption in the normal function of the brain caused by a bump or blow to the head), history of falling, generalized muscle.	B4835	B4835 T22 Div5 Art5-72541 Unusual Occurrences 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice A comprehensive assessment of Resident 1 was conducted when he returned to the facility on July 30, 2019. His care plans were updated on July 30, 2019 to reflect his current risk factors for fall and interventions were developed to address specific risk factors. Similarly, physician's orders were reviewed on July 30, 2019 for the devices or alarms that were to be utilized for Resident 1. Resident 1's care plan interventions for fall and injury prevention are communicated with the staff during change-of-shift huddles daily to ensure that interventions are followed through. CNA 1 was provided a one-on-one in-service by the Assistant Director of Nursing (ADON) on July 23, 2019 regarding fall prevention and management, specifically about communicating and coordinating with the supervising licensed nurse and assigned CNA whenever helping out with a resident who is not assigned to him.	

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	CA910000276	A. BUILDING: _____ B. WING _____	C 09/27/2019

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B4835	Continued From page 1 weakness, left hemiplegia and hemiparesis (paralysis [inability to move] and weakness of the muscles of the lower face, arm, and leg on the left side of the body), seizure (a sudden, uncontrolled electrical disturbance in the brain that can cause changes in behavior, movements or feelings, and in levels of consciousness) and dementia (decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities). A review of a "Morse Fall Risk Screen," (a fall risk assessment) dated 12/13/18, indicated Resident 1 had a score of 65. A score of 45 and above means high fall risk. A review of Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated 6/19/19, indicated Resident 1's cognition (thought process) was intact. The MDS indicated Resident 1 required a one-person physical assist with bed mobility, dressing, eating, toilet use and personal hygiene. The MDS indicated Resident 1 required a two-person physical assist moving to or from a bed, chair and or wheelchair to a standing position. According to the MDS, Resident 1 was receiving antidepressant (medication to treat depression) medication. A review of Resident 1's history and physical (H/P) report, dated 7/5/19, indicated Resident 1 could make needs known, but could not make medical decisions. A review of Resident 1's care plan, dated 7/22/19, indicated Resident 1 had an actual fall incident. The staff's interventions included to transfer Resident 1 to the hospital for evaluation, assess the resident for pain, injury, change in range of	B4835	Resident 1's fall incidents on July 22, 2019 and July 29, 2019 were investigated by the California Department of Public Health on July 30, 2019, thus, they were no longer reported. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken The Assistant Director of Nursing (ADON) will review incidents and accidents that occurred from July 2019 to the present month to identify residents who may have been affected by the same deficient practice. The review will focus on identifying incidents and accidents that constitute an unusual occurrence. This will be completed on October 7, 2019. The reporting procedure will be followed for any other incident or accident that is identified to constitute an unusual occurrence. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur	

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B4835	Continued From page 2 motion, mobility and level of consciousness, provide first aid for presence of injury, and to determine the cause of the fall. A review of a "Situation Background Assessment and Recommendation" ([SBAR] an internal communication form), dated 7/22/19 and timed at 2 p.m., indicated Resident 1 had a fall and sustained a skin tear (a wound caused by shear, friction, and/or blunt force resulting in separation of skin layers). A review of Resident 1's Progress Note, dated 7/22/19 and timed at 1:20 p.m., indicated. Resident I was found on the right side lying on the floor in his room. According to the nursing progress note, Resident 1 had a frontal (middle of the face) cut measuring one inch with minor bleeding and was transferred to the hospital. A review of a facility to hospital "Transfer Form," dated 7/22/19 and timed at 2:10 p.m., indicated Resident 1 was totally dependent on the staff for bathing, dressing, toileting, transfers and eating. This form indicated Resident 1 who had a high fall risk, had a skin tear on the forehead measuring 1 by 0.5 centimeters ([cm] unit of measurement). A review of Resident 1's Hospital Transfer Form, dated 7/22/19 and timed 1:40 p.m., indicated Resident 1 who was non ambulatory (unable to walk), totally dependent on the staff for bathing, dressing, toileting, transfers and eating, and had a fall with injuries. A review of Resident 1's SBAR form, dated 7/29/19 and timed at 4:10 p.m., indicated Resident 1 had a fall from a wheelchair and sustained an abrasion (a skin scraping or wearing	B4835	The DON and the Administrator will review fall incidents daily to ensure that unusual occurrences are reported to the California Department of Public Health (CDPH) promptly as specified in Title 22 and in the facility policy. All facility staff will be provided an in-service on Unusual Occurrences, including reporting procedures to follow, by the Nurse Consultant on October 16, 2019. 4. How the facility plans to monitor its performance to make sure that solutions are sustained The Administrator will present, to the QAA Committee, a monthly report on incidents and accidents that were reported to CDPH during the QAPI meeting to ensure compliance to Title 22 requirements and the facility policy on reporting unusual occurrences. Any recommendations for further review or additional interventions from the QAA Committee will be acted upon by the Administrator.	

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B4835	Continued From page 3 away) and laceration (injury to the skin and the soft tissue) on the forehead. A review of Resident 1's progress note, dated 7/29/19 and timed 6:38 p.m., indicated at 4 p.m., Resident 1 fell on the floor. This note indicated Resident 1 was on the floor in his room with the wheelchair next to him. According to a nursing progress note, Resident 1 had a reopened frontal head laceration measuring 2.5 cm by 2.1 cm, a left upper eye brow laceration, a 1.2 by 1.5 cm upper facial abrasion, and a 1.6 cm mid-upper lip laceration with bleeding. On 7/30/19 at 2:40 p.m., during an interview, the facility's administrator (ADM) stated that Resident 1's falls that resulted in lacerations were not reported to DHS because the injuries were not a result of an abuse. A review of a facility's policy titled, "Accidents and Incidents, Investigating and Reporting," with a revised date of 7/2017, indicated the facility would comply with current rules and regulations governing accidents and or incidents involving a medical device. A review of a facility's undated policy titled, "Unusual Occurrence Reporting," indicated the facility would report unusual occurrences or other reportable events which affect the health or welfare of residents, employees and visitors as required by federal or state regulations. This policy also indicated all allegations of abuse and neglect.	B4835		