STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285124	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR CARE CENTERS-NELIGH LLC	**PO BOX 66, 1100 NORTH T STREET NELIGH, NE 68756**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D7 Based on observations, record review and interview; the facility failed to develop and/or revise interventions for the prevention of falls for Resident 17 who was assessed to be at risk for falls. The sample size was 3 and the total facility census was 30. A. Review of the facility policy Fall Prevention and Fall Leaf Program with a revision date 2/20 revealed at the time of admission, a Fall Risk Assessment was to be completed to determine a resident's risk for falls. If the resident had a score of 10 or greater the Fall Leaf Program would be initiated and a Fall Risk Care Plan would be developed. A Fall Leaf was to be placed on the door of a resident with a score of 10 or greater or if the resident had 1 or more falls in the past 3 months. Should a resident incur a fall, a Fall Incident and Investigation report was to be completed and an interdisciplinary review would be conducted to determine the need for additional fall prevention interventions and/or revision of current interventions. B. Review of Resident 17's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 10/8/19 revealed [DIAGNOSES REDACTED]. Additionally, Resident 17 had impaired cognitive function and required extensive assistance with ambulation, bed mobility, transfers, dressing, toileting, and personal cares. Review of Resident 17's admission Fall Risk assessment dated [DATE] revealed the resident's fall risk score was an 11. Additional instructions on the Fall Risk Assessment tool indicated if the total score was 10 or greater, the resident should have been considered at high risk for potential falls and a prevention protocol should have been initiated immediately and documented on the Care Plan. Review of Resident 17's Care Plan dated 10/30/19 did not include the resident's risk for falls or interventions to prevent falls. Review of an updated Care Plan with revision date 11/7/19 indicated Resident 17 was at risk for falls related to confusion, unaware of safety needs, and wandering. Nursing interventions included the following: -anticipate and meet the resident's needs; -be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident was to receive prompt response to all requests for assistance; -encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility; -ensure the resident was wearing appropriate footwear and using walker; -Physical Therapy (PT) to evaluate and treat as ordered or as needed; and -6/23/20 sensory alarm at all times in bed and chair. Review of a facility Fall Incident and Investigation Report dated 1/1/20 at 4:30 AM revealed Resident 17 was found on the floor next to the bed with the resident's right hand on the walker and all bedding on the floor. The resident had attempted to self-transfer from the bed. The resident sustained [REDACTED]. No new interventions for fall prevention were developed and added to the resident's Care Plan. Review of a facility Fall Incident and Investigation Report dated 1/3/20 at 8:25 PM revealed Resident 17 was discovered sitting on the floor of the resident's room. The resident reported slipping out of the chair. The report also noted Resident 17 required assistance with Activities of Daily Living (ADL's) and had poor safety awareness. The room was re-arranged for better visualization of the resident while seated in the recliner. The Care Plan was not updated with the intervention. Review of a facility Fall Incident and Investigation Report dated 1/5/20 at 10:00 AM revealed Resident 17 had attended the church service and was sitting in a rocking chair rocking, then was observed on the floor. The resident was to attend church services using a wheelchair to ensure safety. The Care Plan was not updated with the intervention. Review of a Fall Incident and Investigation Report dated 1/9/20 at 2:59 PM revealed Resident 17 was seated on the floor in front of the recliner. The foot rest of the recliner remained extended. Staff were educated to leave the foot rest of the recliner down as the resident had had poor safety awareness and had not been using the call light for assistance. The Care Plan was not updated with the intervention. Review of a Fall Incident and Investigation Report dated 1/10/20 at 6:55 AM revealed a staff member heard the resident's alarm sounding and noted the resident on the floor with a sheet wrapped around the resident. The alarm was on and functioning. The resident sustained [REDACTED]. A request for the physician to review the resident's medications was submitted due to increased falls. The Care Plan was not updated with the intervention. Review of a Fall Incident and Investigation Report dated 1/28/20 at 7:23 PM revealed Resident 17 was in the hallway across from the resident's room when a nurse heard the sensor alarm sounding. The staff visualized the resident sit down on the floor. The resident was noted to have poor safety awareness and failed to wait for assistance to stand and ambulate. Anti-rollback bars (a device designed to prevent a wheelchair from rolling back and away from the user as they attempt to sit down or stand up from the wheelchair) were to be placed on the wheelchair. The Care Plan was not updated with the intervention. Review of a facility Fall Incident and Investigation Report dated 3/16/20 at 3:34 PM revealed Resident 17 was sitting on the floor with the alarm sounding. The resident's bed was in the low position and a floor mat was next to the bed. The resident's Care Plan did not identify use of the fall mat or that the resident's bed was to be in the lowered position. Review of a facility Fall Incident and Investigation Report dated 5/13/20 at 1:30 AM revealed Resident 17 was found lying on the floor mat next to the bed. An alarm was placed on the bed to alert staff if the resident was restless. The Care Plan was not updated with the intervention. Review of a facility Fall Incident and Investigation Report dated 7/5/20 at 5:10 AM revealed upon entering Resident 17's room, the resident was observed rolling off the edge of the bed onto the floor mat. The bed alarm was on and sounded. No new interventions were developed or updated on the Care Plan. Review of a facility Fall Incident and Investigation Report dated 7/19/20 at 7:30 PM revealed a staff member heard Resident 17's alarm sound. Upon arrival, Resident 17 was found lying on the resident's right side with the resident's head under the wheelchair. The resident sustained [REDACTED]. The resident also had a bruise which measured 3.2 cm by 2.5 cm located on the outer left arm. The resident was to be assisted to the recliner after the supper meal. The Care Plan was not updated with the fall intervention. An interview with the Administrator on 8/6/20 from 7:55 AM to 8:15 AM, confirmed when the resident was assessed at a high risk for falls upon admission, fall interventions should have been addressed and implemented on the resident's Care Plan. The Administrator also confirmed the facility had not updated the resident's Care Plan with each of the resident's falls and with new and/or revised fall prevention interventions.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.09 Based on observations, interviews, and record reviews; the facility failed to provide care and services for Resident 17 related to fluid retention and to identify/assess and monitor bruising for Resident 2 The sample size was 2 and the facility census was 30. Findings are: A. Review of the Policy titled Skin Assessment with a revision dated of 2/20 revealed when completing a skin assessment, staff were to note any skin conditions

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

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers and [MEDICAL CONDITION]. B. Review of Resident 2's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 5/7/20 revealed [DIAGNOSES REDACTED]. The resident was cognitively intact and required assistance with bed mobility, transfers, dressing, toilet use and hygiene. Review of Resident 2's current undated Care Plan revealed the resident was on an anticoagulant (medication used to thin blood in an effort to reduce the risk of [MEDICAL CONDITION]) therapy. Nursing interventions included: -apply prolonged pressure to venipuncture sites as needed; -avoid activities which could lead to injury; and -monitor, document and report adverse effects including blood tinged or red urine, black tarry stools, sudden severe headaches, lethargy and bruising. During interview on 8/3/20 at 1:49 PM, the resident identified having pain to bilateral arms. Resident 2 pointed out dark purple bruising to the top of right hand, to left forearm, top of left hand and below the left elbow. Resident 2 indicated the bruising was related to staff attempting to draw the resident's blood. During observation on 8/3/20 at 2:00 PM, the resident had a large, dark purple bruise below the left elbow to the left forearm and dark purple bruising to the tops of both the right and left hand. There was no evidence in the medical record that the facility identified the presence of bruising to Resident 2's left elbow/forearm and bilateral hands, assessed and then documented the assessment in order to monitor ongoing healing of areas. During interview on 8/5/20 at 10:48 AM, the Director of Nursing verified there was no documentation related to bruising for Resident 2. Review of a Nursing Progress Note dated 8/5/20 at 1:45 PM revealed the following areas of bruising: -left forearm which measured 6 centimeters (cm) by 5 cm; -top of left hand which measured 2.7 cm by 3 cm -below left elbow which measured 1.9 cm by 1.9 cm; and -top of right hand which measured 4.2 cm by 2.7 cm. The note further indicated the probable cause of the bruising was repeated attempts on 7/31/20 to obtain a sample of blood for testing. C. Review of Resident 17's MDS dated [DATE] revealed [DIAGNOSES REDACTED]. The resident's cognitive function was impaired and needed extensive assistance with dressing, bed mobility, transfers, toilet use and personal cares. Review of Resident 17's electronic physician order [REDACTED]. An interview with NA-D on 8/4/20 at 2:30 PM confirmed Resident 17 was wearing socks and shoes. NA-D was not aware the resident should have been wearing [MEDICAL CONDITION] Wear. An observation on 8/5/20 at 7:30 AM revealed Resident 17 was seated in a wheelchair wearing ankle socks and shoes and no [MEDICAL CONDITION] Wear was on. Resident 17's legs were in a dependent position and [MEDICAL CONDITION] was present to the resident's lower legs. An interview with LPN-B on 8/5/20 at 7:32 AM confirmed Resident 17 was not wearing [MEDICAL CONDITION] Wear because the resident's [MEDICAL CONDITION] Wear was in the laundry and would attempt to put them on the resident sometime this AM when they were returned from the laundry. In addition, LPN-B reported Resident 17 sometimes tried to remove the [MEDICAL CONDITION] Wear or refused to wear them. LPN-B reported when this happened it was documented on the TAR (Treatment Administration Record) and an entry was made in the resident's Progress Notes about the refusal. An observation on 8/5/20 at 11:30 AM revealed Resident 17 was wearing ankle socks and shoes without [MEDICAL CONDITION] Wear on. An observation on 8/6/20 at 8:30 AM showed the resident was sitting up in a wheelchair with [MEDICAL CONDITION] Wear on the resident's left leg and the right leg had only an ankle sock and shoe on. [MEDICAL CONDITION] was also observed on Resident 17's lower right leg. Review of Resident 17's Progress Notes revealed the following entries regarding the administration of the resident's [MEDICAL CONDITION] Wear: -7/9/20 at 7:14 PM unavailable -7/13/20 at 7:15 PM unavailable -7/14/20 at 1:56 PM unavailable -7/19/20 at 9:28 AM unavailable -7/21/20 at 2:57 PM unavailable -7/23/20 at 9:25 AM not on -7/27/20 at 8:37 AM not available -7/28/20 at 9:37 AM unavailable -7/30/20 at 2:43 PM unavailable -7/31/20 at 2:01 PM not available -8/4/20 at 10:20 AM no [MEDICAL CONDITION] Wear at this time, in laundry During an interview on 8/6/20 at 07:55 AM with the administrator, the administrator confirmed the resident's progress note entries had noted the resident's [MEDICAL CONDITION] Wear was not available or unavailable. The administrator also noted sometimes the resident had refused to wear the [MEDICAL CONDITION] Wear and this should have been documented as such in the resident's progress notes. In addition, the administrator confirmed staff should have requested additional sets of [MEDICAL CONDITION] Wear so they would be available.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D7(a) (b) Based on observations, interview and record review; the facility failed to implement fall interventions, to identify causal factors of falls, and to develop and/or revise fall prevention interventions for the prevention of ongoing falls for Resident 34. The sample size was 3 and the total facility census was 30. Findings are: A. Review of the facility policy Fall Prevention and Fall Leaf Program with a revision date 2/20 revealed at the time of admission, a Fall Risk Assessment was to be completed to determine a resident's risk for falls. If the resident had a score of 10 or greater, the fall leaf program would be initiated. The Fall Risk Assessment was to be completed quarterly, annually and with any significant change in condition. A Fall Leaf was to be placed on the door of a resident with a score of 10 or greater or if the resident had 1 or more falls in the past 3 months. Should a resident incur a fall, a Fall Incident and Investigation report was to be completed and an interdisciplinary review would be conducted to determine need for additional fall prevention interventions and/or revision of current interventions. B. Review of Resident 34's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 5/20/20 revealed the following: -severe cognitive impairment; -extensive assistance with bed mobility, transfers, dressing and toilet use; -unsteady and only able to stabilize with human assistance when moving from a seated to standing position, while walking, when turning around and facing the opposite direction while walking, when moving on and off the toilet, and during surface-to-surface transfers (between bed and chair or wheelchair); and -occasionally incontinent of bowels and bladder. Review of the undated current Care Plan indicated Resident 34 was at risk for falls and had poor safety awareness. Nursing interventions included the following: -limited to extensive assistance with transfers and ambulation; -4/7/20 Physical Therapy (PT) to evaluate and treat; -provide a clutter free environment; -provide a well lit environment; -sensor alarm at all times (bed and chair); and -video monitor in room for safety awareness. Review of a Fall Risk Evaluation dated 3/28/20 at 8:10 PM revealed the resident was at high risk for falls. Review of a Fall Incident and Investigation report dated 3/28/20 at 8:10 PM revealed the resident's fall alarm sounded and when staff responded, the resident was found on the floor in front of the wheelchair. The report indicated the resident had poor safety awareness with a history of falls. No causal factors were identified and no new interventions were developed. Review of a Fall Incident and Investigation report dated 4/2/20 at 4:15 AM revealed the resident was found on the floor. The report further revealed the sensor alarm was not intact. The resident sustained [REDACTED]. Staff replaced the batteries and when checked, the alarm was now functioning properly. Review of a Fall Incident and Investigation report dated 4/9/20 at 2:30 AM revealed the resident's alarm was sounding and staff found the resident on the floor in front of the bathroom. The resident was incontinent of urine. The report indicated the sensor alarm and a video monitor were in use at the time of the resident's fall. The resident sustained [REDACTED]. The resident was screened by PT on 4/10/20 and therapy was initiated for unsteadiness and decreased strength. Review of a Fall Incident and Investigation Report dated 4/24/20 at 7:01 PM revealed staff entered the resident's room in response to the roommate's call light. Upon entering the room, the resident's fall alarm was heard and the resident was found on the floor. No causal factors were identified and no additional fall interventions were put into place. Review of a Fall Incident and Investigation report dated 5/19/20 at 8:40 AM revealed the resident had attempted to self-transfer, lost balance and then sat on the floor. The resident was having loose stools and was incontinent of stool. review of the resident's medical record revealed [REDACTED]. Review of a Nursing Progress Note dated 5/20/20 at 2:36 AM revealed the resident's fall alarm was sounding and the resident was standing in the middle of the resident's room with disposable incontinent brief around the resident's ankles. The resident had been involuntary of loose stool. review of the resident's medical record revealed [REDACTED]. Review of a Fall Incident and Investigation report dated 5/26/20 at 9:00 PM revealed the resident's call light was on and the fall alarm was sounding. The resident was found on the floor, next to the resident's bed with the resident's head underneath of the wheelchair. The resident had attempted to self-transfer without locking the wheelchair's brakes. The resident sustained [REDACTED]. A screen was sent to therapy for anti-roll back bars (a device designed to prevent a wheelchair from rolling back and away from the user as they attempt to sit down or stand up from the wheelchair) to be placed on the wheelchair. Review of a Fall Incident and Investigation report dated 6/1/20 at 11:45 AM revealed the resident had self-transferred in room. The resident's roommate told the resident to sit down, and the

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) resident sat on the floor. No causal factors were determined related to the resident's self-transfer, no current interventions were revised and no further interventions developed. Review of a Fall Incident and Investigation report dated 6/2/20 at 8:45 PM revealed the resident's fall alarm was sounding and the staff heard the resident fall as they approached the resident's room. The resident sustained [REDACTED]. The report indicated the facility was awaiting anti-roll back bars for the resident's wheelchair and the bars were on order. Staff were encouraged to assist the resident to the bathroom after the evening meal and then into the recliner. Review of an Occupational Therapy (OT) Plan of Care dated 6/3/20 revealed the resident was seen due to positioning deficit as the resident was unable to reach the floor to self-propel with falls related to attempts to self-transfer. There was no evidence OT evaluated the resident's wheelchair for anti-roll back bars or that the bars had been ordered. Review of a Fall Incident and Investigation report dated 6/15/20 at 9:50 AM revealed the staff were assisting the resident with ambulation, the resident attempted to sit without a chair and then was lowered to the floor. During observations of Resident 34 on 8/3/20 at 9:37 AM, 10:43 AM and at 1:10 PM and on 8/4/20 at 1:10 PM there was no video monitor in the resident's room and there was no Falling Leaf observed on or around the resident's door to indicate the resident was at risk for falls. During an interview on 8/4/20 at 1:15 PM, Nurse Aide (NA) - C confirmed Resident 34 did not have a Falling Leaf on the resident's room door to indicate the resident was at risk for falls and there was no video monitor in the resident's room. Interview with the Director of Nursing on 8/5/20 at 11:13 AM confirmed the following: -with falls on 3/28/20 at 8:10 PM, 4/24/20 at 7:01 PM and on 6/1/20 at 11:45 AM, no causal factors were identified, current fall interventions were not revised and no new interventions were developed; -direct care staff were to monitor the placement and function of the fall alarms every shift. With the resident's fall on 4/2/20 at 4:15 AM there is no documentation to indicate when staff last checked the resident's alarm to determine if the alarm was functioning properly; -with fall on 5/19/20 at 8:40 AM, no new interventions were developed and current interventions were not revised; -an intervention was identified with the resident's fall on 5/26/20 at 9:00 PM for anti-roll back bars to the resident's wheelchair. No anti-roll back bars were placed on the resident's wheelchair; and -no Fall Incident and Investigation report was completed after the resident's fall on 5/20/20 at 2:36 AM, current interventions were not revised and no new interventions developed. C. Review of Resident 17's MDS dated [DATE] revealed [DIAGNOSES REDACTED]. Additionally, Resident 17 had impaired cognitive function and required extensive assistance with ambulation, bed mobility, transfers, dressing, toileting, and personal cares. Review of Resident 17's admission Fall Risk assessment dated [DATE] revealed the resident's fall risk score was an 11. Additional instructions on the Fall Risk Assessment tool indicated if the total score was 10 or greater, the resident should have been considered at high risk for potential falls and a prevention protocol should have been initiated immediately and documented on the Care Plan. Review of Resident 17's Care Plan dated 10/30/19 did not include the resident's risk for falls or interventions to prevent falls. Review of an updated Care Plan with revision date 11/7/19 indicated Resident 17 was at risk for falls related to confusion, unaware of safety needs, and wandering. Nursing interventions included the following: -anticipate and meet the resident's needs; -be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident was to receive prompt response to all requests for assistance; -encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility; -ensure the resident was wearing appropriate footwear and using walker; -Physical Therapy (PT) to evaluate and treat as ordered or as needed; and -6/23/20 sensory alarm at all times in bed and chair. Review of a facility Fall Incident and Investigation Report dated 1/1/20 at 4:30 AM revealed Resident 17 was found on the floor next to the bed with the resident's right hand on the walker and all bedding on the floor. The resident had attempted to self-transfer from the bed. The resident sustained [REDACTED]. No new interventions for fall prevention were developed. Review of a facility Fall Incident and Investigation Report dated 1/3/20 at 8:25 PM revealed Resident 17 was discovered sitting on the floor of the resident's room. The resident reported slipping out of the chair. The report also noted Resident 17 required assistance with Activities of Daily Living (ADL's) and had poor safety awareness. The room was re-arranged for better visualization of the resident while seated in the recliner. Review of a facility Fall Incident and Investigation Report dated 1/5/20 at 10:00 AM revealed Resident 17 had attended the church service and was sitting in a rocking chair rocking, then was observed on the floor. The resident was to attend church services using a wheelchair to ensure safety. Review of a Fall Incident and Investigation Report dated 1/9/20 at 2:59 PM revealed Resident 17 was seated on the floor in front of the recliner. The foot rest of the recliner remained extended. Staff were educated to leave the foot rest of the recliner down as the resident had had poor safety awareness and had not been using the call light for assistance. Review of a Fall Incident and Investigation Report dated 1/10/20 at 6:55 AM revealed a staff member heard the resident's alarm sounding and noted the resident on the floor with a sheet wrapped around the resident. The alarm was on and functioning. The resident sustained [REDACTED]. A request for the physician to review the resident's medications was submitted due to increased falls. Review of a Fall Incident and Investigation Report dated 1/28/20 at 7:23 PM revealed Resident 17 was in the hallway across from the resident's room when a nurse heard the sensor alarm sounding. The staff visualized the resident sit down on the floor. The resident was noted to have poor safety awareness and failed to wait for assistance to stand and ambulate. Anti-rollback bars were to be placed on the wheelchair. Review of a facility Fall Incident and Investigation Report dated 3/16/20 at 3:34 PM revealed Resident 17 was sitting on the floor with the alarm sounding. The resident's bed was in the low position and a floor mat was next to the bed. Review of a facility Fall Incident and Investigation Report dated 5/13/20 at 1:30 AM revealed Resident 17 was found lying on the floor mat next to the bed. An alarm was placed on the bed to alert staff if the resident was restless. Review of a facility Fall Incident and Investigation Report dated 7/5/20 at 5:10 AM revealed upon entering Resident 17's room, the resident was observed rolling off the edge of the bed, onto the floor mat. The bed alarm was on and sounded. No new interventions were developed and current interventions were not revised to prevent further falls. Review of a facility Fall Incident and Investigation Report dated 7/19/20 at 7:30 PM revealed a staff member heard Resident 17's alarm sound. Upon arrival, Resident 17 was found lying on the resident's right side with the resident's head under the wheelchair. The resident sustained [REDACTED]. The resident also had a bruise which measured 3.2 cm by 2.5 cm located on the outer left arm. The resident was to be assisted to the recliner after the supper meal. During observations on 8/4/20 at 7:10 AM, 8:40 AM, 2:03 PM and 2:30 PM and on 8/5/20 at 7:30 AM and 11:30 AM, there was no Fall Leaf observed on or around Resident 17's door to note the resident was at risk for falls. During an observation on 8/4/20 at 7:10 AM Resident 17 was sitting in the recliner in the resident's room with the foot rest extended. An interview with the Administrator on 8/6/20 from 7:55 AM to 8:15 AM, confirmed when the resident was assessed at a high risk for falls upon admission, fall interventions should have been developed and also indicated fall prevention interventions should have been implemented to prevent further falls for the resident.