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F 000	INITIAL COMMENTS A complaint investigation was conducted from 03/15/23 through 03/17/23. The following intakes were investigated NC00199528 and NC00199608 and resulted in immediate jeopardy. Past non-compliance was identified at: CFR 483.12 at tag F600 at scope and severity J. Tag F600 constitued Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, family, and Emergency Room (ER) Physician interviews, the facility failed to protect a resident's right to be free from an injury of unknown origin when Resident #1 was found on 03/11/23 at approximately 8:12 AM to have facial swelling	F 600	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 03/30/2023

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and bruising for 1 of 2 residents reviewed with injuries of unknown origin. Resident #1 was transferred to the local ER for evaluation where it was determined that Resident #1 had an acute subdural hematoma (bleeding on the brain), multiple facial fractures, and a large subcutaneous (under the skin) hematoma (blood collected and pooled under skin) over the mandible (jaw) that measured 4.7 centimeters (cm) by 3.1 cm and required an additional transfer to another hospital that had a trauma intensive care unit to care for and treat Resident #1's injuries.

The findings included:

Resident #1 was admitted to the facility on 01/07/20 with diagnoses that included dementia and acquired absence of left lower leg.

A physician order dated 04/18/22 read, Apixaban (blood thinner) 2.5 milligrams (mg) by mouth every twelve hours for atrial fibrillation (heart arrhythmia).

The quarterly Minimum Data Set (MDS) assessment dated 12/30/22 revealed that Resident #1 was severely cognitively impaired, understood what others were saying and was able to make self-understood. The MDS further revealed that Resident #1 required extensive assistance with transfers and total assistance with bed mobility. Additionally, Resident #1 had an impairment to one lower extremity. Physical behaviors and rejection of care were noted one to three days during the assessment reference period. No falls were reported during the assessment reference period.

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An observation of Resident #1's room was made on 03/15/23 at 10:41 AM. The room contained two resident beds, one was occupied, and one was empty. The empty bed belonged to Resident #1. The bed contained no side rails, a bolster mattress (mattress with approximately one inch elevated sides) and was low to the floor. There was a fall mat to the right side of bed on the floor and directly next to the right side of bed near the head of bed was a straight back chair.

Resident #1's roommate was interviewed on 03/15/23 at 10:47 AM. The Roommate stated that they had taken Resident #1 somewhere because "they said she fell out of bed." The Roommate stated that she heard the staff taking care of Resident #1 "that night" but she heard nothing out of the ordinary.

An incident report dated 03/11/23 at 8:37 AM completed by Nurse #1 read, Nurse Aide (NA) #1 notified this Nurse of injury to Resident #1 and asked if anything had been reported. This Nurse responded "no" and proceeded to Resident #1's room to assess. Resident #1 was sitting up in bed, awake and alert with unlabored breaths preparing to eat breakfast. Swelling noted to entire left side of face, including left orbital (eye) area, bruising to left lower jaw. Also, an abrasion to the left side of neck possibly caused by a braided cloth choker (necklace) worn by Resident #1. Due to Resident #1's impaired cognition and inability to get precise answers to questions when asked if she fell or was hit in the face the decision was made to transfer to the local Emergency Room (ER). The Nurse Supervisor was made aware and agreed with transferring Resident #1 to the ER.

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Nurse #1 was interviewed via phone on 03/15/21 at 1:21 PM and confirmed that she worked on 03/11/23 from 7:00 AM to 7:00 PM and was responsible for Resident #1. She stated that when she arrived for work, she received report from Nurse #2. Nurse #2 stated that during the night shift 7:00 PM to 7:00 AM there were no falls, no complaints of nausea, diarrhea, or vomiting and after counting the narcotics Nurse #2 left the facility and Nurse #1 stated she proceed to start her day. Nurse #1 stated she remained at her medication cart stocking it with supplies that she would need to begin her morning medication pass and around 8:10 AM NA #1 came running down the hallway telling Nurse #1 to come and see Resident #1. As Nurse #1 and NA #1 were quickly walking down the hallway NA #1 asked "did you get anything in report about Resident #1" and Nurse #1 stated she replied "No." Nurse #1 stated they walked into Resident #1's room and she "could not believe what she saw" Resident #1's left side of her face was twice as large as the right side of her face and reddish bruising that was turning purple in spots was noted. Nurse #1 stated that the bruising appeared new within three to four hours. She proceeded to recall that Resident #1's left eye was puffy and almost completely shut while the right eye was completely open. Nurse #1 stated she asked Resident #1 did you fall out of bed and the resident stated in a very low tone "yes." Nurse #1 stated she moved from the end of Resident #1's bed and approached her on the left side where she also found an abrasion with broken skin under her chin and thought that the very fine rope choker necklace that Resident #1 wore may have caused that area on her neck. Nurse #1 went to the hallway and summoned the Nurse Supervisor to the room. NA #1 and NA #2 had set

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Resident #1 up to eat her breakfast tray and when the Nurse Supervisor and Nurse #1 returned to bedside she was attempting to feed herself a bite of breakfast. Nurse #1 stated she asked Resident #1 if someone had hit her, and she replied "yes" then when asked again would say "no". Nurse #1 stated that she and the Nurse Supervisor went to the desk and called Emergency Medical Services (EMS) to come and transfer Resident #1 to the ER and within ten to fifteen minutes they arrived and transferred Resident #1 to their stretcher and headed to the ER. Nurse #1 added that surprisingly Resident #1 had no verbal or nonverbal signs of pain during the course of the morning. She was not moaning, crying, grimacing, or guarding.

A Nurses note dated 03/11/23 at 10:14 AM written by the Nurse Supervisor read, at 8:12 AM Nurse #1 came to the nurses' station and stated that Resident #1's face was swollen, and her eye was closed. This nurse went to Resident #1's room and noted the left side of her face was swollen extending to eye and neck area. Discoloration on jaw line black/blue in color. Resident #1 denied pain, denied falling and when asked she does not answer due to her dementia. Vital signs were taken, and recorded and EMS was called, and she was transferred to the ER.

The Nurse Supervisor was interviewed via phone on 03/15/23 at 11:46 AM who confirmed that she was working in the facility on 03/11/23 from 7:00 AM to 7:00 PM. She stated she was at the nursing station at around 8:10 AM making sure that all the staff had shown up for work when Nurse #1 came very quickly to the desk and asked me if anything had been reported about Resident #1's face, and I replied "NO" and we

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walked towards Resident #1's room. The Nurse Supervisor stated that when she entered Resident #1's room she could very clearly see her jaw was swollen, her left eye was swollen closed, and her jaw line was black and blue. She stated she very lightly touched Resident #1's swollen left jaw and it was very "hard and the skin was pulled taut." The Nurse Supervisor stated she asked Resident #1 if she had fallen or if someone had hit her and she did not respond to either question. Resident #1 also had an abrasion to her left neck area that may have been caused by a choker necklace that she had on. She stated that she removed the covers and inspected Resident #1 and found no other bruising and during the interaction she had no verbal or nonverbal signs of pain. The Nurse Supervisor stated that she was very confused as to what happened to Resident #1 because nothing had been reported to Nurse #1 or herself and initially, she thought maybe it was an abscessed tooth or infection of some sort. The Nurse Supervisor stated that she and Nurse #1 returned to the desk and proceeded to call EMS to transfer Resident #1 to the ER. She added that she only worked at the facility on the weekends, and she had seen Resident #1 last Sunday evening before the end of her shift and she had none of the bruising that she observed on 03/11/23. Sometime after Resident #1 was transferred to the ER, Nurse #1 learned that it was not an abscessed tooth, and she had some other injuries that were found while the ER was running tests and she immediately notified the Director of Nursing (DON) and Administrator of what had occurred.

NA #1 was interviewed on 03/15/23 at 3:13 PM who confirmed that she was working in the facility on 03/11/23 from 7:00 AM to 3:00 PM. NA #1

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stated that when she came to work there was no NA from third shift to do walking rounds with, so she and NA #2 began doing a round and around 8:00 AM the breakfast trays arrived on the unit. NA #1 stated that NA #2 picked up Resident #1's breakfast tray and walked into the room and immediately walked back to the hallway and stated, "what happened to this lady's face" and both NAs went back into Resident #1's room. NA #1 stated when she walked in and saw Resident #1, she said "what is wrong with her face" it was so disfigured. NA #1 stated that she summoned Nurse #1 immediately to the room who summoned the Nurse Supervisor to the room and ultimately, they decided to send Resident #1 to the ER. NA #1 stated that she had not been in Resident #1's room prior to NA #2 delivering the breakfast tray and discovering her swollen face but stated she had worked with her last Monday, and she was fine and had no bruising to her face at that time. NA #1 stated that Resident #1 had a bolster mattress (mattress with approximately 1-inch sides) but did not move around in the bed a lot. She explained that Resident #1 did not like to be turned from side to side, it was almost like she had a fear of falling and would push against you if you were turning her side to side. NA #1 added that Resident #1 did not appear to be in any pain and even when the Nurse Supervisor touched the left side of her face she did not flinch, moan, or grimace.

NA #2 was interviewed via phone on 03/15/23 at 12:34 PM who confirmed that she worked in the facility on 03/11/23 from 7:00 AM to 3:00 PM. NA #2 confirmed that when she arrived at work that morning there were no third shift NAs there to do walking rounds, so she and NA #1 began doing a round. At approximately 8:00 AM to 8:15 AM the

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breakfast trays arrived on the unit. She stated that she picked up Resident #1's breakfast tray and proceeded to her room. When NA #2 arrived the privacy curtain between the two beds was pulled so she pushed the curtain back and sat the breakfast tray on Resident #1's bedside tray and that is when she saw her face. She stated Resident #1's eye, lip, and cheek were swollen and bruised. She stated she walked back to the hallway and asked NA #1 to come and look at Resident #1 and asked her if she knew what had happened to Resident #1 and she replied "no." NA #2 stated she went and summoned Nurse #1 to the room and ultimately the Nurse Supervisor came as well. Nurse #1 and the Nurse Supervisor did not know what had happened because nothing had been reported that morning, so they decided to send Resident #1 to the ER. During the time that the staff were in Resident #1's room there were no signs that she was hurting, no moaning or groaning, guarding, or grimacing. NA #2 stated that when she delivered Resident #1's breakfast tray on 03/11/23 that was the first time she had seen or been in her room that day since there was no staff from night shift to do walking rounds.

Nurse #2 was interviewed via phone on 03/15/23 at 4:22 PM who confirmed that she worked in the facility on 03/10/23 from 7:00 PM to 7:00 AM and was responsible for Resident #1. Nurse #2 confirmed that the only time she interacted with Resident #1 was around 9:00 PM when she took her nighttime medications into her. She stated Resident #1 was in the bed and there was no bruising or swelling to her face. She stated that NA #3 and NA #4 worked at different times throughout the night shift, and she observed them on the hallway and in/out of resident rooms. She

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stated that no incident involving Resident #1 was reported to her throughout the shift and when she reported off to Nurse #1, she indicated that during the night there were no falls and to her knowledge all was well with the residents. Nurse #2 added that when she took Resident #1 her medications at 9:00 PM she had no verbal or nonverbal signs of pain or discomfort and was her usual self.

NA #3 was interviewed via phone on 03/15/23 at 4:05 PM who confirmed that she worked in the facility on 03/10/23 from 11:00 PM to 7:00 AM. She stated that initially when she reported to work, she was assigned a different unit but when another NA did not show up for work, she got pulled to assist on the unit where Resident #1 resided. She confirmed that she did not get any report when she took over the unit. NA #3 stated that she was only in Resident #1's room one time that night at around 3:30 AM and that was to provide incontinent care to her. She stated that when she went to the room to provide care Resident #1's roommate had a lamp at bedside that was on and there was enough light in the room to see so NA #3 did not turn the overhead light on. She stated that Resident #1 was in bed, and she explained to her that she was going to change her. She stated that she turned Resident #1 to one side (could not recall which side) tucked the soiled brief under her, then tucked the clean brief under her and returned Resident #1 to her back to remove the dirty brief from the other side and secure the clean brief. NA #2 stated that she was only in the room maybe 10 minutes and she was so focused on changing Resident #1 and getting to the next room because she had so many residents to look after that night. NA #3 stated she did not look at Resident #1's face and

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saw no bruising or swelling. NA #3 stated that Resident #1 did not fall out of bed on her shift, and she had no knowledge of how Resident #1 received the injuries that she did.

NA #4 was interviewed via phone on 03/15/23 at 2:59 PM who confirmed that he worked at the facility on 03/10/23 from 7:00 AM to 11:00 PM. NA #4 stated that this was his first day in the facility and one of the nurses had given him a brief orientation to the unit and brief information about the residents on the unit when he arrived. He confirmed that he recalled Resident #1 and stated that he provided her routine incontinent care and repositioning throughout the day as well as assisting her with meals. He explained that Resident #1 would scoot to the edge of the bed and each time he would pass by her room he would have to go in and move her back to the middle of the bed and he also lowered her bed as low as it would go. NA #4 also confirmed that Resident #1 had a fall mat to each side of her bed. NA #4 stated that he last saw Resident #1 around 10:30 PM and she was in bed in the same condition she had been throughout the day. He stated that she had no facial swelling or bruising and denied that Resident #1 had fallen out of the bed on his shift. He stated he had no knowledge of how Resident #1 received her injuries. NA #4 added that no NAs were present at change of shift for him to report off too, but he spoke to the nurse (cannot recall which nurse) and she told him he was ok to leave and signed his sign out sheet and he left the facility.

Review of a Weekly Skin Assessment dated 03/10/23 at 6:33 PM and completed by Nurse #3 revealed that Resident #1 skin was warm and dry, and no skin abnormalities were noted.

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Nurse #3 was interviewed on 03/15/23 at 12:04 PM who confirmed that she worked on 03/10/23 from 7:00 AM to 7:00 PM and was responsible for Resident #1. Nurse #1 confirmed that NA #4 worked on the unit with her that day and it was his first time in the building so she gave him a brief orientation to the unit and to the residents. Nurse #3 stated NA #4 did well throughout the day and she saw him going in/out of resident rooms providing incontinent care, assisting with meals, and answering call lights. Nurse #3 explained that on 03/10/23 Resident #1's roommate had some acute issues going on and she was in/out of their room several times throughout the shift. The last time Nurse #3 recalled being in Resident #1's room was at approximately 6:45 PM checking on Resident #1's roommate. She stated Resident #1 was in bed as she did not want to get up that day and was dressed in a top with a brief on and was covered with a blanket. Nurse #3 also stated that she completed a head to toe skin assessment on Resident #1 because it was scheduled to be done on her shift. The skin assessment revealed no skin issues and at the time of the skin assessment (documented at 6:33 PM) Resident #1 had no facial bruising or swelling. Nurse #3 stated she had cared for Resident #1 over the last couple of years and knew that she was very frightened of the edge of the bed and did move much from the center of the bed. She stated that on 03/11/23 around 8:30 AM the Nurse Supervisor called and asked Nurse #3 about Resident #1's injuries. Nurse #3 stated she had absolutely no idea what had happened because when she saw her last on 03/10/23 she was in bed and was her usual self.

Resident #1's family member was interviewed via

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phone on 03/15/23 at 10:07 AM who confirmed that Resident #1 remained in the ICU and continued to have a feeding tube that was inserted through her nares to provide nutritional support to Resident #1. The family member indicated that the hospital staff were able to get the bleeding on the brain stopped and were hoping that they could avoid having to do surgery on Resident #1's facial fractures, they were "hoping they would heal on their own." The family member recalled that on 03/11/23 they received a call from the nurse at the facility (did not know which nurse) letting the family know that Resident #1 was being transferred to the local ER for evaluation of some facial swelling and the nurse thought it was an abscessed tooth. The family member stated they agreed to the transfer and before they could get ready to go and meet Resident #1 at the ER the ER doctor called stated that Resident #1 had a subdural hematoma and multiple fractures of her face and the doctor was insistent that the injuries came from some type of injury or trauma. The doctor explained to the family member that they did not have a Neurologic Unit and wanted to transfer Resident #1 to another local hospital that a Trauma ICU for further treatment and of course the family member agreed.

Review of ER documentation from the local ER dated 03/11/23 read in part, clinical impression, and disposition: Subdural hematoma, multiple closed fractures of the facial bone. Patient presents for evaluation of facial swelling. On exam the patient is afebrile (without temperature) and vital signs are stable. She has significant swelling, ecchymosis (discoloration of skin resulting from bleeding underneath) to the left side of her face. Computerized Tomography (CT)

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scan was obtained and is notable for multiple facial fractures along with small subdural hemorrhage. The patient is hypertensive (elevated blood pressure), this fluctuated some but ultimately placed on Cardene (medication to treat high blood pressure) drip for blood pressure control in the setting of her hemorrhage. The Patient will be transferred to another facility for ongoing care relative to traumatic injuries. The report was electronically signed by the ER Physician.

The DON was interviewed on 03/15/23 at 3:33 PM, she stated that on 03/11/23 she was home and received a call from the Nurse Supervisor who stated that Resident #1 had been found to have a swollen face and indicated she thought something happened. The DON stated she asked the Nurse Supervisor what she thought, and the Nurse Supervisor indicated she was hoping that it was an abscessed tooth and indicated that they were sending her to the ER. The DON stated that within an hour and a half another staff member had called and stated that Resident #1 had facial fractures, subdural hematoma, and bruising on the inside and outside of her mouth. The DON stated she immediately got up called the Administrator and came to the facility to begin an investigation. The DON stated that when she arrived at the facility Resident #1 was already at the ER, but they began the investigation of injury of unknown origin. She stated she pulled her management team together and they began interviewing all the involved staff members while other managers and supervisors began education on abuse, neglect, and falls or accidents. All residents who were cognitively intact were interviewed to determine if any other abuse had occurred and the non-cognitively intact residents

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	345250	A. BUILDING _____ B. WING _____	C 03/17/2023

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had a weekly skin assessment done to determine if there were any additional injuries. The DON stated that no other findings were noted during the interviews or skin assessments. The DON stated that they reported the incident to the State Survey agency and notified local law enforcement. In addition to the education that was completed they also implemented a walking round sheet for oncoming and off going nurses to go from room to room and visualize each resident at the beginning and end of their shift and then they each signed the form. Additionally, the DON stated she reviewed the last three months of incident reports to ensure that no potential abuse situations were missed, and none were identified. The DON stated that on 03/13/23 they had a Quality Assurance Performance Improvement (QAPI) meeting and further discussed the incident and what they were doing to correct the issue. Going forward the DON stated she would be doing several different types of audits and monitoring to ensure that the plan they put into place was effective that included monitoring weekly skin assessments, monitoring all incident reports in daily clinical meeting, and monitoring the walking round sheets to ensure the staff were compliant.

The Administrator was interviewed via phone on 03/17/23 at 10:02 AM and confirmed that on 03/11/23 at approximately 11:00 AM the DON called her to report that Resident #1 had been transferred to the ER for evaluation of facial swelling and was found to have multiple facial fractures and a hematoma. The Administrator stated she immediately came to the building and while enroute called the facility and had the staff to begin obtaining witness statements. When the Administrator arrived at the facility Resident #1

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was already in the ER but she went to her room to see the environment to see if that would help her piece together what had occurred. She stated that they called staff and interviewed them over the phone then had them come to the facility to re-interview them and no one was owning up to having any knowledge of what had happened with Resident #1. The Administrator stated they interviewed and/or completed a skin assessment on all residents to determine if there were other injuries of unknown source, they began reviewing the last sixty days of incident reports to ensure no other injuries were missed. The Administrator stated she completed and submitted a twenty-four-hour initial investigation to the State Survey agency and also notified local law enforcement as well as Adult Protective Services. The Administrator stated that they obtained a timeline from each employee, so they knew who was in Resident #1's room and when but again the interviews did not provide clues as to what had occurred. She added that they spoke to other alert and oriented residents on the unit and none of them heard anything unusual that night. Two employees were asked to not return to the facility and the Administrator stated she was going to substantiate the allegation of injury of unknown origin but did not have an alleged suspect. The DON and other management team was responsible for conducting the audits and monitoring and turning them into the Administrator weekly for her review and then would be presented to the facility's QAPI committee.

The ER Physician was interviewed via phone on 03/17/23 at 1:25 PM and confirmed that she assisted in treating Resident #1 in the local ER on 03/11/23. Initially the patient was brought in for

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facial swelling that the facility staff had noticed that morning. The ER Physician stated obviously her left side of her face was very swollen and a CT scan was done and showed a small brain bleed, multiple left side facial fractures, and bleeding under the skin. The ER Physician also stated that her colleague had called the facility to inquire if the resident had a fall and the staff stated that there had been no fall reported. She added that Resident #1 was bed bound and her extensive injuries would have come from either a fall or some type of trauma. Given the bluish color of her bruising she would estimate the injury to have occurred in the past two days. The fractures were very indicative of some type of trauma and the type of brain bleed that Resident #1 had was more likely caused from trauma than a spontaneous bleed. She stated that when Resident #1 arrived in the ER her blood pressure was very high so they began treating it with intravenous (IV) drip medication and generally they would repeat the CT scan in six to eight hours to see if the brain bleed was getting bigger which may necessitate surgery but Resident #1 was transferred to high level care before the CT scan could be repeated. The MD explained that with multiple trauma injuries and a head bleed that patient needs to be evaluated by a trauma specialist and combined with the fact that they did not have a maxillofacial surgeon to assess her injuries really is what necessitated the transfer to a higher level of care.

The facility provided the following corrective action plan with a completion date of 03/13/23:

Corrective Action that will be accomplished:

On 03/11/23, upon notification of the change in

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condition by assigned nurse aide, the resident was immediately assessed by the license nurse, and an order obtained for evaluation at the emergency department.

All residents in the facility were interviewed or assessed on or before 03/13/23 by the Director of Nursing and/or assigned licensed nurse to identify any additional injury or unreported incidents with no additional concerns identified.

Resident incidents for the past sixty days were reviewed by the Director of Nursing and Nursing Home Administrator on or before 03/13/23 to ensure timely notification and follow up occurred with no additional concerns identified; any previous injury of unknown origin had timely follow up at the time of discovery.

Measures for systemic change:

On or before 03/13/23 facility all staff were educated on abuse reporting policy and expectations to include injuries of unknown origin, proper communication of incident and changes in condition, and assessment of resident following any incident by the Director of Nursing/designee. This education will include new hires, and agency staff to be delivered prior to accepting assignments.

Education provided by the Director of Nursing/designee, for licensed nurses to include expectations for shift to shift rounding, including completion of Nurse Rounding Log, and abuse reporting policy and expectations to include injuries of unknown origin.

Education also included proper communication of

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incidents and changes in condition, and assessment of residents following any incident to be completed on or before 03/13/23. This education will include new hires and agency staff to be delivered prior to accepting assignments.

How corrective action will be monitored:

Beginning week of 03/13/23, Director of Nursing or Assistant Director of Nursing will monitor clinical meeting and white board review of five incidents per week for eight weeks to ensure proper documentation, notification, assessment and follow up for any resulting change in condition has been carried out, to include immediate provider notification.

Beginning week of 03/13/23 Director of Nursing or Assistant Director of Nursing will review weekly skin assessment of five random residents per week for eight weeks to ensure appropriate follow up any new or unusual findings.

Beginning week of 03/13/23, licensed nurses will document shift to shift reporting communication on the Nurse Rounding Log. Director of Nursing, Assistant Director of Nursing, or Nurse Supervisor will validate the appropriate shift to shift communication by reviewing Nurse rounding log daily for two weeks and then at least twice weekly for four weeks.

The Director of Nursing will review the audits to identify patterns/trends and will adjust the plan to maintain compliance.

The Director of Nursing will review the plan, with IDT, during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI

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F 600	Continued From page 18 committee. The Corrective action plan was validated on 03/15/23 and concluded the facility had implemented the plan effective 03/13/23. The facility educated all staff on abuse, neglect, and injuries of unknown origin, the education material and employee signature sign in sheets along with staff interviews were used to verify the education had been provided. The facility implemented a walking round sheet that licensed nursing staff were educated to use at the beginning and end of their shift. The walking round sheets were reviewed and licensed nursing staff interviews confirmed that they had been educated and instructed on how and when to use the walking round sheet. The staff were also educated on reporting of any fall or incident with resident immediately to the licensed nurse to ensure timely assessment, treatment, notification and documentation of the occurrence. Interviews with licensed nursing staff confirmed education had been provided and they verbally reported understanding of what needed to occur if a resident fell, or abuse was reported. The facility submitted a 24 hour initial report to the State Survey agency and began, conducted and concluded their investigation of the injury of unknown origin. All documentation used for reporting was reviewed with no issues noted.	F 600		