



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

LESLIE M. CLEMENT – DEPUTY DIRECTOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 25, 2011

Jody Galloway, Administrator
Renaissance Assisted Living-Creekview
Po Box 1687
Idaho Falls, ID 83403

Dear Ms. Galloway:

An unannounced, on-site complaint investigation survey was conducted at Renaissance Assisted Living - Creekview from November 14, 2011, through November 15, 2011. During that time, interviews and record reviews were conducted with the following results:

Complaint # ID00005250

Allegation #1: The facility did not obtain medical services for a resident in a timely manner, when the resident was injured during a fall.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing emergency services in a timely manner. The facility was required to submit a plan of correction.

Allegation #2: The facility nurse did not assess residents after falls.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.01 for the nurse not assessing residents after falls. The facility was required to submit evidence of resolution within 30 days.

Jody Galloway, Administrator
November 25, 2011
Page 2 of 2

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

A handwritten signature in black ink, appearing to read "Gloria Keathley", with a long horizontal flourish extending to the right.

Gloria Keathley, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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November 29, 2011

CERTIFIED MAIL #: 7007 3020 0001 3745 7712

Jody Galloway
Renaissance Assisted Living - Creekview
5685 South Bannock Hwy
Pocatello, ID 83204

Dear Ms. Galloway:

Based on the Complaint Investigation conducted by our staff at Renaissance Assisted Living - Creekview on November 15, 2011, we have determined that the facility failed to provide coordination of outside agency care and emergency services.

This core issue deficiency substantially limits the capacity of Renaissance Assisted Living - Creekview to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **December 30, 2011**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ◆ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ◆ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ◆ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ◆ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ◆ What date will the corrective action(s) be completed by?

Return the **signed and dated** Plan of Correction to us by **December 12, 2011**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

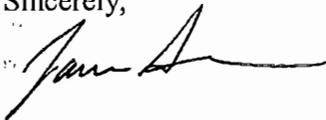
In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies. See the IDR policy and directions on our website at www.assistedliving.dhw.idaho.gov. If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted..

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **December 15, 2011**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities in Idaho, the Department will have no alternative but to initiate an enforcement action against the license held by Renaissance Assisted Living - Creekview.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626 and ask for the RALF program.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program
Medicaid Licensing & Certification

JS/ka

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R875	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/15/2011
NAME OF PROVIDER OR SUPPLIER RENAISSANCE ASSISTED LIVING - CREEKVIE		STREET ADDRESS, CITY, STATE, ZIP CODE 5685 SOUTH BANNOCK HWY POCATELLO, ID 83204		
(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) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the complaint investigation conducted on 11/14/2011 through 11/15/2011 at your residential care/assisted living facility. The surveyors conducting the survey were: Gloria Keathley, LSW Team Leader Health Facility Surveyor Karen Anderson, RN Health Facility Surveyor Abbreviations: CNA = certified nurse assistant MAR = medication assistance record PRN = as needed pt = patient res = resident RN = registered nurse rt = right	R 000	The following policies & procedures have been put in place to prevent any further incident of inadequate care Emergency Procedures has been included with our incident/accident policy. We have updated our Change in Conditions Policy to include a time frame in which Administrator RN needs to be notified in & respond by A new incident accident report including RN name & time responded has been included RN assesment to be completed within 24 hrs.	
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: IDAPA rule 16.03.22.011.08 defines inadequate care as: When a facility fails to provide specific services to its residents, including emergency intervention and coordination of outside services. IDAPA rule 16.03.22.430.05 states, "Each facility	R 008		

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

Q61K11

If continuation sheet 1 of 8

accept 12/19/11
[Signature]

Bureau of Facility Standards

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R 008	<p>Continued From page 1</p> <p>must provide to the resident:</p> <p>i. Emergency interventions and coordination of outside services."</p> <p>Based on record review and interview, it was determined the facility failed to coordinate a resident's care with outside services. As a result, 1 of 1 sampled residents (#3), who required outside medical care, did not receive medical treatment in a timely manner. The findings include:</p> <p>Resident #3 was admitted to the facility on 2/8/10 with a diagnosis of dementia. The resident's health declined and she was placed on hospice services for comfort care.</p> <p>The facility's admission agreement, signed by the resident, contained a "Better Safe than Sorry Policy." The policy documented "Authorization to Transfer" with the following, "Conditions for emergency transfers are, but not limited to:...(B) Pain resulting from a fall or complaint of pain from the resident..."</p> <p>An "Incident/Accident Report," dated 8/6/11, documented Resident #3 fell at 7:00 AM, in the dining room and hit her head on the chair. The resident was assisted back to the chair and did not have any "sign of injuries". The administrator's follow-up to the incident, dated 8/7/11, documented "Hospice was notified...Red area noted..."</p> <p>The investigation of the incident did not specify where the red area was located on her body. Nor was there a nursing assessment by the facility RN or hospice RN regarding the fall.</p>	R 008	<p>A new Intermittent Nursing Services Policy has been included.</p> <p>Review of Policies & Procedures has been included in all new hire employee paperwork.</p> <p>Current Staff Received in-service on 9-15-2011 Regarding Documentation, How to handle a fall, Ombudsman & Asst Ombudsman taught class on a In-Service on Nov 21, 2011 included informational letters</p>	

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R 008	<p>Continued From page 2</p> <p>An "Event/Incident Report," dated 8/7/11, documented Resident #3 had an unwitnessed fall at 7:10 AM. Caregivers heard the fall and observed the resident laying on her right side, on the floor near the kitchen. A caregiver documented the resident was checked for injuries. When her right hip was touched by a caregiver, the resident stated it hurt. The caregivers assisted the resident up off the floor and over to the couch. A caregiver documented the resident limped while being transferred. The event report further documented the on-call nurse was notified. The event report was not signed by the facility RN until 8/12/11. There was no documentation from the facility's on-call nurse, on the event report or in the resident's record. There was no documentation a nurse assessed the resident after falling twice in two days.</p> <p>The administrator documented on a follow-up to the incident report on 8/7/11, that Resident #3 had a fall and staff assisted her up off the floor and over to the couch. The resident was able to walk to the couch and had no signs of pain. The facility's on-call nurse was notified. Additionally, she documented staff were instructed by the nurse to monitor and call her back with any concerns.</p> <p>Both incident reports documented Resident #3 fell and needed assistance off the floor. However, the caregiver's incident report, dated 8/7/11, documented the resident verbalized pain when a caregiver touched her hip and the resident limped while being assisted to the couch. In contrast, the administrator's report dated 8/7/11, documented the resident walked to the couch and had no signs of pain. Despite abnormal findings of the resident limping and complaining of pain, the resident was not further evaluated by a medical</p>	R 008	<p>Provided off the Dept of Health & Welfare Website dated 1-2007</p> <p>Provision of Emergency Services and 3-2007 Delivery of Hospice in a RALF.</p> <p>Current Staff also attended or received documentation with updated Policy & Procedure on 12-9-2011.</p> <p>All new policies have been placed in the Policy & Procedure book for staff to refer to. Staff has been encouraged to review P&P book often.</p>	

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R 008	Continued From page 3 professional. A "Progress Notes Report," dated 8/7/11 at 10:00 AM, documented staff reported Resident #3 fell walking down the hall. Two caregivers assisted the resident up and the resident complained of pain and rubbed at her back. A caregiver notified a hospice agency's nurse. The progress note further documented, the on-call nurse called and checked on resident throughout the day and a caregiver gave Resident #3, a PRN medication for pain. A "Progress Notes Report," dated 8/8/11 at 10:00 AM, documented the resident fell while walking down the hallway on 8/7/11 at 7:10 AM. Staff reported Resident #3 stood up and walked back to the couch. At 10:30 AM, a caregiver documented they took the resident to the bathroom, and the resident complained of pain. Staff notified the on-call nurse to come assess the resident. There was no documentation from the facility's on-call nurse, or caregivers that staff notified the nurse when Resident #3 complained of pain on 8/7/11 at 10:30 AM. Further, there was no documentation Resident #3 received any additional pain medication after falling and complaining of pain. The August 2011, MAR documented the resident only received her routine medications. A "Progress Notes Report," dated 8/8/11 at 4:09 PM, documented the resident was not able to bear weight when the hospice CNA arrived. A hospice CNA visit note, dated 8/8/11 (untimed), documented the CNA had come to assist the resident with a shower and was informed of the	R 008	As of 12-9-2011 All policies are in place and correction have been completed & documented <i>[Signature]</i> 12-15-2011	

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R 008	Continued From page 4 resident's fall on 8/7/11. The CNA documented, "She had fallen the night before, she could barely walk. She was very difficult to transfer...I got her in the shower...I transferred her back into her room. She said she was in a lot of pain...I called her nurse, she said she would go look at her today." A hospice nurse note, dated 8/8/11(untimed), documented, "Staff stated pt fell and hit head on 8/6/11, no injuries noted. Fell again on 8/7/11, on RT side, got up and walked to couch. No injuries or abrasions noted but was not able to walk very good after sitting for awhile. Pt still in bed, moans when we sit her up. No injuries or abrasions on body. Does not seem to be in pain when Rt hip is palpated. Pt will not put any weight on legs requires 2 people to assist in transferring and walking." The nurse documented, at 4:00 PM, that the family had decided to take the resident to the emergency room. A hospice nurse note, dated 8/8/11 at 7:30 PM, documented, "The family called to say the resident had a fractured right hip." There was no documentation in the resident's record that the facility's on-call nurse came to assess the resident on 8/6/11, when the resident fell and hit her head on the dining room chair. There was no documentation the on-call nurse came to assess the resident on 8/7/11, when Resident #3 was no longer able to bear weight and had pain. Also, there was no documentation caregivers called the nurse to inform her the resident was experiencing pain, or ask the nurse what they could give the resident for pain. The August 2011, MAR documented the resident received her routine medications which included,	R 008		

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R 008	Continued From page 5 Tylenol and Tramadol. The administrator documented in the "progress notes" on 8/8/11 at 10:00 AM, "Staff reports they gave res prn for pain." The MAR did not reflect that the resident received any prn pain medications. On 11/14/11 at 2:15 PM, the administrator stated the resident fell on 8/7/11. She stated the staff did not witness the fall, but heard her fall in the hallway. The administrator further stated, the resident was able to get up and walk after falling and staff called the nurse to report the fall. She also stated a hospice nurse came, on 8/8/11, to assess the resident. On 11/14/11 at 3:40 PM, the facility nurse stated she had received a call on 8/7/11 from staff, reporting the fall. She stated she instructed staff to call the on-call nurse, as she was out of town. She further stated, staff had not informed her of the previous fall, on 8/6/11, when the resident hit her head. She stated, "I would have told the caregivers to send her out to be evaluated because you never know what injury could have occurred when a resident hits their head." On 11/14/11 at 4:00 PM, a family member stated she felt the hospice nurse did not come to the facility in a timely manner. On 11/15/11 at 10:00 AM, Caregiver A stated, "We walked the resident to the loveseat and then called the nurse to tell her about the fall. We let the nurse know that the resident seemed fine and was walking on her own. Towards the end of my shift, [Resident's name] was sitting on the same spot on the couch and had not moved for a while. I gave her Tylenol per the nurse and I was told they would send a nurse out. I felt a nurse should have come out, because I'm not a doctor."	R 008			

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R 008	Continued From page 6 On 11/15/11 at 10:12 AM, the facility's on-call nurse stated, "I was the back-up nurse for the facility on the weekend when the resident fell. Staff told me the resident had fallen but seemed to be okay. I instructed the caregiver to call me if the resident had any changes. I was only called two times that day; once right after the fall happened and then another call an hour later. Both times I was told the resident was okay and was not complaining of pain or that she had a decrease in mobility." She further stated, "A hospice nurse assessed the resident on 8/8/11, and the family decided to take her to the emergency room, and she was diagnosed with a fractured right hip." On 11/15/11 at 12:00 PM, Caregiver B stated he worked the evening/night shift on 8/7/11, and noticed the resident was not moving around much after the fall. He further stated, he had not talked to a nurse concerning the resident. On 11/15/11 at 3:40 PM, Caregiver C stated, "I worked both days the resident fell. The first fall she hit her head and had a bump on the back of her head. The next day she fell again." Caregiver C stated, "I helped the resident up and she was limping. We sat her down on the couch and I pushed on her hip and asked her if it hurt? The resident answered, yes, it hurts." Caregiver C additionally stated, "I think the nurse came in that day, but I'm not sure." On 11/14/11 through 11/15/11, Caregivers A, B, and C stated they would refer to the incident-event policy for steps to take during emergencies. The "Incident-Event Policy" reviewed on 11/15/11,	R 008		

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R 008	<p>Continued From page 7</p> <p>did not instruct caregivers on who to contact in the event of an injury or emergency. The policy only directed caregivers on how to fill out an incident report.</p> <p>Resident #3 had a fall and hit her head on 8/6/11. There was no documentation caregivers had called the facility nurse. The resident had another fall on 8/7/11 at 7:10 AM. The resident required assistance from two caregivers to get her up off the floor and walk her to the couch. The facility's on-call nurse was informed of the fall and instructed the caregivers to call her back if the resident had any changes with mobility or pain. Caregivers documented the resident was no longer able to bear weight and had pain, but there was no documentation caregivers had called the nurse to notify her of the resident's change in condition.</p> <p>Resident #3 fell on 8/6/11, and fell again on 8/7/11 at 7:10 AM. She had difficulty walking and complained of pain. She was not assessed by qualified medical personnel until approximately 33 hours later. This resulted in the resident experiencing pain and a delay in medical treatment. This resulted in inadequate care.</p>	R 008		

