| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345204 | A. BUILDING _____ B. WING _____ | C 08/21/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| STONECREEK HEALTH AND REHABILITATION | 455 VICTORIA ROAD ASHEVILLE, NC 28801 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the Complaint Investigation Event ID #3ZE811. | F 000 | | |
| F 156 SS=B | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.<br><br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered | F 156 | | 9/9/14 |

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

Electronically Signed | 09/09/2014

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 156 | Continued From page 1 | F 156 | | |

under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and

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| F 156 | Continued From page 2<br>applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to post the phone number for the State Complaint Intake Unit, failed to list the current Division name, and failed to list the current Division phone number.<br><br>Findings Included:<br><br>An observation on 08/20/14 at 3:00 PM revealed the patient bill of rights was posted in the front hall across from the receptionist desk. Listed at the bottom of the bill of rights was the following number for the Division of Facility Services: 1-919-733-8499. The telephone number for the State Complaint Intake Unit was not listed.<br><br>On 08/20/14 at 2:45 PM a call was placed to the phone number 1-919-733-8499 and a message was heard stating the telephone number had been disconnected.<br><br>On 08/20/14 an interview with the Administrator at 4:00 PM revealed she had tried to call the posted telephone number 1-919-733-8499 and it was no longer in service.<br><br>On 08/22/14 an interview with the Administrator at 4:00 PM verified the name and telephone number for the State Complaint Intake Unit had not been | F 156 | Disclaimer Clause:<br>Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law.<br><br>The current division name, address, and complaint intake phone number were posted in a visible location at the front lobby on 8-21-14. The posting also informs residents and/or visitors of their right to file a complaint with the state agency.<br><br>All current residents and/or responsible parties were provided with a copy of Resident Rights including a listing of the current division, address, complaint intake phone number, and notice of their right to file a complaint with the | |

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|---|---|---|---|---|
| F 156 | Continued From page 3<br>posted. | F 156 | state agency.<br><br>All future residents will be provided a copy of<br>resident rights upon admission which includes a<br>listing of the current division name, address, and<br>complaint intake phone number. This form also<br>contains a statement notifying the resident and/or<br>responsible party of their right to file a complaint<br>with the current state agency. This same form will<br>be provided throughout the year during Resident Council Meetings.<br><br>The receptionist will ensure daily the current agency, address, and complaint intake phone number along with the statement<br>regarding the residents and/or visitors right to<br>file a complaint with the current agency is posted at the front lobby.<br><br>To ensure quality assurance, the Administrator or designee will review compliance of Resident Rights specific to the posting and notification of the current agency, address, complaint intake phone number, and statement of the right to file a complaint with the current agency during the Quality Assurance Meeting for at least three consecutive meeting and every six months afterward. | |

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|---|---|---|---|---|
| F 156 | Continued From page 4 | F 156 | All corrective action will be completed on or before September 9, 2014. | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. | F 431 | | 9/9/14 |

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| F 431 | Continued From page 5<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interview the facility failed to maintain medication refrigerator temperatures between 36 - 46 degrees Fahrenheit (F) for 1 of 2 medication refrigerators (West Wing).<br><br>The findings included:<br><br>On 08/20/14 at 10:30 AM, an observation of the medication refrigerator on the West Wing revealed a temperature of 28 degrees F. A review of the refrigerator temperature logs from January 1, 2014 through August 20, 2014 revealed documentation of temperatures below 36 degrees F as follows: January, February and March 2014 - every day; April 2014 - 19 days, May 2014 - 2 days, June 2014 - 9 days, July 2014 - 5 days and August 2014 - 15 days.<br><br>On 08/21/14 at 6:45 AM, an observation of the medication refrigerator on the West Wing revealed a temperature of 34 degrees F.<br><br>On 08/21/14 at 10:21 AM, an observation of the medication refrigerator on the West Wing revealed a temperature of 34 degrees.<br><br>The medication refrigerator contained 18 vials of Lorazepam injectable, 4 boxes of Copaxone injectable, 7 Novolog Flexpens and 5 vials of Novolog insulin. Review of the manufacturer's instructions for storage of each of the medications revealed instructions which stated: "store refrigerated at 36 - 46 degrees Fahrenheit." | F 431 | Disclaimer Clause:<br>Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law.<br><br>The medication refrigerator was replaced with a new refrigerator on 8-21-14. All medications located within the refrigerator that could have an adverse effect based upon temperature were properly disposed and replaced on 8-21-14.<br><br>All licensed nursing staff was in-serviced by the Director of Nursing and Staff Development Coordinator between the dates of 8-21-14 to 9-5-14. The in-services included proper temperature range for medication refrigeration storage, process for ensuring temperatures are appropriate, and procedure for action if the medication refrigerators are not within proper range of 36-46 degrees Farenheit.<br><br>To ensure Quality Assurance, a member of Nurse<br>Management will check all refrigerators used for<br>medication storage daily. This is in addition to the | |

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| STONECREEK HEALTH AND REHABILITATION | 455 VICTORIA ROAD ASHEVILLE, NC 28801 |

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| F 431 | Continued From page 6<br>An interview on 08/21/14 at 6:45 AM with Nurse #1 revealed she was regularly assigned to work the 11:00 PM to 7:00 AM shift on the West Wing. Nurse #1 stated she was responsible for checking the temperature of the West Wing medication refrigerator every night and she usually checked the temperature at the beginning of her shift. She stated if she saw a temperature outside the acceptable range she would sometimes adjust the setting and recheck it later but didn't always remember to do that. Nurse #1 pointed out that there was no place on the refrigerator temperature log to document a recheck of the temperature or to indicate the setting was adjusted. She stated she hadn't reported the temperatures being out of range to the on-coming nurse or to the Maintenance Director and acknowledged that she should have reported it.<br><br>An interview on 08/21/14 at 1:12 PM with the Unit Manager for the West Wing revealed she had not been notified that the temperature was too cold in the medication refrigerator. When asked what the acceptable temperature range was, she stated it was 36 to 46 degrees F.<br><br>An interview on 08/21/14 at 3:37 PM with the Director of Nursing (DON) about her expectation for the action that should be taken for a medication refrigerator temperature being too cold revealed she would expect the nurse to adjust the setting on the refrigerator and re-check the temperature. The DON stated she would expect the nurse to notify either herself or the Maintenance Director if the temperature was consistently colder than the acceptable range. The DON stated she was not aware of any problem with the medication refrigerator | F 431 | temperature check completed by third-shift nursing staff. If it is determined that third-shift nursing staff does not follow the in-serviced procedures for ensuring proper storage of refrigerated medications, immediate action will be completed by a designated member of the Nurse Management Team.<br><br>The Director of Nursing and/or Administrator will review findings In the Quality Assurance Meeting for a minimum of three consecutive meetings and quarterly during pharmacy review on-going.<br><br>All corrective action will be completed on or before September 9, 2014. | |

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| F 431 | Continued From page 7<br>temperature on the West Wing.<br><br>An interview on 08/21/14 at 3:44 PM with the Maintenance Director revealed he had not been notified of any problem with the temperature of the medication refrigerator on the West Wing being colder than the acceptable range.<br><br>An interview on 08/21/14 at 5:21 PM with the Administrator about her expectation for action that should be taken when the medication refrigerator temperature was too cold revealed she would expect the nurse to adjust the setting, re-check the temperature and notify the Maintenance Director if there was a problem. | F 431 | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident interview and staff interviews, the facility failed to completely document assessments for 1 of 5 | F 514 | Disclaimer Clause:<br>Preparation and or execution of this plan does not constitute admission or | 9/9/14 |

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|---|---|---|---|---|
| F 514 | Continued From page 8<br>residents reviewed for falls (Resident #19). Findings included:<br><br>Resident #19 was readmitted to the facility on 04/17/14 with diagnoses including multiple sclerosis (MS), osteoporosis, general osteoarthritis, debility, gait abnormality and lack of coordination. Her Minimum Data Set (MDS) dated 07/14/14 documented her as being cognitively intact and requiring extensive two person assistance with transfers and toileting. This MDS documented one fall with no injury and another fall with injury since reentry into the facility. Review of her care plan updated on 05/21/14 included the problem of a self-care deficit requiring assistance with ADL, mobility and transfers. Another problem was a risk of falls with numerous and appropriate interventions including assistance with transfers. Review of Resident #19's medical record revealed a fall risk evaluation form dated 05/21/14 with a score of 14, indicating the resident was at high risk for falls.<br><br>Review of a resident incident report dated 07/08/14, an internal document not a part of the medical record and provided by the facility, revealed narrative describing Nurse Aide (NA) #1 as assisting Resident #19 in the bathroom on 07/08/14 at 1:33 PM when "resident knees buckled during transfer from toilet and was lowered to floor onto her knees", "no harm or injury" and "monitor for any injuries." Vital signs were stable, the physician was notified and medications noted as taken in the previous 8 hrs included analgesics/narcotics. Risks noted were a fall history, tremors/MS, arthritis/osteoporosis, fracture, incontinency and sensory limitations. A plan for 24 hour follow up included the presence | F 514 | agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law.<br><br>Resident #19 received a complete physician assessment on 7-10-14 by the Attending Physician and an Orthopedic consult via Attending Physician on 7-10-14. Interventions were in place on 7-10-14.<br><br>All licensed nursing staff was in-serviced by the Director of Nursing and Staff Development Coordinator between the dates of 8-21-14 to 9-5-14. The in-services included documentation guidelines for clinical records and charting guidelines including guidelines for accident/incident documentation.<br><br>An audit was completed to ensure all residents with a reported accident/injury since August 21, 2014 had appropriate documentation, with accurate completion of the clinical record including but not limited to vital signs, pain assessments and assessments of the extremity affected, if applicable.<br><br>To ensure Quality Assurance, a member of Nurse Management will review any accident/injuries to ensure completion of the clinical record including documentation of the incident, vital signs, pain | |

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| F 514 | Continued From page 9<br>of a knee immobilizer, the incident was reported in progress notes on 07/08/14 and was addressed in the care plan. The incident report noted NA #1 as reporting the incident and the report as completed by the unit nursing coordinator (Nurse #2).<br><br>Review of Resident #19's medical record revealed nursing notes dated 07/08/14 at 11:49 PM documenting the resident complaining of being cold all over, having a temperature of 102. 5 degrees Fahrenheit and having garbled speech. A urinalysis with culture and sensitivity was collected and an ordered chest x-ray revealed a suspected early pneumonitis for which Resident #19 was started on antibiotics. Several nursing notes on 07/09/14 and 07/10/14 documented assessments related to the suspected infection and included a review of weight loss.<br><br>Review of another nursing note written and signed by Nurse #2 and dated 07/10/14 at 11:18 AM revealed that on 07/08/14 NA #1 reported she was assisting Resident #19 to a standing position from the toilet when the resident's leg buckled. This note documented NA #1 as having a gait belt around Resident 19's waist but as unable to hold the resident's weight and lowering the resident to the floor onto her knees. This note documented a nurse (Nurse #3 was assigned to Resident #19 on the day shift of 07/08/14) as assessing the resident who denied pain, moved all extremities well, assisted to a wheelchair (WC) without difficulty, vital signs were stable and the doctor (MD) was notified. Another nursing note written and signed by the director of nursing (DON) and dated 07/10/14 at 11:29 AM revealed Resident #19 complained of right ankle pain on the 11:00 PM to 7:00 AM shift the previous night (Nurse #1 | F 514 | assessment, and assessment of the affected extremity for a minimum of three days following the incident.<br><br>The Director of Nursing and/or Administrator will review findings at least weekly.<br>These findings will be presented to the Quality Assurance Committee for a minimum of six months.<br><br>All corrective action will be completed on or before September 9, 2014. | |

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|---|---|---|---|---|
| F 514 | Continued From page 10 | F 514 | | |

was assigned to Resident #19 on this shift), the on-call MD was notified, ordered x-rays were completed and results were received by the MD. This note documented an order to apply a knee immobilizer to Resident #19's right leg until an orthopedic physician practice called with an appointment.

On 08/18/14 at 12:00 PM Resident #19 was observed awake, alert and conversant in her WC, wearing a knee immobilizer to her right leg and her right foot elevated and resting in the WC foot rest.

On 08/18/14 at 12:00 PM an interview with Resident #19 revealed NA #1 was assisting her in the bathroom when her legs gave out and she fell to the floor. She stated NA #1 went to get Nurse #3 and this incident occurred approximately three weeks prior. She stated a nurse who worked the night shift, whose name she could not remember, was the one who arranged for her to get an x-ray.

On 08/20/14 at 2:21 PM an interview with Nurse #3 revealed NA #1 came to her and reported that Resident #19 had fallen during either a transfer to or from the toilet with NA #1 reporting she had eased the resident down to the floor when the resident's legs gave out. She stated there was nothing significant on her assessment, the resident had full range of motion, was without complaint of pain and she had pulled up the resident's pant legs to inspect her legs. Nurse #3 stated there was no obvious deformity. She stated she and NA #1 assisted the resident back into the WC and she went to the nursing station to report the incident to Nurse #2. She stated she did not do any documentation, she did not fill out an incident report nor complete a progress note,

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|---|---|---|---|---|
| F 514 | Continued From page 11 | F 514 | | |

either in the electronic chart or on a piece of paper.

On 08/20/14 at 2:51 PM an interview with NA #1 revealed she was with Resident #19 when she fell in the bathroom while in the process of standing her up from her WC and during a pivot of her legs they started to buckle, at which point the resident was lowered to the ground. She stated she pulled the bathroom call bell, Nurse #3 arrived who did an assessment of the resident and with Nurse #3 they assisted the resident back into her WC.

On 08/20/14 at 4:20 PM an interview with Nurse #2 revealed nurses had the responsibility of assessing residents after a fall, notifying the physician and responsible person, obtaining treatment if there was an injury, continuing to monitor the resident, charting on the fall and completing an incident report. She stated leadership followed up on all falls and provided analysis. Nurse #2 stated nurses should have a progress note and incident report done within 24 hours of a fall and that so long as the incident report was done other notes could follow after that. She stated Nurse #3 told her of Resident #19's fall the day it occurred and that although Nurse #3 could fill out an incident report, she was willing to help and it depended on who had the time. Nurse #2 stated Nurse #1 should have done a progress note of her assessment. She stated Resident #19 complained of pain on the night shift and this should have been reported to the day shift. Nurse #2 stated she did a late entry progress note regarding the fall. She stated leadership relied on the incident reports and nurses relied on progress notes and their shift-to-shift reports. Nurse #2 stated she went

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345204 | A. BUILDING _____ B. WING _____ | C 08/21/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| STONECREEK HEALTH AND REHABILITATION | 455 VICTORIA ROAD ASHEVILLE, NC 28801 |

| (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 |
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| F 514 | Continued From page 12 | F 514 | | |

back to do the progress note for personal reasons as she was the nurse who completed the incident report. Nurse #2 stated she would have preferred that Nurse #3 had written a progress note but it depended on what was going on in the day. Nurse #2 stated she checked on Resident #19 on the days after the fall for any uncontrolled pain.

On 08/21/14 at 7:32 AM an interview with Nurse #1 revealed she recalled assessing Resident #19 for pain, speaking about the resident to the DON and obtaining an order for an x-ray. She stated she assessed the resident's leg which had a good sized bruise under her knee and looked to have an obvious deformity above her ankle on the medial side. She stated did not think the resident called her into the room, but that while she was in there for some other reason Resident #19 complained about her leg hurting and that the day prior she had fallen. Nurse #1 stated her assessment did not lead her to think the resident was in any great pain as the resident was not crying and the resident stated it was just sore. She stated the resident asked her to first check her toes, which were fine and without abrasion, but as she worked up the resident's leg she observed a bruise. Nurse #1 stated she was surprised when the resident told her she had fallen because she did not hear anything in report and would have expected to have received this information from the nurse she was in report with. She stated she wrote this information down on the 24 hour report sheet and verbally communicated it to the oncoming nurse and the DON. Nurse #1 stated she spoke with the on-call physician during her shift and obtained an order for an x-ray. She stated her pain and leg assessment on the resident should have been

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| F 514 | Continued From page 13<br>documented. She stated sometimes she could document right away and other times she had to do it at the end of her shift.<br><br>On 08/21/14 at 4:09 PM an interview with the DON revealed she expected nurses to chart any change of condition and assessments before the end of the day and before nurses left for the day. She stated facility policy and procedure was to document occurrences as soon as possible. She stated documentation should have occurred after Resident #19's incident and follow up assessments to a fall should include vital signs, pain assessments and assessments of the extremity affected by the fall. | F 514 | | |