STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145070	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GROVE OF BERWYN, THE	**3601 SOUTH HARLEM AVENUE BERWYN, IL 60402**

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 0684 **Level of harm -** 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** Based on observation, interview and record review the facility failed to implement its wound care prevention and management program policy by failure to provide ongoing clinical assessment, documentation, notification of physician for any skin changes to obtain appropriate treatment, wound pain assessment and care plan evaluation and revision. This failure resulting to necrosis/gangrene of bilateral feet and transfer to the hospital for further evaluation and treatment. This deficiency affects one (R1) of two residents reviewed for wound care management. Findings include: On 3/10/20 at 1:41pm, V3 (Family member) stated that she informed the nurse (she cannot remember the name but able to recognize her when she sees her) 2 weeks ago of R1's skin discoloration on right foot and nothing was done. Her both feet got worse and became necrotic/gangrene. No wound treatment/dressing was provided to R1. On 3/10/20 at 10:34am, R1 is lying across the bed with both lower extremities hanging from the bed and both feet touching the floor. No socks on right foot exposing 100% necrotic/gangrene great toe, 2nd and 3rd toes with dried open wound and with long toe nails. Foul smelling odor coming the gangrene toes. Right foot swollen/[MEDICAL CONDITION], reddened and dry skin. She is very sleepy unable to maintain conversation. V7 (Licensed Practical nurse) stated that she is not familiar with R1, she is floated to different units. She does not know if she has wound treatment. V7 assessed R1's necrotic/gangrene right foot. R1 complained of pain as she touches her right foot. V7 stated that she has 100% necrotic/gangrene tissues on Right great toe, 2nd and 3rd toes. Her entire right foot is cold to touch. Foul smelling coming from necrotic/gangrene toes. She removed the sock on her left foot and observed necrotic tissue on left great toe, 2nd and 3rd toe. No open wound noted. Left foot swollen. R1 complained of pain when she touches her left foot. She stated the left foot is cold to touch too. She stated that she will call V9 Wound care nurse. V7 LPN stated that she has not given her medication yet because she is lethargic. On 3/10/20 at 10:38am, V8 (Certified Nurse Assistant) stated that she is regularly taking care of her and has not seen her with bilateral feet dressing. Her black skin discoloration on her both feet/toes are the same no changes. She cannot remember when she developed it, but it has been there. On 3/10/20 at 10:51am, V7 (LPN) gave R1 her morning medications but was not given pain medication as needed. On 3/10/20 at 11:11am, V9 (Wound care Coordinator) stated that R1 was admitted on [DATE] with skin intact. She stated that she documented on 3/5/20 the necrotic/eschar 100% on right foot 2nd and 3rd digit tips. No other skin issues noted during assessment. She stated that she notified V12 (Nurse Practitioner) and informed V3 (Family member). Reviewed R1's medical record with V9 indicated re-admission comprehensive assessment dated [DATE] indicated skin assessment intact, podiatric- no problem with feet. No comprehensive skin evaluation was done on 3/5/20. On 3/6/20 R1's physician order [REDACTED]. with dry dressing once daily/PRN if loose or soiled every day shift to promote healing ordered by V13 (Primary care Physician). R1 was not seen by wound care physician. On 3/10/20 at 12:01pm, Observed V9 (Wound care coordinator) performed wound treatment to R1. She assisted R1 from sitting on bed to lying position. R1 complained of pain as she touches and position her both feet. She cleanses left foot with wound cleanser. She applied Vit A and D to dry skin of entire foot. R1 complained of pain and moans x 5, stating ouch. She wrapped the 100% necrotic/gangrene great toe, 2nd and 3rd toe with [MEDICATION NAME]-soaked gauze and wrapped it with dry gauze bandage. R1 complained of pain as she wrapped the left toes. She cleanses the right foot with wound cleanser. R1 complained of pain as she cleans the right toes. She applied Vit A and D ointment to dry skin of entire right foot. R1 complained of pain. She wrapped the 100% necrotic/gangrene right great toe, 2nd and 3rd with [MEDICATION NAME]-soaked gauze and wrapped it with dry gauze bandage. R1 complained of pain and moans x 6 as she applied the gauze, stated ouch. She positions R1 on sitting position and applied both socks. R1 complained of pain as she applied her socks. On 3/11/20 at 9:30am, V9 (Wound care coordinator) stated that she did not document wound assessment done with R1's yesterday and did not call V12 (Nurse Practitioner) or V13 (Primary care Physician) for new order of increased progress of 100% necrotic/gangrene tissues of Right foot to great toe, 2nd and 3rd; and Left foot great toe, 2nd and 3rd toe. No comprehensive skin evaluation was done. V7 (LPN) did not documented assessment done with R1 bilateral necrotic feet and did not call V12 or V13. On 3/11/20 at 9:58am, V12 (Nurse Practitioner) stated that she sees R1 for V13 Primary Care physician. She has seen R1 several times since admission. She comes to the facility on daily basis and will ask floor nurses if she needed to see assigned residents for any clinical conditions that needed to be addressed. She is not aware of R1's necrotic/gangrene toes on both feet. Reviewed R1's progress notes documented by V12 indicated that all her 12 visits from admission, she documented: Ext- no redness or swelling to feet, no BLE [MEDICAL CONDITION] and skin intact. She admitted she did not perform physical examination of R1's BLE. She was notified of her leg pain upon standing and addresses the concern when she visited her on 2/26/20. She did not assessed/examined R1's BLE but ordered doppler ultrasound for BLU. Reviewed R1's Arterial ultrasound of bilateral extremities dated 2/26/20 with V12 indicated: History: Swelling if limb. Impression: mild to moderate [MEDICAL CONDITION] without occlusion, bilateral lower extremities. Surveyor requested V12 and V9 (Wound care coordinator) to examine R1's bilateral necrotic/gangrene feet. On 3/11/20 at 10:17am, R1 lying on bed, undressed gown and loosen disposable brief but covered with blanket. She is sleepy but responsive. She complained of pain as V9 (Wound care coordinator) repositioned her on bed. V9 removed right sock, R1 complained of moans and flexed her right leg when she touched her. V9 removed right foot dressing. Observed necrotic/gangrene of right great toe, 2nd and 3rd toes 100% with dried open wound and with long toe nails. R1 moans and complained of pain as V12 (Nurse practitioner) assessed her right foot. V12 stated I was informed that she is in this condition. She stated that R1 has necrotic/gangrene on right great toe, 2nd and 3rd toes with dried open wounds and foul-smelling odor coming from the gangrene toes. Entire foot/ankle swollen, reddened and cold to touch. V9 removed left sock and wound dressing. Again, R1 moans and complained of pain as she touches her. V12 assessed R1's left foot and stated her great toe, 2nd and 3rd toes 100% necrotic/gangrene, no open areas and with long toe nails. Foot and ankle swollen, reddened and cold to touch. V12 stated that she will call V13 (Primary Care Physician) to update with R1's clinical condition. On 3/11/20 at 10:56am, R1 sleepy but responsive and stated that she has pain rate of 10/10 on her bilateral feet. She stated that she has not received yet her morning and pain medication. On 3/11/20 at 12:50pm, V12 Nurse Practitioner stated that she spoke with V12 Primary care physician and discussed R1's increased progression of necrotic/gangrene on both feet and order to send her to hospital for further evaluation and management. On 3/11/20 at 2:41pm, V9 Wound care coordinator stated that she does wound treatment for [REDACTED]. She stated that she asked both V7 (LPN) and V16 (RN), who worked on 3/10/20 and 3/11/20 to give R1 her pain medication 1-hour prior her wound dressing. When asked what time she asked V7 and V16 to give her medication, she stated she cannot remember for V7 but for V16 she asked around 8:15am. Reviewed R1's MAR (Medication administration record) for March 2020 indicated that R1 was not given PRN (as needed) pain medication . R1's physician order [REDACTED]. She stated that she will write a standing order for pain medication of R1, 1 hour prior to wound treatment. On 3/11/20 at 2:53pm, V13 Primary care physician stated that he expected

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145070	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GROVE OF BERWYN, THE	3601 SOUTH HARLEM AVENUE BERWYN, IL 60402

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 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) that the nursing staff will call him for any changes in resident condition and follow the facility's protocol in wound management. He stated that R1's possible embolism of BLE causing occlusion. Her anti-coagulant aspirin and [MEDICATION NAME] were on hold due to recent subdural hematoma. He would like to see her in the hospital to evaluate the bilateral necrosis/gangrene of her feet. He will follow up with neurosurgery and vascular surgeon. On 3/12/20 at 10:52am, V17 (LPN) that on 2/20/20 she worked on 3-11 shift. V3 (Family member) at bedside and concern of R1's skin discoloration on 2nd digit/toe of right foot. R1's denied pain, no [MEDICAL CONDITION] and no open areas. She documented it but did not notify V13 (Primary Care Physician) or V12 (Nurse Practitioner). She wrote it to be follow up in 24-hour report. She notified V9 (Wound care Coordinator) the following day (2/21/20). She did not able to follow it up because she was floated to another unit. Reviewed of R1's progress notes dated 3/11/20 documented by V12 (Nurse Practitioner) indicated: R1 was examined for BLE (Bilateral lower extremities) necrotic toe. Ext: mild BLE [MEDICAL CONDITION]. SKIN: redness to bilateral feet with necrosis to left foot digits 1-3 and right foot digits 1-3. Review of R1's progress notes dated 3/8/20 indicated: No open area, redness or swelling noted. R1 has old scabs to both lower extremities. The documentation was deleted/strike out by V7 (LPN) on 3/10/20 at 12:52pm (after surveyor observed her assessment of R1's bilateral necrotic/gangrene feet/toes on 3/10/20 at 10:34am) and she did late entry notes for 3/8 indicated: Open areas noted on left foot between great toe and 2nd toe. Toes noted to be dark in color, cool to touch. Facility's Wound Care Program Care guidelines revised date 7/3/19 indicated: Procedures: 1. Timely identification of residents assessed to be risk for skin breakdown. a) The Braden scale must be completed by a licensed nurse on admission/readmission and weekly for the first week of admission/re-admission in the facility. 2. Proper identification of risk factors that can impact in the development of unavoidable ulcer or may impede with healing process if resident does not have an ulcer. 3. Prevention of skin breakdown includes but not limited to: c) Inspection of skin every shift with care signs of breakdown. 5. Skin protection. 7. Pain a) Observe and assess for indication of pain and or discomfort. b) Manage pain by controlling source of pain. d) offer/administer [MEDICATION NAME], if ordered prior to dressing changes. 9. Documentation. c) The care plan shall be evaluated and revised based on resident's response to treatment; treatment goals and outcomes. d). The resident's skin alteration/breakdown (pressure ulcer, arterial, diabetic, venous ulcers and etc) shall be documented in the resident's clinical records in accordance to the facility's policy and in compliance to current regulatory standards. 11. Wound assessment for pressure, diabetic, venous and arterial wounds: documentation shall include but not limited to: type of wound and or ulcer, location, date, stage (if applicable), length, width and depth; wound bed description, wound edge description and if present, exudates, undermining, tunneling and wound related pain. Facility's Skin care treatment regimen revised date 8/2/19 indicated: it is the policy of this facility to ensure prompt identification, documentation, and to obtain appropriate treatment for [REDACTED].
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on observation, interview and record review, the facility failed to follow its fall prevention policy to ensure that the resident (R1) who is high risk for fall and had 4 fall incidents with visits to hospital for evaluation, is placed on fall preventive measures to prevent from falling. The facility also failed to implement fall interventions for residents (R2, R3 and R4) who are high risk for fall. This deficiency affects all four (R1, R2, R3 and R4) residents reviewed for fall prevention management. On 3/10/20 at 1:41pm, V3 (Family member) stated that R1 has 4 fall incidents and visits to the hospital for evaluation since admission on 1/31/20. She has history of subdural hematoma. No fall preventive measures are in placed such as bed/wheelchair alarm, floor mats or bed rails. On 3/10/20 at 10:34am, R1 is lying across the bed, with both lower extremities hanging from the bed and feet touching the floor. No nonskid sock on her right foot. Headboard has more than 12 inches space away from the wall. No floor mat next to her bed and no bed or wheelchair alarm attached. She is very sleepy unable to maintain conversation. At 10:38am, V8 (CNA) stated that R1 is high risk for fall. She has several fall incidents and should have floor mat and alarm. R1's bed in not on lowest position because when she placed it in lowest position the bed wheels touches floor and does not locked. The bed should be raised slight up for the bed frame to touch the floor as [MEDICATION NAME] or locked it in placed. On 3/10/20 at 2:44pm, V5 (Fall Coordinator) stated that fall assessment is done upon admission, re- admission, quarterly, annually and after each fall. V2 (DON) and herself are responsible for completing the fall root cause analysis. They will discuss it with IDT (Interdisciplinary team) and update the care plan after each fall. R1 was admitted on [DATE]. Her admission fall assessment is 0, low risk. She came with walker. R1 has several fall incidents since admission and on high fall risk. She is not on the list for fall intervention daily monitoring log in the unit because she does not have safety devices such as floor mat or bed/wheelchair alarm. She stated that her recent fall was on 3/9/20. She has not done the post fall investigation, post fall assessment and updated care plan after her fall. Record review of R1's fall incident of the following dates: 1). 2/8/20 Unwitnessed fall incident indicated: R1 found sitting on floor. She stated that she was looking for her breakfast, lost her balance and fell . She was sent out to the hospital for evaluation. She came back from the hospital without new order. Post fall investigation dated 2/8/20 signed by V5 (Fall coordinator) given by V11 (Nurse Consultant) on 3/11/20 indicated R1 attempting to ambulate and lost her balance. New interventions: Frequently re-orientation to surrounding. Encourage participation in activities to promote strengthening exercise and physical mobility. Encourage to change position slowly. Fall assessment signed on 2/10/20 score of 14, high risk for fall 2). 2/16/20 Unwitnessed fall documented by V18 (RN) indicated that at 12n, R1's roommate notified the nurse that she was on the floor. R1 was found lying on the floor on her right side next to her bed. R1 stated that she was trying to reach her cellphone and slid down the bed. R1 was sent out to the hospital for evaluation. She came back on the same day at 6:12pm without new orders. NO fall incident done. NO post fall investigation done. Care plan was not updated after fall. NO fall assessment done. This fall incident was not log in facility's monthly fall report. V2 (DON) and V5 (Fall coordinator) informed. 3). 3/2/20 Unwitnessed fall incident indicated: R1 noted lying on her right side on the floor next to bed. She was unable to tell what had happened. She was sent out to the hospital for evaluation and was admitted with [DIAGNOSES REDACTED]. Post fall investigation dated 3/4/20 not signed, given by V11 (Nurse Consultant) on 3/11/20 indicated: R1 fell out from bed attempting to get candy and lost her balance. New intervention: Medication review. Fall assessment done signed on 3/2/20 score of 10, high risk. 4). 3/9/20 Unwitnessed fall incident indicated: R1 observed lying on the floor by her bedside on her room, no apparent injury noted. She stated she want her breakfast. She was sent out to hospital for evaluation and returned the same day without new order. Post fall investigation dated 3/10/20 but submitted by V11 (Nurse Consultant) on 3/11/20 indicated: R1 lost her balance attempting to get up and look for her breakfast. New intervention: Bed/chair alarm to alert staff when R1 attempts to get out of bed. Fall assessment signed 3/10/20. On 3/10/20 at 3:18pm, Discussed concerns with V11 (Nurse Consultant) regarding fall preventive measure for R1 and why she was not on list for fall intervention log in the unit for safety devices despite of her 4 falls incidents with hospital visits. She stated that R1 does not necessarily has to have floor mat and wheelchair alarm. She added that they have 24 hours after the fall incident happened to do post fall investigation and update the care plan. Informed V11 that per R1's medical record fall incident happened on 3/9/20 at 7:05am. On 3/11/20 at 9:58am, V12 (Nurse Practitioner) stated that she sees R1 for V13 (Primary Care physician). She seen R1 several times since admissions. She comes to the facility on daily basis and will ask floor nurses if she needed to see assigned residents for any clinical conditions that needed to be addressed. She was not aware that R1 has 4 falls incidents. She is only aware of 1 fall incident that she addressed it on her visit dated 2/17/20. She expected the facility to follow their facility's protocol in fall prevention and management. R1 was initially admitted from hospital with history of subdural hematoma and non-displaced right pubic ramus fracture after fall while ambulating in the bathroom. No surgical intervention for pubic ramus fracture and was weight bearing as tolerated. R1 was admitted to the nursing home facility for rehabilitation. On 3/11/20 at 2:53pm, V13 (Primary care physician) stated that he has not seen R1 in the facility, but he sees her in the hospital when she was transferred several times due to fall incident. V12 (Nurse Practitioner) sees his residents for him. He is expected the facility to follow its fall prevention and management protocol. R1's care plan date initiated 2/2/20 given by V11 (Nurse Consultant) indicated: She is high risk for falls due to use of [MEDICAL CONDITION] medications, side effects of prescribed medications, unsteady gait due to lower extremities weakness and [MEDICAL CONDITION]. Interventions revisions dated only on 2/2/20 and 2/8/20. NO interventions revision/updated after fall incidents on 2/16/20, 3/2/20 and 3/9/20. On 3/10/20 at 10am, R2 is up in wheelchair, no wheelchair alarm applied as indicated in fall intervention daily monitoring log. Called V4 (LPN) and he searched for R1's wheelchair for alarm. He stated he does not have wheelchair alarm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145070	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GROVE OF BERWYN, THE	**3601 SOUTH HARLEM AVENUE BERWYN, IL 60402**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) attached but he should have one. V4 searched for wheelchair alarm in his room, drawers and cabinet, no alarm device was found. He called V5 (Fall coordinator) for R2's wheelchair alarm. V1 (Administrator) was notified of concern identified. On 3/11/20 at 1:22pm, V15 (CNA) stated that she was assigned to R2 yesterday. She is aware that R2 is on high fall risk. She stated that the night shift gets him up and should applied the wheelchair alarm. She stated she did not check R2 if he had the alarm. R2's care plan date initiated 2/20/20 given by V11 Nurse Consultant indicate: He is high risk for fall related to cognitive impairment, difficulty maintaining standing position, impaired balance during transition, impulsivity or poor safety awareness and dementia. Interventions list in part dated 2/20/20 indicated: Bed and wheelchair alarm. Staff to ensure the device is in place and in good working condition. On 3/10/20 at 10:06am, R3 is sleeping on bed. The bed is pushed against the wall with floor mat on right side of the bed. His bed was placed on high position. Showed R3's bed to V4 (LPN). He stated that it should be in lowest position. He adjusted the bed to lowest position. On 3/10/20 at 10:08am, V6 (CNA) stated that R3 should be in lowest position. She admitted raising his bed when providing his breakfast tray. She forgot to put it in lowest position when she collected the tray. On 3/10/20 at 12:25pm, R3 lying in bed stated he is done with his lunch. His bed in not in lowest position. Called V6 (CNA) to the R3's room and showed the bed. She stated it should be on lowest position and adjusted the bed to its lowest position. She stated she forgot to place it in lowest position after she took the lunch tray. R3's care plan initiated on 11/21/19 given by V11 (Nurse Consultant) indicated: He is high risk for fall related to current medication use, poor safety awareness, unsteady gait and disease process. Interventions listed in part dated 11/21/19 indicated: Keep the bed in the lowest position for safety. No floor mat written in interventions. On 3/10/20 at 10:30am, R4 is lying in bed. Her bed in pushed against the wall and floor mat placed on left side of the bed. The bed is placed on high position. Bilateral top/half side rails up. Showed to V7 (LPN) and stated that the bed should be on lowest position. She adjusted the bed in lowest position. On 3/10/20 at 10:38am, V8 (CNA) stated that R4 is high risk for fall. She stated that R4 is on bed rails, floor mat and bed to the lowest position. Informed her that R4's bed was not on lowest position when rounds made with V7 (LPN). She stated that she raised the bed when she served breakfast this morning and forgot to place it in lowest position when she collected the tray. On 3/11/20 at 10:40am, R4 lying on bed, with floor mat on left side of the bed. The bed is not on the lowest position. Called V14 (CNA) and showed R4's bed position. She stated that the bed should be in lowest position since she is a fall risk. She found the bed control connected to bed is inside the bedside drawer of R4. She tried to adjust the bed, but it was not working. She paged the maintenance director. At 10:54am, Maintenance came in to check and found out that the wall outlet is loosen and the bed cord was unplugged. He fixed it and plugged the bed cord. V14 (CNA) adjust the bed to the lowest position. R4's Care plan dated initiated 11/7/20 indicated: She is high risk fir fall related to neoplasm of the brain, Cerebral infarction, abnormalities of gait and mobility, [MEDICAL CONDITION] and collapse. Intervention listed in part dated 11/11/20: Keep the bed in lowest position for safety. Facility's Fall Occurrence policy revised date 7/30/19 indicated: its policy of the facility to ensure that residents are assessed for risk for falls and intervention are put in place to prevent them from falling. Procedure: 2). Those identified as high risk for fall will be provided interventions to prevent falls. 4). An incident report will be completed by the nurse each time a resident fall. 5) The Falls Coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of fall. 6). The nurse may immediately start interventions to address falls in the unit even prior to the fall coordinator's investigation. 8) The fall coordinator will add the intervention in the resident's care plan.