STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAK NURSING AND REHABILITATION CENTER LLC	455 31ST STREET MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
OK/TAG ✓	Correction Date: 3/31/23 The following deficiency resulted from a On-Site Revisit of the Complaint Survey ending January 31, 2023, and investigation of Complaints #110839-C, #111894-C and a Facility Self-Reported Incident #111820-I conducted on March 20, 2023 - March 29, 2023. Complaint #110839-C was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and staff interviews, the facility failed to complete appropriate vital signs and Neurological Assessments post unwitnessed resident falls, when the residents were not able to say whether or not they hit their head during the fall, for 3 of 5 residents reviewed with fall histories (Resident's #1, #2 and #6). The facility reported a census of 55 residents.	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tracy Brunell — TITLE: Administrator — (X6) DATE: 03/31/2023 ~~03/30/2023~~

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 IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAK NURSING AND REHABILITATION CENTER LLC	455 31ST STREET MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 1 Findings Include: 1. The 1/9/23 Minimum Data Set (MDS) Assessment Tool revealed Resident #1 scored 10 out of 15 points possible on the Brief Interview for Mental Status (BIMS) Cognitive Assessment that indicated moderate cognitive impairment. Diagnoses included cancer, non-Alzheimer's dementia, depression and idiopathic normal pressure hydrocephalus (water accumulation on the brain), and the resident had 2 or more falls since the previous assessment. The MDS revealed the resident required at least 1 staff assist for transfers to and from bed or chair, ambulation and toileting. A High Risk for Falls Problem initiated on the Nursing Care Plan on 7/15/22 directed staff on the following: a. Anticipate and meet my needs. (Initiated: 07/15/2022) b. Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance. (Initiated: 07/15/2022) c. Ensure that I am wearing appropriate footwear when ambulating or mobilizing in wheelchair. (Initiated: 07/15/2022) d. Resident to wear Gripper socks to prevent future falls. (Initiated 3/22/23) An Impaired Cognitive Function Problem initiated 10/17/22 on the Nursing Care Plan directed staff on the following: a. Ask yes/no questions in order to determine the resident's needs. (Initiated: 10/17/2022) b. Communication: Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAK NURSING AND REHABILITATION CENTER LLC	455 31ST STREET MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2	F 684		

The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. (Initiated: 10/17/2022)

An Alteration in Neurological Status related to Normal Pressure Hydrocephalus Problem initiated 10/19/22 on the Nursing Care Plan directed staff on the following:
a. Monitor/document/report signs or symptoms of tremors, rigidity, dizziness, changes in level of consciousness, slurred speech. (Initiated: 10/19/2022)
b. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. (Initiated: 10/19/2022)

A Nursing Progress Note transcribed by Staff B, Licensed Practical Nurse (LPN), 3/22/23 at 7:20 a.m. stated:
Resident found sitting on his buttock's on the floor beside his bed. Reports "I slid right off the bed." Full Range of Motion all 4 extremities. Denies hitting head. Neuro's intact.

A notation "Sleeping", transcribed by Staff C, Registered Nurse (RN), was documented for the required 11:05 p.m. vital sign and neurological assessment on the 3/22/23 "Neuro Check" form associated to the Resident #1's fall.

2. The 3/1/23 MDS Assessment Tool revealed Resident #2 scored 6 out of 15 points possible on the BIMS Cognitive Assessment that indicated severe cognitive impairment. Diagnoses identified included osteoporosis, generalized muscle weakness and unsteady on feet, and required extensive assistance of at least 1 staff for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAK NURSING AND REHABILITATION CENTER LLC	455 31ST STREET MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3	F 684		

transfers to and from bed or chair, ambulation and toileting, and had 2 or more falls without injury since the prior assessment completed 1/25/23.

A High Risk for Fall related to impulsiveness, gait and balance deficits and unaware of safety needs problem initiated 12/8/21 on the Nursing Care Plan directed staff on the following:
a. Additional "call don't fall" sign placed in room. (Initiated: 03/24/2023)
b. Call Don't Fall sign placed in room to remind resident to call for help. (Initiated: 02/02/2023)
c. Call light within reach and encourage me to use it, if not cognitively impaired, for assistance as needed. (Initiated: 12/08/2021)
d. Ensure resident wears appropriate footwear when ambulating or mobilizing in wheelchair. (Initiated: 12/08/2021)
e. I need a safe environment with: floors free from spills and/or clutter; adequate, light; A a working and reachable call light, and personal items within reach. (Initiated: 12/08/2021)
f. Offer toileting every hour prompt and cue. (Initiated: 11/01/2022)
g. Slip resistant strips to floor In front of toilet. (Initiated: 02/15/2023)

An Impaired Cognitive Function Problem initiated 12/15/21 on the Nursing Care Plan directed staff on the following:
a. Ask yes/no questions in order to determine my needs. (Initiated: 12/15/2021)
b. Communicate with resident/family/caregivers regarding my capabilities and needs. (Initiated: 12/15/2021)
c. Communication: Face me when speaking and make eye contact. Reduce any distractions- turn off TV,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAK NURSING AND REHABILITATION CENTER LLC	455 31ST STREET MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4	F 684		

radio, close door etc. Provide me with necessary cues- stop and return if agitated. (Initiated: 12/15/2021)
d. Present just one thought, idea, question or command at a time. (Initiated: 12/15/2021)

A Nursing Progress Note transcribed by Staff A, LPN, at 7:08 p.m. on 3/23/23 stated:
Found sitting on floor facing toilet with wheelchair behind. Self transferred from toilet. Temperature 97.6 Blood Pressure 148/86 Pulse 100 Respirations 18 Oxygen Saturation 94% on Room Air. Range of Motion all extremities. Denies pain/discomfort. Denies hitting head.

A notation "Sleeping", transcribed by Staff C, RN, was documented for the required 10:45 p.m. and 11:45 p.m. vital sign and Neurological Assessment on the 3/23/23 "Neuro Check" form associated to the Resident #2's fall.

3. The 1/18/23 MDS Assessment Tool revealed Resident #6 scored 8 out of 15 points possible on the BIMS Cognitive Assessment, that indicated severe cognitive impairment. Diagnoses identified included Multiple Sclerosis, non-Alzheimer's dementia, anxiety and repeated falls, required assistance of at least 1 staff to transfer to and from bed and chair, ambulation and toileting, and had not had a fall since the 1/12/23 admission to the facility.

A Fall Risk Problem initiated 1/24/23 on the Nursing Care Plan directed staff on the following:
a. Bed in lowest position when unattended by staff. (Initiated: 02/13/2023)
b. Call don't fall sign in room, to remind resident to use call-light to notify staff for assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAK NURSING AND REHABILITATION CENTER LLC	455 31ST STREET MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5	F 684		

(Initiated: 01/24/2023)
c. Call light within reach and encourage the resident to use it, if not cognitively impaired, for assistance as needed. (Initiated: 01/24/2023)

An Impaired Cognitive Function related to Dementia Problem initiated 1/24/23 on the Nursing Care Plan directed staff to complete the following:
a. Ask yes/no questions in order to determine the resident's needs. (Initiated: 01/25/2023)
b. Communication: Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues stop and return if agitated. (Initiated: 01/25/2023)
c. Use task segmentation to support short term memory deficits. Break tasks into one step at a time. (Initiated: 01/25/2023)

A Nursing Progress Note transcribed by Staff A, LPN at 10:13 p.m. on 2/12/23 stated:
Called to room per roommate and stated "He fell out of bed". Upon entering room noted resident laying on left side on floor beside bed. Alert and verbalizes no pain it's cold down here. Temperature 96.8 Blood Pressure 108/66 Pulse 60 Respirations 16 Oxygen Saturation 95% on Room Air. Pupils Equal Reactive to Light. Range of Motion all extremities.

A form last updated 11/2017, labeled "Neuro Checks", with written directives to "use if resident hit their head or had an unwitnessed fall", directed staff to complete vital sign and Neurological Assessments every 15 minutes x 4 times, every 30 minutes x 4 times, every hour x 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAK NURSING AND REHABILITATION CENTER LLC	455 31ST STREET MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6	F 684		

times, every 4 hours x 4 times, and then every shift for 2 days.

Resident #6's Neuro Checks form dated 2/12/23 revealed "sleep" recorded by Staff A, LPN, and without any documentation of the required assessments as required and scheduled on 2/12/23 at 11:15 p.m. and 11:45 p.m., and on 2/13/23 at 12:15 a.m., 12:45 a.m., 1:45 a.m., 2:45 a.m., 3:45 a.m. and 4:45 a.m. The next vital sign and Neurological Assessment was completed at 9:45 a.m. on 2/13/23.

The facility's Incidents and Accidents policy dated 2022 directed staff on the following:
a. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions.
b. In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet. Abnormal findings will be reported to the practitioner.

Staff interviews revealed:
a. On 3/29/23 at 6:35 a.m., Staff B, LPN, stated staff used the "Neuro Checks" Form when residents had unwitnessed falls, the frequency of the required assessments were written on the form, nurses were expected to complete the assessments, if a resident was asleep the nurse had to wake the resident to assess their neurological status as increased sleeping/difficulty to awaken the resident was a potential sign of neurological deficits and it was not appropriate to leave the resident asleep.
b. On 3/29/23 at 8:08 a.m., Staff D, RN stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAK NURSING AND REHABILITATION CENTER LLC	455 31ST STREET MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7	F 684		

staff were supposed to check vital signs and Neuro Assessments and record them on the Neuro Check Form after a resident's fall. The form tells the staff how often to complete the assessments, if a resident was asleep the nurse should wake the resident because the Neuro Assessment requires that and increased lethargy/sleepiness is one of the signs you watch for with a head injury.

c. On 3/28/23 at 12:32 p.m., Staff A, LPN, stated Nurses were supposed to use the Neuro Checks form to document vital signs and Neuro checks, the form has the frequency for checks on it, if a resident is asleep when a check as due, and if they could have behaviors she would let the resident sleep and would not wake them, she could assess them if they woke up and would write the time she did it on the form.

d. On 3/29/23 at 8:57 a.m., the Director of Nursing (DON) stated she expected Nursing Staff to follow the set protocol on the Neuro Checks Form if a resident had an unwitnessed fall, the assessments should be completed even if the resident was asleep, staff were expected to wake the resident to complete the assessments as that was an important part of the neurological assessment. She expected staff to consult with the Physician for orders if they wanted to deviate from the assessment protocol.

Silver Oak Nursing and Rehabilitation Plan of Correction

The Plan of Correction does not constitute an admission or agreement by Silver Oak Nursing and Rehabilitation of truth, or the facts alleged, or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correction shall serve as Silver Oak Nursing and Rehabilitation credible allegation of compliance.

F684

1. Resident #6 no longer reside in the facility. Resident #1 and #2 have been re-assessed and no concerns noted.

2. Actions taken to protect resident in a similar situation:

- All residents who have experienced a fall since 2/23/2023 were reassessed with no concerns noted.
- Systematic change that included creation and implementation of electronic Nero Assessments *Ivy* Neuro Check Nursing staff educated on the electronic version, With EMR version IDT will monitor in the Clinical Morning Meetings.

3. Licensed nursing staff were educated by DON/Designee on facility protocol for assessment and intervention, neuro assessments and post fall assessments, completing appropriate vital signs and Neurological Assessments post unwitnessed resident fall, when the resident is not able to say whether or not they hit their head during a fall, and to notification to MD if any abnormal finds.

4. DON/Designee will conduct audits daily times 2 weeks then, weekly times 4 weeks, then bi-weekly times one month, and as needed thereafter results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. DON is responsible for monitoring and follow up as needed.

Compliance Date: 3/31/2023

Clinical Meeting Follow up

Follow up at Stand-Down Meeting

PORTALS:

- ❑ Hospital Transfers SBAR & E-interact
- ❑ Orders
  – in queue, pending confirmation/review, on order manual, on order electronic, waiting to be received, needing follow up
- ❑ Ombudsman Log
- ❑ Evaluations – scheduled and inprogress
- ❑ Lab/Rx Results- did we notify MD/family & document in MR (-) findings?
- ❑ Weights & Vitals - did we notify MD/family $ document in MR (-) findings?

RTH: ***AHCA/DHEC/DHHS/DIA/ Transfer/Discharge Process, PCC Hospital Transfer Log Fields completed**

ROOM CHANGES: (Dots, Kitchen Notified)

UCN DASHBOARD REVIEWS:

- ❑ Daily
- ❑ Orders/Visits
- ❑ MDS/CP/ADT

PLANNED DC TODAY: (Quick ADT / DC Orders)

ADMISSION CHART REVIEWS:

- ❑ Review Admission NN for completion
- ❑ Chart Review (follow PCC New Admission Checklist): Consents, Inventory, 3008, DNR, Hospital DC Summary, Hard Scripts Have Orders, Order Summary (signed by 2 nurses), Weight obtained, PASRR, Review of Medication Availability validated by MAR, **Leave of Absence order generated in PCC if applicable**

Isolation- Organism/location	**QAPI/PIP plans-**
New ABT - Dx/stop date/Parenteral v/s PO Surveillance Infection Criteria	**New Psychotropic -** AIMs, BMF for antipsychotic, hypnotic, anxiolytic and antidepressants, consent, dx (appropriate for the medication used, psych consult if indicated, 14 days for PRN psychotropic medications and indication for use (Behavior for which we are monitoring)
Regrets to Return: (RTH residents who decide not to return and/or expire in hospital - notify Nurse Consultant as well)	**Any new Medical Records Request** re: Clinical Risk/NOI (review chart with IDT)

CENSUS:_____ **DAILY CLINICAL MEETING CHECKLIST**

DATE: _____

Department members that should be in attendance include the DON, UCNs, ADON, SSD, FNS, Rehab Director and MDS. Prior to meeting, print out 24-hour report, Order listing report, POC Audit report, Med administration audit from day prior, alert listing report (including cleared alerts) and review to identify areas of concern for discussion at meeting. New admission charts are to be brought to the meeting. Department members will also address issues as able during meeting, and assign follow up for outstanding issues and plan for discussion on completion later in the day. Admission chart reviews are to occur immediately prior to or following Stand-Up meeting.

PDPM ELEMENTS:

- ❑ Structure the order of your discussion so that you start the meeting covering the Medicare Part A admissions who are in the first 3 days of their stay.
- ❑ During the PDPM part of the discussion please:
  - Have PCC open to the Medical Diagnosis (Med Diag) tab for each resident and pay close attention to the Clinical Category column, especially those codes which are listed as "N/A, not an acceptable Primary Diagnosis"
  - Have all 5 your PDPM Rapid Guides out for review and utilize them to capture all relevant conditions, plan assessments needed to clarify conditions, and ensure appropriate services are being delivered: 1) Case Mix Group and Index, 2) Nursing Category Grouper, 3) PT/OT Component Grouper, 4) SLP Component Grouper, and 5) NTA Component Grouper
  - Have out and follow the PDPM Data collection tool as an outline for the discussion on these residents.
- ❑ After the discussion of the med A admissions in the first 3 days of the stay the following department members may leave the Daily Clinical meeting: ED, FRD, FNS, SSD.
- ❑ Skilled documentation focused diagnosis is entered into the "Special Instructions" area within PCC

DAILY CLINICAL MEETING REVIEW:

***For all abnormal findings or COC, did we notify MD/family and document changes?*

- ❑ 24/72 Hour Report
- ❑ Med Pass status
- ❑ POC Assignment status
- ❑ Unreviewed laboratory and radiology results
- ❑ Immunization issues
- ❑ High risk progress notes
- ❑ Order Pending Confirmation
- ❑ Daily summary
- ❑ Incomplete admissions
- ❑ Order Listing Report
- ❑ Alert Listing Report
- ❑ Medication Admin Report Run for Day Prior
- ❑ TAR - PAIN

FALLS/INCIDENTS (Monthly Fall Compliance Tool):

COVID-19 Vaccine (New Admission) addressed:

INFLUENZA/Pneumo (New Admission) addressed:

ADMISSIONS:

DISCHARGES:

RISK MANAGEMENT REVIEW:

- ❑ Risk Management

Nero's Fall

Revision Date: 09/6/22

Neuro Check Assessment Form

KEY:

Neuro Checks:

- q 15 min x 1 hr
- q 30 min x 1 hr
- q 1 hr x 4 hrs
- q 4 hrs x 24 Hrs
- q shift until 72 hrs

Level of Consciousness:
1. Fully Conscious – awake, aware, oriented
2. Lethargic – responds slowly to verbal stimuli
3. Obtunded – very drowsy, responds to touch stimuli
4. Stupor – responds only to painful stimuli
5. Coma – absent response to stimuli

Movement:
1. All 4 extremities
2. Arms only
3. Legs only
4. R arm only
5. L arm only
6. R leg only
7. L leg only
8. No movement/ unusual movement

Hand Grasp:
1. Equal and strong
2. R weakness
3. L weakness
4. None

Speech:
1. Clear
2. Slurred
3. Rambling
4. Aphasic

Pupil Reaction:
1. Brisk
2. Sluggish
3. Fixed

Pupil Size Bilateral:
1. Equal
2. Not equal

Date	Time	Temperature	Pulse	Respiration	Blood Pressure	Level of Consciousness	Movement	Hand Grasp	Speech	Pupil Reaction Right Eye	Pupil Reaction Left Eye	Pupil Size Bilateral	See Nurse's Notes	Initials

Resident Name: _____ **Room #:** _____ **Physician:** _____ **Med. Rec. #:** _____