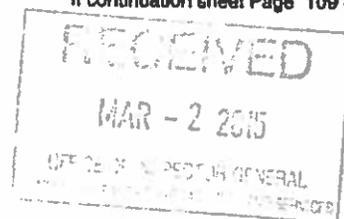


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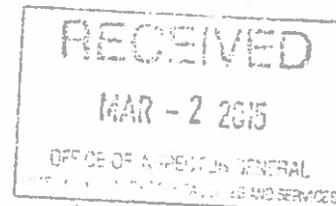
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
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F 323	Continued From page 108 history of blood clots in the leg, and arthritis. The RP stated the resident had a weak bladder causing frequent toileting, a bad knee and could not stand for long periods. The RP continued to say the resident was not experiencing any organ failure or decline and found it concerning that the resident was fine one day and unresponsive the next day. Further review of Resident #20's closed clinical record revealed the resident had fallen on 12/10/14 and sustained a head injury. Review of Resident #20's previous Fall Scene Investigation report, dated 12/10/14, revealed the resident fell at 5:30 AM and was found by staff on the floor with the bed alarm not sounding. The resident sustained a hematoma that was dark purple in color to the left side of the head and to the right thumb. The report stated staff witnessed the resident trying to silence the bed alarm after attempting an unsafe transfer earlier in the shift. Further review of documentation did not indicate whether nursing had increased resident supervision, to monitor for bed alarm manipulation or unsafe transfers prior to the fall. Continued review of the nursing documentation revealed Resident #20's physician was not notified of the fall with injury on 12/10/14 until 9:00 AM, three and half (3.5) hours later. Telephone interview with CNA #9, on 01/08/15 at 2:05 PM, regarding Resident #20's fall on 12/10/14, revealed she found the resident behind the door in his/her room. She stated no alarm was sounding to alert staff the resident was out of bed when she entered the resident's room. She stated it appeared the resident was trying to get into the closet, fell against the closet door, and sustained a goose egg injury to the forehead. She	F 323	Continued from page 108 Improvement/Interdepartmental Team Committee (QAPI/IDT) is established to monitor care and services given to the resident to ensure quality and continuity of care is provided to all residents. The QAPI/IDT will consist of Social Servies, MDS Nurse, Restorative/Wound Care Nurse, Clinical Documentation Review Nurse, Risk Care Manager, Director of Nursing and Administrator. The Committee will meet daily (Monday-Friday excluding Holidays) and review the charts based on the following criteria: new admission, re-admission, any resident's sent to emergency room, any resident that has had a significant change in condition. As part of this audit, the following areas will be reviewed: Physician orders, nurse's notes, C.N.A. care sheets, restorative/therapy (notes, screens, documentation), scheduled toileting program, event report documentation completed, care plans. Any/all areas of concern will be discussed and addressed with the appropriate departent. A QAPI/IDT log is updated with each meeting. The QAPI/IDT Committee is a Quality Assurance subcommittee. The Director of Nursing and Administrator provided education to the QAPI/IDT members reflecting the purpose and duties involved. The Clinical Documenation Review Nurse is responsible for the oversight of the QAPI/IDT Meeting.		



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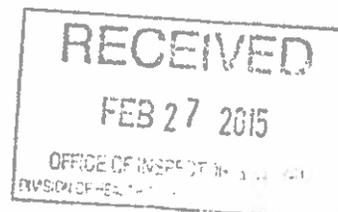
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F 323	<p>Continued From page 109</p> <p>stated by the next day the bump on Resident 20's forehead had swollen tremendously and was purple in color.</p> <p>Telephone interview with LPN #12, on 01/08/15 at 9:00 AM, regarding Resident #20's fall on 12/10/14, revealed she heard two CNAs yelling for assistance from Resident #20's room. She stated the resident was found in the floor behind the closed bedroom door by the closet door. She stated there was no alarm sounding at the time the resident was found. The LPN stated the resident was seen earlier in the shift fiddling with the alarm box. She stated the resident was assessed and found to have a hematoma to the left side of the forehead and right thumb.</p> <p>Further review of the Fall Scene Investigation report, dated 12/10/14, revealed the root cause of the fall was resident attempted unsafe transfer and turned off alarm. Previously in the shift the resident attempted an unsafe transfer and tried to figure out how to turn off the alarm. The Director of Nursing (DON), Administrator (ADM) and Risk Manager (RM) met regarding the fall on 12/19/14 and there was no documented evidence on the form that the DON or Administrator had made recommendations or provided direction to change the plan of care.</p> <p>Continued interview with Resident #20's Responsible Party (RP), on 01/09/15 at 4:05 PM, revealed the resident had fallen on 12/10/14 and had hit their head and sustained a hematoma to the forehead and bruise to the hand. The RP stated the resident was on blood thinning medication for the history of a blood clot in the leg, and this caused the increased bruising seen on the resident's face, neck and shoulder, after</p>	F 323	<p>Continued from page 109</p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained?</p> <p>Every month, the Director of Maintenance will present to the Quality Assessment and Assurance Committee, on an ongoing basis, the findings of the room audits completed by himself, the Maintenance Assistant and other assigned staff. A monthly report will be completed and presented to the Quality Assessment and Assurance Committee by the members who meet with the Standards of Care, Falls Committee, and QAPI/IDT meeting on an ongoing basis. The Quality Assessment and Assurance Committee will discuss the findings and determine if further actions are needed.</p>		



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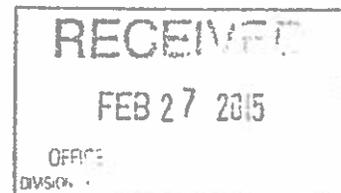
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F 323	<p>Continued From page 106</p> <p>resident cleaned up. CNA #2 said Resident #20 had bruising to the face, neck and shoulder and the resident complained about his/her face hurting so she did not wash it. She stated Resident #20 was squinting the left eye and complained of eye pain. She stated she left and came back about an hour and half (1.5) later, during breakfast tray delivery, to check on the resident and found the resident lifeless and unresponsive. She stated she was told in report the resident had fallen during the night, but no information was provided that indicated the resident had experienced a decline or was expected to pass soon. She stated she informed the nurse and the nurse came and assessed the resident. The CNA stated she was not aware the resident was on blood thinning medication. She stated that type of information was important to know because of the potential for bleeding if the resident experienced an injury.</p> <p>Interview with the Unit Manager, on 01/08/15 at 11:20 AM, and review of the Nursing Notes, dated 12/15/14 and timed at 8:25 AM, revealed the Unit Manager was called to Resident #20's room by an aide and the resident was found unresponsive to touch and verbal stimuli. She also noted a dried red tinged substance to the resident's lower lip and he/she was gurgling with wet lung sounds. She contacted the physician, who was in the building, and received an order to send the resident to the emergency room.</p> <p>Review of Resident #20's Emergency Room record, dated 12/15/14 and timed at 9:51 AM, revealed Resident #20's eyes were assessed upon admission and the findings revealed the left pupil was dilated (indicating neurological changes). An X-ray of the brain was ordered and</p>	F 323	<p>Continued from page 106</p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained?</p> <p>Every month, the Director of Maintenance will present to the Quality Assessment and Assurance Committee, on an ongoing basis, the findings of the room audits completed by himself, the Maintenance Assistant and other assigned staff. A monthly report will be completed and presented to the Quality Assessment and Assurance Committee by the members who meet with the Standards of Care, Falls Committee and QAPI/IDT meeting on an ongoing basis. The Quality Assessment and Assurance Committee will discuss the findings and determine if further actions are needed.</p>		



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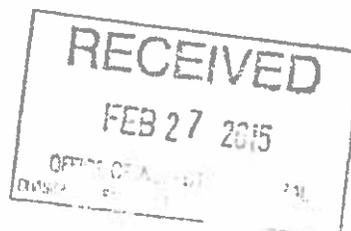
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F 323	<p>Continued From page 107</p> <p>the results were communicated to the emergency room physician at 10:25 AM and revealed a large brain bleed.</p> <p>Continued review of Resident #20's hospital record revealed the Physician's clinical report, dated 12/15/14 and timed at 10:27 AM, stated Resident #20's History of Present Illness and Chief Complaint was a changed mental status: "this started yesterday and was still present. It was abrupt in onset (since last night's fall). The patient was found unresponsive. (Via daughter: Patient fell 6 days ago and again last night. The first fall resulted in a contusion above the left eye, and it has been worsening ever since)". The physician documented a Final Diagnosis of a fall (6 days ago and the evening prior to admission) with subsequent change in mental status with resultant large acute subdural hematoma (bleeding of the brain).</p> <p>Continued review of the Physician's documentation revealed the care provider reviewed Resident #20's test results with the family and counseled them regarding patient's critical condition and poor prognosis for survival. The family requested comfort measures only. The resident expired 20 hours later at 6:00 AM on 12/16/14.</p> <p>Interview with Resident #20's Responsible Party (RP), on 01/09/15 at 4:05 PM, revealed the facility did not contact them at the time of Resident #20's fall; it was not until the facility was in the process of transferring the resident to the emergency department were they notified of the fall. The RP stated the resident was relatively healthy for a ninety year old. RP said the resident had memory problems, history of falls, high blood pressure,</p>	F 323			



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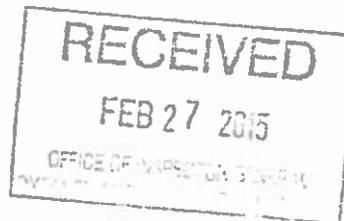
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F 323	Continued From page 108 history of blood clots in the leg, and arthritis. The RP stated the resident had a weak bladder causing frequent toileting, a bad knee and could not stand for long periods. The RP continued to say the resident was not experiencing any organ failure or decline and found it concerning that the resident was fine one day and unresponsive the next day. Further review of Resident #20's closed clinical record revealed the resident had fallen on 12/10/14 and sustained a head injury. Review of Resident #20's previous Fall Scene Investigation report, dated 12/10/14, revealed the resident fell at 5:30 AM and was found by staff on the floor with the bed alarm not sounding. The resident sustained a hematoma that was dark purple in color to the left side of the head and to the right thumb. The report stated staff witnessed the resident trying to silence the bed alarm after attempting an unsafe transfer earlier in the shift. Further review of documentation did not indicate whether nursing had increased resident supervision, to monitor for bed alarm manipulation or unsafe transfers prior to the fall. Continued review of the nursing documentation revealed Resident #20's physician was not notified of the fall with injury on 12/10/14 until 9:00 AM, three and half (3.5) hours later. Telephone interview with CNA #9, on 01/08/15 at 2:05 PM, regarding Resident #20's fall on 12/10/14, revealed she found the resident behind the door in his/her room. She stated no alarm was sounding to alert staff the resident was out of bed when she entered the resident's room. She stated it appeared the resident was trying to get into the closet, fell against the closet door, and sustained a goose egg injury to the forehead. She	F 323			



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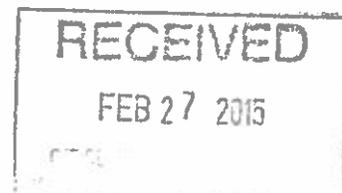
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F 323	<p>Continued From page 109</p> <p>stated by the next day the bump on Resident 20's forehead had swollen tremendously and was purple in color.</p> <p>Telephone interview with LPN #12, on 01/08/15 at 9:00 AM, regarding Resident #20's fall on 12/10/14, revealed she heard two CNAs yelling for assistance from Resident #20's room. She stated the resident was found in the floor behind the closed bedroom door by the closet door. She stated there was no alarm sounding at the time the resident was found. The LPN stated the resident was seen earlier in the shift fiddling with the alarm box. She stated the resident was assessed and found to have a hematoma to the left side of the forehead and right thumb.</p> <p>Further review of the Fall Scene Investigation report, dated 12/10/14, revealed the root cause of the fall was resident attempted unsafe transfer and turned off alarm. Previously in the shift the resident attempted an unsafe transfer and tried to figure out how to turn off the alarm. The Director of Nursing (DON), Administrator (ADM) and Risk Manager (RM) met regarding the fall on 12/19/14 and there was no documented evidence on the form that the DON or Administrator had made recommendations or provided direction to change the plan of care.</p> <p>Continued interview with Resident #20's Responsible Party (RP), on 01/09/15 at 4:05 PM, revealed the resident had fallen on 12/10/14 and had hit their head and sustained a hematoma to the forehead and bruise to the hand. The RP stated the resident was on blood thinning medication for the history of a blood clot in the leg, and this caused the increased bruising seen on the resident's face, neck and shoulder, after</p>	F 323			



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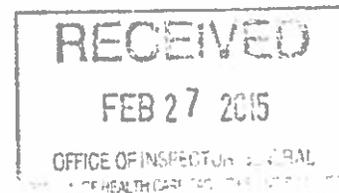
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F 323	<p>Continued From page 110</p> <p>the fall on 12/10/14. The RP stated they expected the facility to provide adequate supervision to prevent falls; however, the facility did not increase monitoring or rounding on the resident.</p> <p>Interview with the Risk Manager (RM), on 01/09/15 at 10:10 AM, revealed the root cause of Resident #20's fall on 12/10/14 was the resident attempted an unsafe transfer and turned off the bed alarm. She stated Resident #20 was on the facility toileting program; however, she had not reviewed the toileting program to determine if Resident #20's was effective and individualized or was the potential root cause for the resident's last two (2) falls. She stated she met with the DON and Administrator, to discuss the 12/10/14 and 12/14/14 falls on 12/19/15 (three days after Resident #20 passed).</p> <p>Telephone interview with the Medical Director, on 01/28/15 at 2:30 PM, revealed he was contacted by the DON on 01/08/15 regarding the Immediate Jeopardy. The Medical Director stated the facility had not done the right things in regard to the fall of Resident #20.</p> <p>Continued review of Resident #20's Fall Scene Investigation reports, revealed Resident #20 had sustained five (5) falls prior to the two (2) falls in December, 2014. The falls occurred on 06/10/14, 06/11/14, 08/09/14, 09/08/14, and 10/20/14.</p> <p>Review of the Fall Scene Investigation report, dated 06/10/14, revealed the root cause of Resident #20's fall was he/she slid out of the wheelchair with no injury. Review of Fall Scene Investigation report, dated 06/11/14, revealed the root cause of the fall was resident slipped and</p>	F 323			



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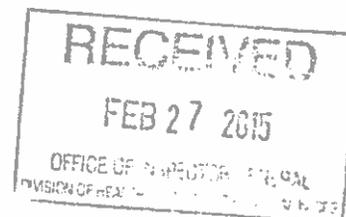
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F 323	<p>Continued From page 111</p> <p>fall, next to the bed, while walking unassisted with no injury. However, there were no recommendations for care plan revisions written under the heading Additional Care Plan/Care Sheet Updates for the fall on 06/10/14 or 06/11/14. In addition, the fall on 06/10/14 was not review by the DON, Administrator and RM until twenty (20) days later on 06/30/14. The fall on 06/11/14 was not reviewed by the DON, Administrator and RM until nine (9) days after the fall on 06/20/14. Further review of Resident #20's plan of care revealed a non-skid liner to the wheelchair was added to the wheelchair on 06/27/14, seventeen (17) days after the fall.</p> <p>Review of the Fall Scene Investigation report, dated 08/09/14, revealed the root cause of Resident #20's fall stated he/she was non-compliant with care and was experiencing intermittent confusion. The resident received no injury from the fall. The Fall Scene Investigation report, dated 09/08/14, revealed the root cause of Resident #20's fall stated the resident was reaching for a trash can. The fall did not result in any injury. The DON, Administrator and RM met on 09/11/14 regarding the falls on 08/09/14 and 09/08/14 and no recommendations for additional changes to the plan of care were documented as given by the DON or Administrator. Further review of Resident #20's plan of care revealed there was no revision to the interventions related to these two (2) falls.</p> <p>Review of the Fall Scene Investigation report, dated 10/20/14, revealed the root cause of the fall was it appeared the resident was ambulating from the toilet to the wheelchair unassisted, slipped and fell without injury. The DON, Administrator and RM met regarding the fall on 10/31/14 and</p>	F 323		



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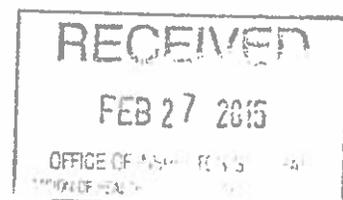
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F 323	<p>Continued From page 112</p> <p>there was no documented evidence on the form that the DON or Administrator had made recommendations or provided direction to change the plan of care. Further review of Resident #20's plan of care revealed a tab alarm pin/clip was added to the care plan on 10/23/14 to sit on the bar next to the toilet.</p> <p>Interview with LPN #5, on 01/08/15 at 9:20 AM, revealed she had placed Resident #20 on the toilet on 10/20/14, and left the resident unsupervised while she was completing tasks out in the resident's room. LPN #5 stated the resident was at high risk for falls, but believed it was safe to leave the resident unsupervised on the toilet. She stated she heard the resident fall and went to the bathroom to find the resident sitting crossed legged on the floor in front of the toilet. She stated the resident had a tab alarm to the bed and chair already and after the fall it was decided the alarm box would be placed on the hand rail next to the toilet. The LPN said that if the resident was left unsupervised again while toileting, it would alarm and notify staff the resident had raised from the toilet. She stated all staff know to supervise residents for safety, and that was done by rounding, which was done every two hours by the nursing assistants when they toileted and turned the residents. The LPN stated she did not provide additional direction to staff regarding increasing supervision of Resident #20 after the fall on 10/20/14. She stated increased supervision was usually done only when a resident was exit seeking.</p> <p>Interview with the Risk Manager (RM), on 01/09/15 at 10:10 AM, revealed the determination of the root cause and interventions to prevent another fall was made by determining what the</p>	F 323		



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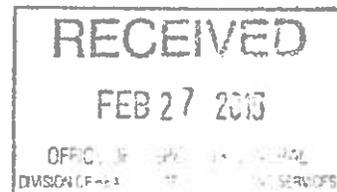
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F 323	<p>Continued From page 113</p> <p>resident was doing at the time. She stated the root cause of an incident was not looked at in the manner that determined what facility systems or processes were not working properly.</p> <p>Interview with the Director of Nursing, on 01/09/15 at 3:00 PM, revealed he didn't remember if he provided any direction to the RM regarding implementing additional interventions for Resident #20.</p> <p>2. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 08/19/13 with diagnoses of Renal Failure, Dementia, Hypertension, Anemia, Osteoarthritis, Coronary Atherosclerosis, Bladder Disorder, Dysuria</p> <p>Review of Minimum Data Set (MDS) for Resident #15, dated 12/02/14, revealed the facility was unable to assess Resident #15 utilizing the Brief Interview for Mental Status (BIMS) due to the resident was rarely/never understood. Review of the Falls care plan, dated 07/15/14, revealed a history of falls with potential for reoccurring falls related to medication use, cognition, immobility, and advancing Dementia. Interventions for the Falls care plan, not dated, revealed the staff was to notify the appropriate parties if a fall occurred; see activity plan for individual interests; sensor alarm; non-skid strips to bed side; verbal reminders to not ambulate or transfer without assistance; properly fitting non-skid soled shoes for ambulation; and, clutter free environment.</p> <p>Review of Resident #15's medical record revealed the resident had fall episodes documented on 06/29/14, 09/15/14, 10/31/14, 11/17/14, 12/15/14, 12/17/14, and 12/24/14.</p>	F 323		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2015
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F 323	Continued From page 114 Review of the Fall Scene Investigation report, dated 06/29/14, revealed Resident #15 fell on 06/29/14 at 4:25 PM. The staff reported witnessing the resident fall in the common area. The investigation report further revealed the resident had stated he/she was trying to get up to go to the bathroom. The resident did not obtain any injuries from this fall. The facility staff identified the root cause of this fall that the resident's foot slid when he/she was getting out of a recliner. The staff left blank the section of the investigation report titled Additional Care Plans/Care Sheet Updates. Review of the care plan revealed no changes, that were dated, were made to the care plan after the fall on 06/29/14. Review of the Fall Scene Investigation, dated 9/15/14, revealed Resident #15 fell on 9/15/14 at 7:00 PM. The fall report stated the resident was attempting to self-ambulate out of the bathroom in the resident room when he/she fell backward onto his/her buttocks. The nurse noted no injuries on this investigation. As the root cause, staff documented the resident was trying to get out of the bathroom. Staff entered n/a (not applicable) in the section of the investigation report titled Additional Care Plans/Care Sheet Updates. There were no changes, that were dated, added to the care plan after the fall on 09/15/14. Review of the Fall Scene Investigation, dated 10/31/14, revealed Resident #15 fell on 10/31/14 at 2:45 PM. The fall report stated staff had found the resident sitting on the floor in the resident bathroom doorway without his/her wheel chair, walker, or alarms. The nurse noted no injuries on this Fall Scene Investigation report. As the root	F 323			



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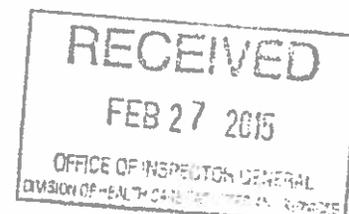
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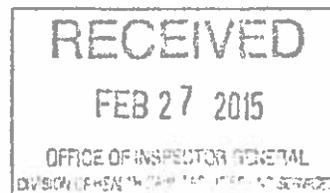
F 323	<p>Continued From page 115</p> <p>cause, staff documented the resident had an unsteady gait. The only notation found under interventions was on 10/31/14 "ER followup fall-slipped to floor unwitnessed found at bathroom door, no injury".</p> <p>Review of the Fall Scene Investigation, dated 11/17/14, revealed Resident #15 fell, on 11/17/14 at 3:20 AM. The staff reported the resident was getting up from the recliner in the common area to go the toilet when the fall occurred. The resident fell face down onto the floor from the recliner. The resident had taken shoes off while sleeping in the recliner. The resident obtained a 0.5 cm laceration to the left eyebrow. The additional care plan section of the form stated staff to continue using alarms as ordered. The following notation was listed under interventions on 11/18/14 "anti-rear tippers to wheelchair, and anti-roll backs to wheelchair". However, the resident fell from a recliner and had no falls from the wheelchair.</p> <p>Review of the Fall Scene Investigation, dated 12/15/14, revealed Resident #15 fell on 12/15/14 at 11:20 PM. The fall report stated another resident reported to staff that he/she had heard someone fall. Staff went to Resident #15's room and found the resident attempting to get back into the bed. The resident had been incontinent of urine. The report further stated the resident had removed the sensor alarm from his/her bed and had placed it on the bedside table. The staff put an alarm in place. The resident hit his/her head and complained of pain in his/her right shoulder. The staff completed the additional care plan section of the form on 12/16/14 and indicated the</p>	F 323		
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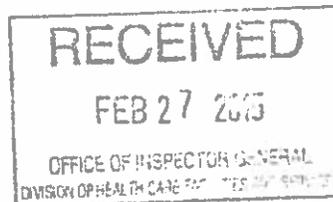
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F 323	<p>Continued From page 116</p> <p>facility would provide the resident with a mattress with raised edges to assist the resident to identify the edge of the bed. However, no interventions were put in place to address toileting needs or the removal of the sensor alarm from the bed. There were no changes made to the falls care plan after the 12/15/14 fall.</p> <p>Review of the Fall Scene Investigation, dated 12/17/14, revealed Resident #15 fell on 12/17/14 at 9:15 AM. The fall report stated the resident had stated he/she was getting up to use the toilet. The resident had been attempting to ambulate unattended in his/her room at the time of the fall. The resident received an abrasion on the mid upper back and a skin tear to the right elbow about 1.8 cm long. The resident was incontinent of urine at the time of the fall. The Additional Care Plan Update section of the form was crossed through. There were no changes made to the falls care plan after the 12/17/14 fall.</p> <p>Review of the Fall Scene Investigation, dated 12/24/14, revealed Resident #15 fell on 12/24/14 at 10:55 AM. The fall report revealed the resident had stated he/she was making the bed at the time of the fall. The resident had been attempting to ambulate unattended in his/her room and was incontinent of urine at the time of the fall. The Additional Care Plan Update section of the form was crossed through. There were no changes made to the falls care plan after the 12/24/14 fall.</p> <p>Interview with the DON, on 01/09/15 at 3:00 PM, revealed it was important to determine the root cause of incidents to ensure the appropriate</p>	F 323		



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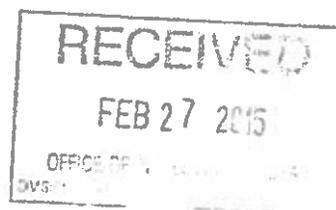
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F 323	<p>Continued From page 117</p> <p>corrective actions were put in place. He stated he had not provided any direction to staff to implement additional interventions for Resident #15.</p> <p>3. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 10/02/13 with diagnoses of Atrial Fibrillation, Arthritis, Hypertension, Seizures, Iron Deficiency Anemia, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Thrombocytopenia, and Generalized Pruritus. Review of Resident #13's Comprehensive Minimum Data Set (MDS) Assessment, dated 08/08/14, revealed the facility assessed the resident utilizing the Brief Interview for Mental Status (BIMS) with a BIMS score of 9. The assessment further revealed the resident triggered at risk for falls due to a history of falls and did not ambulate, but used a wheelchair for mobility.</p> <p>Review of Resident #13's Comprehensive Care Plan, dated 10/10/13, revealed that prior to the resident's admission to the facility he/she had a history of crawling from one place to another in his/her home. The care plan further revealed interventions for falls prevention, not dated, that stated staff was to place a sensor alarm to bed and chairs as ordered; notify appropriate parties if falls occurred; mattress with raised edges; non-skid socks; low bed with floor mats; verbal reminders to not ambulate or transfer without assistance; and, proper fitting non-skid soled shoes for ambulation and transfers.</p> <p>Review of the Quarterly MDS, dated 10/28/14, revealed Resident #13 required the assistance of one (1) staff member for transfers.</p>	F 323			



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F 323	<p>Continued From page 118</p> <p>Interview, on 01/09/15 at 12:05 PM, with LPN #5 revealed it was her understanding that prior to Resident #13's admission to the facility, the resident crawled from chairs/furniture in his/her home to the floor as a means of getting around, and at times, the resident had exhibited this behavior as a means of transfer/locomotion since he/she had been living at the facility.</p> <p>Review of Resident #13's nurses' notes, revealed on 10/10/14 at 12:30 AM, Resident #13 was found crawling on the floor mat beside his/her bed. The resident had defecated on the floor mat. Staff toileted the resident, and assisted him/her back to bed. At 4:40 AM, after the resident was transferred by staff via wheelchair to the Orchard Unit sitting area, the resident's chair alarm sounded and he/she was found crawling on the floor. The Nurses' notes revealed the resident was assessed by the nurse and neurological (neuro) checks were initiated. Further review of the nurses' notes revealed on 10/10/14 at 7:00 AM, Resident #13 was again found on the floor of the unit's day room/sitting area. The resident was positioned on the floor between his/her wheelchair and another chair. The resident was assessed and a small laceration (1-2 centimeters) was found at the back of his/her head. Resident #13's physician was notified and the resident was transferred to a hospital emergency department for evaluation.</p> <p>Interview, on 01/09/14 at 2:40 PM, with the Unit Manager (UM) for the Orchard Unit, revealed Resident #13 was not care planned to crawl from one area to another on the Orchard Unit, such as from his/her wheelchair to the floor. The UM stated she had seen Resident #13 crawl out of his/her wheelchair, but further stated it was not</p>	F 323			



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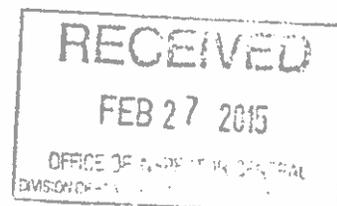
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F 323	<p>Continued From page 119</p> <p>safe for the resident to crawl out of the wheelchair. The Orchard UM stated Resident #13's falls care plan should have been updated after the resident fell two (2) times on the floor of the Orchard Unit on 10/10/14. The UM stated that after Resident #13's return from the hospital, he/she could have been evaluated by therapy to determine if any other safety interventions could have been appropriately implemented to protect the resident while seated in the wheelchair.</p> <p>4. Review of the clinical record for Resident #17 revealed the facility admitted the resident on 02/11/14 with diagnoses of Fractured Leg, Toxic Encephalopathy, Anemia, Heart Disease, Chronic Pulmonary Heart Disease, Hypertension, Atrial Fibrillation, Cardiac Murmurs, and Osteoarthritis.</p> <p>Review of Minimum Data Set (MDS) for Resident #17, dated 01/06/15, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of eleven (11), indicating cognitively intact.</p> <p>Review of Resident #17's medical record revealed the resident sustained three (3) falls since admission occurring on 06/19/14, 12/20/14 and 12/25/14.</p> <p>Review of the Fall Scene Investigation report, dated 06/19/14, revealed Resident #17 fell on 06/19/14 at 8:50 AM. The staff found Resident #17 on the floor in the resident's room. The staff did not witness the resident fall. The resident obtained a laceration to the forehead, along with skin tears to left forearm and right elbow, and staff sent Resident #17 to the emergency room for an evaluation. The root cause portion of the</p>	F 323		

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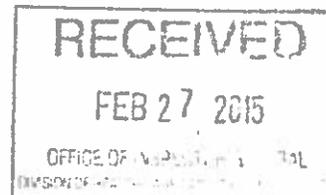
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F 323	<p>Continued From page 120</p> <p>document stated it appeared the resident fell asleep and fell out of the wheelchair head first into the foot rail of the bed.</p> <p>Review of the care plan for Resident #17, dated 02/20/14, revealed staff had not added new interventions to the falls section of the care plan after the resident fell on 06/19/14.</p> <p>Review of the Fall Scene Investigation report, dated 12/20/14, revealed Resident #17's second non-injury fall occurred on, 12/20/14 at 5:45 PM. The investigation report stated the staff found the resident in his/her room on the floor in front of the wheelchair. The investigation report further stated the resident was wearing regular socks and no shoes at the time of the fall. Review of the nurses' notes, dated 12/21/14 at 10:50 AM, revealed the alarm clip had slipped off the resident's shirt, preventing the alarm from sounding.</p> <p>Review of the care plan for Resident #17, dated 02/20/14, revealed staff had not added new interventions to the falls section of the care plan after the resident fell on 12/20/14.</p> <p>Review of the Fall Scene Investigation report, dated 12/25/14, revealed Resident #17, had a non-injury fall on, 12/25/14 at 6:45PM. The report stated staff witnessed the resident attempting to take his/her shoes off when he/she slid out of the wheelchair.</p> <p>Review of the care plan for Resident #17, dated 02/20/14, revealed staff had not added new interventions to the falls section of the care plan after the resident fell on 12/25/14.</p>	F 323		



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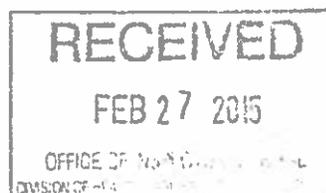
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F 323	<p>Continued From page 121</p> <p>Interview with CNA #3, 01/08/15 at 11:00 AM, revealed the CNAs and Nurses checked the alarms to make sure they were functioning by checking to see if it would beep; however, Resident #17 would take the alarm off on his/her own.</p> <p>Observation of Resident #17, on 01/08/15 at 8:30 AM, revealed the resident was in his/her room, sitting in a wheelchair, with a tab alarm safety pinned to the resident's shirt and shoes on his/her feet. The resident was eating breakfast at that time.</p> <p>Interview with Resident #17, on 01/08/15 at 10:10 AM, revealed Resident # 17 had three (3) falls in the last six (6) months. Resident #17 stated the first fall, in June, occurred in the resident's room. The resident stated he/she had attempted to get up to use the toilet when his/her foot became caught under the bed. The resident stated he/she fell and hit their head while trying to get up and the head injury required stitches. Resident #17 then discussed the two (2) falls in December 2014. The resident stated both falls were due to him/her sliding out of the wheelchair. The resident stated staff had placed a cushion in the seat of the wheelchair for him/her to sit on, but the cushion made the seat even more slippery. Resident #17 further discussed the tab alarm to his/her shirt. The resident stated the string attaching the clip to the alarm box was too short and when he/she leaned forward the clip would slide off his/her shirt or the pin would pull out of the alarm box causing the alarm to go off. The resident stated the alarm would bother him/her and the resident would take it off the shirt when it was getting on his/her nerves. The resident further stated that after falling he/she agreed to</p>	F 323			



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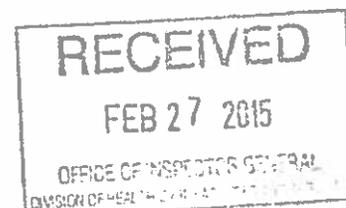
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F 323	<p>Continued From page 122</p> <p>have the alarm clip pinned to his/her shirt so that it would stay attached.</p> <p>Interview with the DON, on 01/09/15 at 3:00 PM, revealed it was important to determine the root cause of incidents to ensure the appropriate corrective actions were put in place. He stated he had not provided any direction to staff to implement additional interventions for #17.</p> <p>5. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 06/15/11 with diagnoses of Hypertension, Deep Vein Thrombosis, Dementia, Schizophrenia and the resident had a history of falls.</p> <p>Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 12/17/14, revealed the facility assessed the resident to need supervision when walking and transferring. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored an eight (8) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Review of the Falls care plan for Resident #8, dated 06/29/11, revealed a potential for falls related to a history of frequent falls, unsteady gait, medication use, immobility, and cognitive deficit. The interventions, not dated, stated the staff was to notify the appropriate parties if a fall occurred; rear anti-tippers to wheelchair, anti-rollbars to wheelchair; mattress with raised edges; properly fitting non-skid soled shoes for ambulation; and, environment free of clutter.</p> <p>Review of the Nursing Notes, dated 12/28/14 and timed at 9:25 PM, revealed the nurse was standing outside Resident #8's room when she</p>	F 323			



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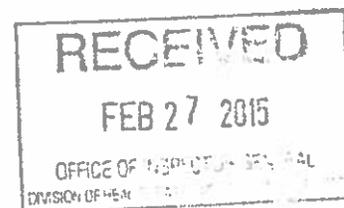
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F 323	<p>Continued From page 123</p> <p>heard a loud sound and upon entering resident's room observed the resident sitting on the bathroom floor. The nursing notes stated the resident was brushing his/her teeth and the resident's legs became weak and the resident fell. The resident was assisted back to bed. Vitals signs documented after the fall were Blood Pressure 200/82, Heart Rate 82, Respirations 18, and Temperature 98.1 degrees Fahrenheit. Nursing documented no injuries noted at the time of the fall; however, nursing noted on, 12/29/14 at 12:30 PM, that the resident complained of right hip and back pain and received an order to obtain an X-ray of the right hip and pelvis. The X-ray findings were negative for a fracture.</p> <p>Review of Resident #8's, Falls Nursing Care Plan, dated 06/29/11, revealed no revisions or updates were made after Resident #8's fall on 12/28/14.</p> <p>Review of Resident #8's Fall Scene Investigation Report, dated 12/28/14, revealed the root cause of the fall was the resident's legs became weak while standing. Interventions listed to prevent future falls and to ensure safety was to place the resident's name on the physician's list for review and to complete neuro-checks. The Summary of Meeting and Additional Care Plan Update sections were blank.</p> <p>Interview with the Advance Practitioner Registered Nurse (APRN) on, 01/07/15 at 2:15 PM, revealed she had not assessed the resident as of 01/07/15 in regards to the fall on 12/28/14. The APRN said according to her review of the physician's documentation in the medical record Resident #8's physician had not performed an assessment to determine the cause of the fall as of 01/07/15. She stated physicians had an</p>	F 323		



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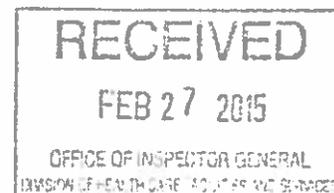
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
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F 323	<p>Continued From page 124</p> <p>important role in falls prevention. She stated the physician would assess medication for potential causes of falls and look at resident's diagnoses to determine if there was a correlation. She stated the physician's input was important to the care of the resident.</p> <p>Interview with the Risk Manager (RM), on 01/07/15 at 10:30 AM, revealed the root cause of Resident #8's fall was the resident's legs became weak while standing. She stated the resident walked, transferred and toileted self and, due to this, the interventions put in place by nursing after the fall to prevent future falls was neuro-checks and a physician consult. She stated she did not review the charts at a later date to determine if interventions were completed. The RM stated she did not complete her documentation under the Summary of Meeting where she would have met with the Administrator and the Director of Nursing to discuss the fall. She stated if the area under Additional Care Plan Update sections was blank there were none to document.</p> <p>Interview with the Director of Nursing on, 01/09/15 at 3:00 PM, revealed he had not provided direction to the Risk Manager regarding adding additional falls prevention interventions to Resident #8's plan of care. He stated he was not aware the physician had not assessed the resident since the fall on 12/28/14. He stated he did not performed chart audits to determine if interventions were completed.</p> <p>6. Review of Resident #16's clinical record revealed the facility originally admitted the resident on 08/05/10, and readmitted the resident on 01/20/11 with diagnoses of Atrial Flutter, Hypertension, Hyperlipidemia, a history of Urinary</p>	F 323			



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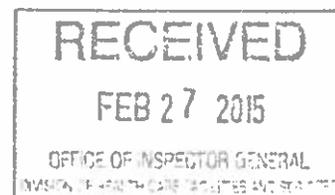
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2015
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F 323	<p>Continued From page 125 Tract Infections (UTIs), Cardiomegaly, and Dementia with Behavior Disturbance.</p> <p>Continued review of Resident #16's clinical record revealed he/she received routine anticoagulation therapy (Coumadin) along with Digoxin and Aspirin for a diagnosis of Atrial Fibrillation. Resident #16's Minimum Data Set (MDS) assessment, dated 12/10/14, revealed the facility could not complete the Brief Interview for Mental Status as the resident rarely/never understood. The MDS further revealed falls were a triggered care area due to trunk restraint used daily; anti-depressant medications; one person assist with locomotion; and, extensive assistance with mobility. Review of his/her Comprehensive Care Plan revealed a care plan for falls with multiple interventions, which included a sensor pad/alarm to the resident's bed.</p> <p>Review of the nurses' notes revealed Resident #16 was found, on 12/30/14 at 2:45 AM, with his/her body half on the bed, and half on the floor. The nurse's note stated the resident had no apparent injuries, but neurological (neuro) checks were initiated by the facility's protocol. The physician was notified later that morning at 10:40 AM and he returned the call at 12:05 PM.</p> <p>Review of the Fall Scene Investigation, revealed it was documented that three (3) hours prior to the incident, Resident #16 was awake, talking and reclining on his/her bed. But, at 2:45 AM CNA #5 observed Resident #16 sitting on the floor on the fall mat beside his/her bed. When the unit's licensed nurse inspected the sensor pad on the bed, the batteries that powered the device were missing.</p>	F 323		



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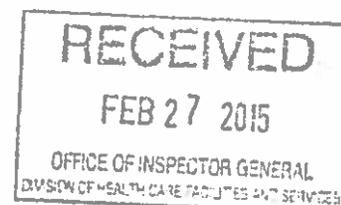
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F 323	<p>Continued From page 126</p> <p>Interview, on 01/09/15 at 9:35 AM, with CNA #5 revealed she was assigned to provide care to Resident #16 on the second shift on 12/29/14 and on the third shift on 12/30/14. CNA #5 stated she prepared the resident for bed by performing perineal care, putting the bed in lowest position, and placing the floor mat beside the bed. However, CNA #5 stated she forgot to check the sensor alarm for function before leaving Resident #16's room. CNA #5 stated that during the early morning hours of 12/30/14 at 2:45 AM, she entered Resident #16's room, turned on the light and saw the resident seated by the bed and on the floor mat. CNA #5 stated Resident #16 was confused. Continued interview with CNA #5 revealed the facility's Staff Development Nurse provided a written in-service on tab and bed alarms and she instructed that it was the CNA's responsibility to be sure the alarms had batteries and were functioning. CNA #5 stated that she could not remember exactly when that in-service occurred. CNA #5 stated Resident #16 was supposed to have a long sensor pad on his/her bed, and the alarm on the pad should sound if the resident tried to get up from bed. CNA #5 stated the staff person responsible for caring for the resident was supposed to test the residents' alarms during his/her rounds at the beginning of the shift. CNA #5 stated she failed to check Resident #16's alarm for function.</p> <p>Interview, on 01/08/15 with the Unit Manager (UM) for the Orchard Unit, revealed she learned about Resident #16's fall on 12/30/14 during the morning staff meeting. The UM stated the night nurse told her the sensor alarm was not working, and the entire box (unit) for the alarm was changed out after CNA #5 found the resident on the floor. The UM stated it was the CNA's</p>	F 323		



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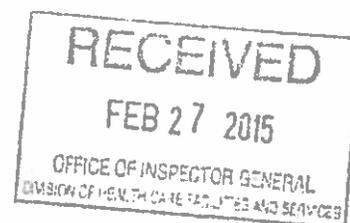
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F 323	<p>Continued From page 127</p> <p>responsibility to check the bed/chair alarms each shift to ensure they had batteries and were functioning. The UM stated she did not know if the night nurse had re-educated CNA #5 to check the residents' bed or chair alarms for batteries and function at the beginning of each shift.</p> <p>Interview, on 01/09/15 at 3:40 PM, with the DON, revealed CNAs were responsible for checking residents bed and chair alarms. In addition, the CNAs were to sign off in a log book, at the end of their shifts, to verify the residents bed and chair alarms had been checked and were functioning. The DON further stated each unit's licensed nurses, the shift supervisor, and ultimately he was responsible for ensuring all residents bed and chair alarms were working, and that all safety measures were in place to protect the residents from potential injury.</p> <p>Interview with the Risk Manager (RM), on 01/09/15 at 9:35 AM, revealed she had received training on fall prevention and filling out the falls investigation forms; however, she had not received training in conducting a root cause analysis. She stated her responsibility was to ensure follow-up occurred after each resident's fall; complete the documentation under the Falls Team Notes section of the Fall Scene Investigation report and report falls data/information to the Resident Safety Committee and Quality Assurance Committee. However, this was not documented, they only track and trended by the month not the individual. She stated the root cause portion of the Fall Scene Investigation form was completed by nursing staff. She stated she continued the investigation process by conducting interviews if needed, reviewing facility documentation, and</p>	F 323		



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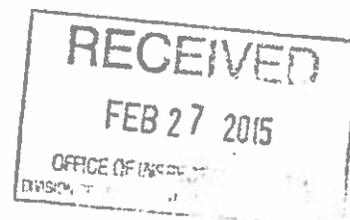
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F 323	<p>Continued From page 128</p> <p>hospital records if the resident was sent out. She stated she would try and meet with the Director of Nursing and the Administrator at least every other week to discuss the findings of the fall, but this was not a set time frame. RM stated her documentation on the Fall Scene Investigation forms was not always complete or timely. She stated the determination of the root cause and interventions to prevent another fall was made by determining what the resident was doing at the time. She stated the root cause of an incident was not looked at in the manner that determined what facility systems or processes were not working properly.</p> <p>Continued interview with Director of Nursing, on 01/09/15 at 3:00 PM, revealed the Risk Manager was responsible for conducting the investigation into resident falls and documenting the conclusion on the bottom portion of the Fall Scene Investigation Report. He stated if a resident experienced a fall it was discussed in the morning meeting the day after the fall occurred. He stated the Administrator, RM and himself would meet to review a resident's fall. He stated he did not keep any record of the meetings and doesn't remember if he provided any direction to the RM. The DON also stated he did not conduct purposeful facility/resident rounds to determine if the facility's system for fall prevention, toileting and physician notification was or was not working to meet the needs of the residents.</p> <p>Interview with Administrator on, 01/09/15 at 5:25 PM, revealed he did not provide direction to the Director of Nursing or the Risk Manager regarding the determination of the root cause for residents fall. He stated he did not provide direction to staff to address this issue or identify if</p>	F 323			



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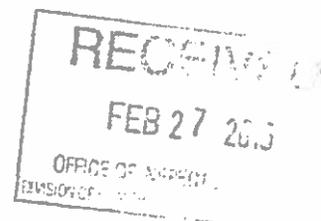
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F 323	<p>Continued From page 129 it was a system issue after being made aware.</p> <p>Telephone interview with the Medical Director, on 01/26/15 at 2:30 PM, post survey due to lecture schedule and inavailability, revealed all resident incidents should be reported to the attending physician whether there was resident injury or non-injury. He further stated if a resident had a fall/accident without injury the attending physician should be notified at least within twenty-four (24) hours. He indicated the attending physician should never be notified by facsimile. The Medical Director stressed the importance of the role of the CNAs, their need for more education, the culpability of the facility and the necessity of never blaming the resident for a fall/accident.</p> <p>Review of the Allegation of Compliance (AOC) revealed the facility implemented the following Immediate steps to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 1. The Medical Director was notified of Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday 01/08/15. 2. A representative of the Governing Body provided the Administrator guidance and education on physician and family notification, supervision and investigation of falls, care plan revisions and scheduled toileting programs on 01/08/15 and 01/09/15. 3. Licensed nurses (DON, Staff Development Coordinator, Risk Care Manager, Restorative/Wound Care Nurse, Minimum Data Set Nurse, House Supervisor, two (2) Unit Managers and a Staff Nurse) completed an audit on 01/10/15 for the one hundred eleven (111) 	F 323			



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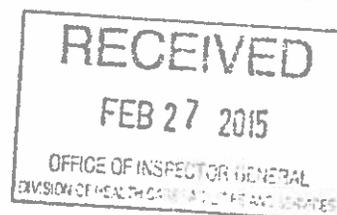
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F 323	Continued From page 130 residents currently in the facility. This included thirty (30) residents who had a fall in the past three (3) months, and eighty-one (81) residents who had no fall within the past three (3) months. The audit included a review of the fall event document for those who had fallen for root cause of the fall, interventions added to the care plans at the time of the fall, times of scheduled toileting program (if any), alarms utilized, care plans, notifications made to the attending physician and resident's responsible party and interventions added after the audit was completed. An action taken as a result of the audit included update/revision to care plans for eleven (11) residents that included reachers; toileting in early morning hours; sensor pads; mattresses; and, non-skid strips to the floor. In addition, one resident's toileting program was addressed as a result of the 01/10/15 audit with changes to the timing of the toileting program based on his/her individualized needs. 4. The Medical Director met with the Director of Nursing (DON) on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program. Revisions were made to the policy, Accident and Incidents, for physician and responsible party notification to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Revision was made to the policy, Falls Prevention, to check safety devices each shift to ensure they are in place and functioning properly. 5. The procedure for conducting neurological checks was reviewed by the DON and the Staff	F 323			



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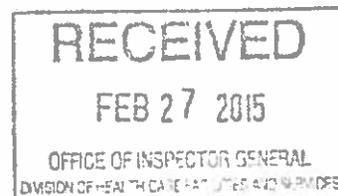
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F 323	<p>Continued From page 131</p> <p>Development Coordinator and all licensed nurses provided education on that process on 01/10/15 through 01/13/15. The DON and the Staff Development Coordinator conducted the inservice training on neurological checks and additional pen lights (used to conduct the neurological checks) were ordered by the DON on 01/12/15.</p> <p>6. The MDS Coordinator, MDS Nurse, DON and Risk Manager are responsible for ensuring care plans are completed/ revised in a timely/accurate manner. The care plans of residents who have fallen would be reviewed weekly in a Standards of Care meeting led by the MDS Nurse and the MDS Coordinator. In attendance at that meeting are the Dietary Manager, Risk Manager, Social Services Representative and the Activity Director. A report would be generated in that meeting of all falls, the review/revision of the residents' care plans and any actions taken to address concerns which would include staff education, staff discipline and care plan revisions to the Quality Assessment and Assurance Committee monthly from January 2015 - December 2015.</p> <p>7. The DON and the Staff Development Coordinator were provided training by the Administrator on 01/09/15 on physician and responsible party notification. The DON and the Staff Development Coordinator initiated all licensed nurses' and Certified Nursing Assistants' (CNA) training on 01/10/15 and continued that training through 01/13/15. A total of one hundred nineteen (119) staff had been trained by 9:30 PM on 01/13/15 with one (1) remaining staff notified they must receive training by their supervisor prior to returning to work. The training to all licensed nurses and certified nursing assistants included:</p>	F 323			



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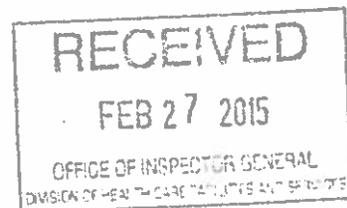
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F 323	<p>Continued From page 132</p> <p>work order process, care plans, certified nursing assistant care sheets, proper use and types of alarms, the scheduled toileting program process/form to be used and proper completion of the form. The licensed nurses received training on: falls and proper process for notification of the resident's physician, the responsible party, the neurological check process, the proper completion of the Event Report Form, review/revision of care plans, root cause analysis process, policy and procedure on Accidents and Incidents, policy on Falls Prevention, Neurological check protocol form and the form used for the Scheduled Toileting Program,</p> <p>8. The Administrator provided training to the Director of Nursing, the Risk Manager and therapy staff on 01/12/15 and 01/13/15 regarding the IJ, policy and procedure revisions, processes of Falls Committee Meeting, quality assessment and assurance committee role to ensure compliance and develop further actions to be taken.</p> <p>9. Three (3) notifications of residents' who fell prior to 01/12/15 was made to the attending physicians and responsible party on 01/12/15 with one (1) physician and the responsible party notification of a fall which occurred on 01/13/15.</p> <p>10. A Falls Committee was initiated 01/12/15 to review fall interventions, to review reviewed/revise care plans and to complete root cause analysis for falls during the meeting. The Falls Committee is comprised of the Administrator, the DON, a MDS Nurse, Social Worker, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services</p>	F 323	



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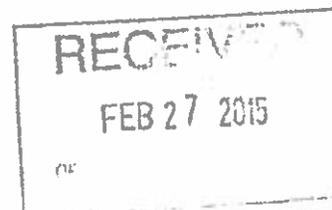
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F 323	Continued From page 133 Manager and meets Monday-Friday. 11. The DON provided training to the Restorative/Wound Care Nurse on 01/08/15, 01/10/15 and 01/12/15 addressing the facility's scheduled toileting program, the toileting program as it relates to falls, review of the four day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program form and the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of the toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee. 12. The Restorative/Wound Care Nurse would audit the toileting program using the Scheduled Toileting Audit tool. The toileting program documentation was to ensure accuracy and completeness of scheduled toileting programs. The audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. On 01/12/15 the Restorative/Wound Care Nurse audited twenty-nine (29) clinical records finding one (1) area of concern and on 01/13/15 she audited twenty-eight (28) clinical records finding one (1) area of concern. The Restorative/Wound Care Nurse is to report identified concerns with the toileting program to the DON and the Quality Assessment and Assurance Committee will review and monitor those findings. 13. The facility will utilize the Quality Assessment and Assurance Committee to review,	F 323			



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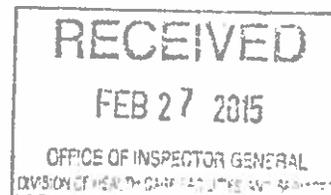
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F 323	<p>Continued From page 134</p> <p>evaluate and monitor for compliance with the notification of physician/responsible party, revision of resident care plans, toileting program and accidents and supervision with the following documents to be utilized: audits for falls, audits of notification of resident's attending physician/responsible party, audits of care plans addressing falls and audits of toileting program. The monthly meeting of the Quality Assessment and Assurance Committee to be held in February 2015 will be the initial meeting to review all of the audit information. These meetings will continue monthly for the next calendar year and will review the audit findings, assess the effectiveness of actions taken, revise action plans if necessary and continue to monitor the specifics of all falls within the facility.</p> <p>On 01/23/15, the State Survey Agency (SSA) validated the facility's AOC prior to exit through observation, interview and record review as follows:</p> <p>1. Telephone interview with the Medical Director, on 01/26/15 at 2:30 PM, post survey due to lecture schedule and unavailability, revealed he was contacted by the Director of Nursing (DON) on 01/08/15 regarding the Immediate Jeopardy. The Medical Director revealed he and the DON discussed several issues in regard to the Immediate Jeopardy i.e. the cause of resident falls, toileting issues/toileting schedules, CNA education, review of residents' medications, use of non-skid socks/shoes (should always be available) and lighting. He also revealed he and the DON discussed revision of the residents' care plans as necessary and the revisions needed for facility policies; specifically Accidents/Incidents, Fall Prevention and the Toileting Program. The</p>	F 323			



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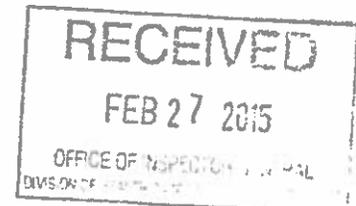
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F 323	<p>Continued From page 135</p> <p>Medical Director indicated he told the DON the question should always be asked after a resident's fall where the facility failed and what should be done to prevent resident falls/accidents.</p> <p>2. Review of the Administrator's notes from telephone conversation with a Governing Body representative revealed the representative retrained the Administrator on the need to ensure policies and procedures were in place (process of physician/family notification, supervision and falls, care plan revisions and scheduled toileting programs). Further review of the Administrator's notes from telephone conversation with a Governing Body representative on 01/09/15 revealed the representative addressed the process of root cause analysis which required intense and in-depth questioning, record review, and resident, staff and witness interviews. Also discussed during the 01/09/15 training of the Administrator by the Governing Body representative was tracking and trending of all falls and assurance audits are in place to ensure processes are being followed with concerns identified to be addressed in staff training.</p> <p>Interview with the Administrator, on 01/23/15 at 10:50 AM, revealed he had a telephone conversation with a Governing Body representative on 01/08/15 and 01/09/15 to include how to complete the process of physician/family notification when a resident had a fall, how to follow the facility policy regarding falls, care plan revisions, the scheduled toileting programs, and the process in-depth root cause analysis.</p> <p>3. Review of the Resident Audit for Immediate</p>	F 323		



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F 323	<p>Continued From page 136</p> <p>Jeopardy January 2015 document revealed one hundred-eleven (111) residents (census of 01/10/15) were reviewed for falls in the past three (3) months-date/time/root cause; interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit with signatures of nurses completing the audits. In addition, record review of Unsampled Resident C's individualized toileting program revealed it had been revised as a result of the audit on 01/10/15 with changes to reflect a time frame for toileting of 3:00 AM - 5:00 AM as the resident had fallen during those hours when attempting to self toilet.</p> <p>Interview with the DON on 01/23/15 at 10:00 AM revealed he was involved in the audit of all residents' charts who were in the facility on 01/10/15 to review all falls within the past three (3) months in regard-date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit.</p> <p>Interview with the Risk Manager, on 1/23/15 at 4:32 PM, revealed she was involved in the review of residents' falls for the past three (3) months that included the current census of one hundred and eleven (111) residents on 01/10/15 and the review covered the date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit.</p> <p>Interview with the Minimum Data Set nurse, on 01/23/15 at 3:44 PM, the Restorative/Wound</p>	F 323			



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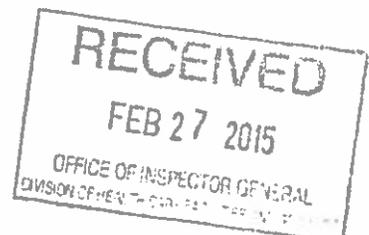
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F 323	<p>Continued From page 137</p> <p>Care Nurse, on 01/23/15 at 3:55 PM, two (2) Unit Managers on 01/23/15 at 4:45 PM, a Staff Nurse, on 01/23/15 at 5:05 PM, and the Staff Development Coordinator, on 01/23/15 at 5:30 PM, revealed they had all been involved in the audit of the facility residents on 01/10/15 to review all falls within the past three (3) months in regard-date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit. Record review of one resident's individualized toileting program revealed it had been revised as a result of the audit on 01/10/15 with changes to reflect a time frame for toileting of 3:00 AM - 5:00 AM as the resident has fallen during those hours when attempting to self toilet.</p> <p>4. Review of the policy, Accident and Incidents, on 01/23/15 at 9:00 AM revealed it had been revised to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Review of the policy, Falls Prevention, on 01/23/15 at 9:10 AM, revealed it had been revised to include the check of safety devices each shift to ensure they are in place and functioning properly.</p> <p>Interview with the Administrator and the DON, on 01/23/15 at 10:05 AM, revealed they had met with the Medical Director on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program and they made revisions to the Falls Prevention and the Accident and Incidents policies.</p> <p>Observation, on 01/22/15 at 10:40 AM, revealed</p>	F 323		

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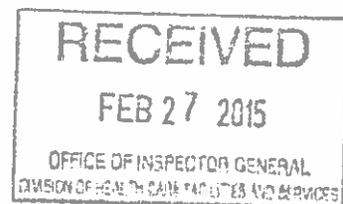
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F 323	<p>Continued From page 138</p> <p>Resident #25 had an alarm on the wheelchair as care planned and on 01/22/15 at 1:00 PM, Resident #25 was seated in the wheelchair with an alarm on the wheelchair. Observation of Resident #27, on 01/23/15 at 8:15 AM and 1:25 PM, revealed an alarm on the resident's wheelchair.</p> <p>Review of the record for Resident #25 revealed the resident's alarm had been checked on day shift per facility policy and was functioning and review of Resident #27's record revealed the resident's alarm had been checked on the day shift per facility policy and was functioning.</p> <p>5. Review, on 01/23/15 at 10:13 AM, of the content for an inservice to licensed nursing staff on 01/10/15 revealed the procedure for conducting neurological checks was reviewed by the Director of Nurses and Staff Development with the nurses and they were informed of additional pen lights (used during the neurological checks) being available in the facility on all of the crash carts. Review of two (2) medical supply company invoices on 01/23/15 revealed additional pen lights had been ordered by the Administrator for nurses to use during neurological checks.</p> <p>Observation of a neurological check performed by Licensed Practical Nurse (LPN) #4 on Resident #26, on 01/22/15 at 12:30 PM, revealed proper technique per standards of nursing practice and followed the facility's retraining for nurses on neurological checks.</p> <p>Interview with LPN #4, on 01/23/15 at 10:20 AM, revealed she had been retrained on neurological checks for residents with possible head injury</p>	F 323	



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F 323	<p>Continued From page 139 during a training provided to all licensed nurses on 01/10/15 by the Staff Development Coordinator and she knew pen lights were available in the facility on the crash carts.</p> <p>6. Interview with the Activity Director, on 01/23/15 at 3:50 PM, revealed she had been present on 01/21/15 in a Standards of Care meeting and had been involved in the review and revision of care plans for residents who had fallen.</p> <p>Interview with the MDS Coordinator, on 01/23/15 at 3:44 PM, revealed she was involved in the Standards of Care meetings weekly, on 01/21/15 and in the review or revision of care plans for residents who had fallen.</p> <p>7. Interview and record review with the DON, on 01/23/15 at 2:19 PM, revealed he was provided training by the Administrator on 01/09/15 on physician/responsible party notification after a resident's fall. He revealed he and the Staff Development Coordinator began on 01/10/15 an all nursing staff training regarding the physician/responsible party notification after a resident's fall, and continued through 01/13/15. A review of in-service training records on 01/23/15 revealed one hundred nineteen (119) staff had been trained by 9:30 PM on 01/13/15 as cross-referenced with the facility human resource department staff roster. The training also included: work order process; care plans; certified nursing assistant care sheets; proper use and types of alarms; the scheduled toileting program process/form to be used and proper completion of the form. The licensed nurses received training on: falls and proper process for notification of the resident's physician; the responsible party, the neurological check process; the proper</p>	F 323			



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F 323	<p>Continued From page 140</p> <p>completion of the Event Report Form; review/revision of care plans; root cause analysis process; policy and procedure on Accidents and Incidents; policy on Falls Prevention; Neurological check protocol form and the form used for the Scheduled Toileting Program.</p> <p>Interview with LPN #1, on 01/23/15 at 1:40 PM and the Restorative Nurse, on 01/23/15 at 3:55 PM, revealed she had been trained on physician/responsible party notification regarding a resident fall, care planning, event reports, scheduled toileting program/four (4) day bowel/bladder trending/proper documentation on 01/10/15 at 9:00 AM.</p> <p>Interview with CNA #11, on 01/23/15 at 1:50 PM, revealed she had been trained on maintenance requests, CNA resident information sheets, resident alarms and the scheduled toileting programs for residents on 01/12/15 at 10:45 PM.</p> <p>Interview with CNA #12, on 01/23/15 at 1:50 PM, revealed she had been trained on how to fill out the toileting program documentation, how to report any maintenance issues, the necessity to check alarms on any residents, to answer call lights timely and to report any concerns immediately.</p> <p>8. Review, on 01/23/15, of a therapy education attendance form and an administrative staff in-service training record each dated 01/13/15 revealed therapy staff and administrative staff had been trained by the Administrator on appropriate protocol to alert the maintenance department of safety issues and maintenance requests and a summary of the IJ received on 01/08/15.</p>	F 323			

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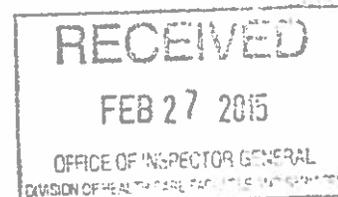
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F 323	Continued From page 141 Interview with the Business Office Manager, on 01/23/15 at 5:10 PM, revealed she received an in-service regarding the Immediate Jeopardy notification and the ramifications of same. She stated the in-service included reporting maintenance concerns and how the facility was doing root cause analysis during the morning meeting. Interview with a Certified Occupational Therapy Aide, on 01/23/15 at 4:50 PM, revealed he received an inservice about the Immediate Jeopardy, the Falls Prevention policy and root cause analysis among other resident falls concerns like the toileting program and all was presented by the Administrator. 9. Review of the nursing notes for Resident #23 and Unsampled Residents B, and C revealed the attending physician and responsible party were notified on 01/12/15 of falls prior to that date and for Unsampled Resident D the attending physician and responsible party was notified on 01/13/15 of a fall which occurred on 01/13/15. Interview with the DON, on 01/23/15 at 2:19 PM, revealed three (3) residents were discovered on 01/12/15 to need physician/family notifications of falls which occurred prior to 01/12/15 and a physician/family notification was made on 01/13/15 regarding a fall on that date all due to implementation of a revised notification system. 10. A Falls Committee meeting attendees sign-in sheet was reviewed on 01/23/15 which indicated the Administrator, the DON, the MDS Coordinator, Social Services #2, the Risk Care Manager and the Restorative/Wound Care Nurse	F 323			

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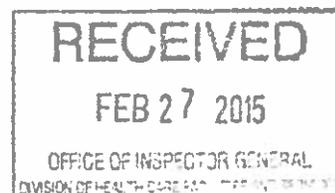
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F 323	<p>Continued From page 142</p> <p>were present at a meeting on 01/12/15 to review residents who had falls.</p> <p>Interview with the DON on 01/23/15 at 2:19 PM indicated the residents who were reviewed for falls at the 01/12/15 Falls Committee meeting were Resident #23 and Unsampled Residents B and C.</p> <p>11. Interview with the Restorative Nurse, on 01/23/15 at 3:55 PM, revealed she was trained by the DON, on 01/10/15 at 9:00 AM, on physician/responsible party notification regarding a resident fall, care planning, event reports, and scheduled toileting program/four (4) day bowel/bladder trending/proper documentation. She stated she had been made aware of the Immediate Jeopardy and the implications of the Immediate Jeopardy on 01/08/15, but she didn't remember if she signed an attendance sheet for that date on 01/12/15.</p> <p>Review of in-service training records revealed the Restorative Nurse signed a training record on 01/09/15 (no time), on 01/10/15 at 9:00 AM and on 01/12/15 (no time).</p> <p>12. Interview with the Restorative Nurse, on 01/23/15 at 3:55 PM, revealed she would use the Scheduled Toileting Audit tool to ensure accuracy and completeness of scheduled toileting programs Monday-Friday. She stated the audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. She indicated she had completed an audit of twenty-nine (29) clinical records on 01/12/15 finding one (1) area of concern and she audited twenty-eight (28) clinical records on</p>	F 323			



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F 323	<p>Continued From page 143</p> <p>01/13/15 finding one (1) area of concern. The Restorative Nurse revealed she would report to the DON each morning Monday-Friday any concerns she had identified from the audits and he would follow-up on them. She stated she would also report her findings to the Quality Assessment and Assurance Committee monthly and the committee would review and monitor those findings.</p> <p>Review of the scheduled toileting audit for January 2015 revealed the audit was started on 01/12/15 and was completed to 01/23/15.</p> <p>13. Interview with the Administrator on 01/23/15 at 5:23 PM revealed the facility utilized the Quality Assessment and Assurance Committee to review, evaluate and monitor for compliance with the notification of physician/responsible party, revision of resident care plans, toileting program and accidents and supervision with the following documents to be utilized: audits for falls, audits of notification of resident's attending physician/responsible party, audits of care plans addressing falls and audits of toileting program. The monthly meeting of the Quality Assessment and Assurance Committee to be held in February 2015 will be the initial meeting to review all of the audit information. These meetings will continue monthly for the next calendar year and will review the audit findings, assess the effectiveness of actions taken, revise action plans if necessary and continue to monitor the specifics of all falls within the facility.</p> <p>Interview with the Director of Nursing, on 01/23/15 at 3:25 PM, revealed the Quality Assurance Committee met and discussed resident charts, care plans, falls, and risk factors.</p>	F 323			



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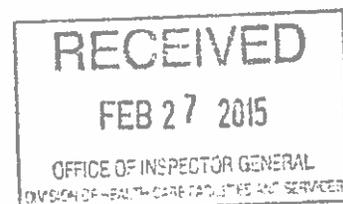
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
(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 323	<p>Continued From page 144</p> <p>As an example, Resident #13 was reviewed, with changes made to the care plan for a Gerichair for comfort and safety, and an OT evaluation for falls.</p> <p>Additional observations during the survey revealed environmental hazards related to equipment maintenance and electrical safety.</p> <p>1. Review of the facility's policy, titled Equipment-General Use for All Residents, dated March 2009, revealed wheelchairs, walkers, crutches, canes, beds, mechanical lifts, etc., would be maintained by the facility for the general use of all residents, and the maintenance staff would provide preventive and general maintenance of the facility's equipment.</p> <p>Observations during environmental rounds on 01/08/15, 01/09/15 and 01/10/15, revealed ten (10) of the facility's seventy-eight (78) wheelchairs, currently in use by residents, had arm rests with vinyl coverings that were cracked, frayed, and/or broken open.</p> <p>Interview, on 01/07/15 at 2:10 PM, with LPN #3, revealed there was a maintenance log kept on the unit at each nurses' station where direct care staff could list any identified safety issues/repair needs for resident rooms and/or resident equipment such as wheelchairs. LPN #3 further stated that cracked/frayed vinyl on wheelchair arm rests increased the risk for resident skin tears, and in turn, could increase the possibility for inflammation of a resident's skin and infection.</p> <p>Interview, on 01/08/14 at 2:25 PM, with the facility's Maintenance Director revealed the direct</p>	F 323			

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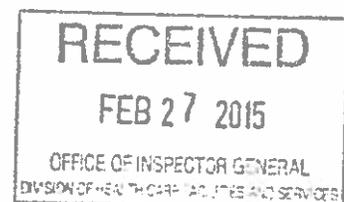
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2015
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F 323	<p>Continued From page 145</p> <p>care staff could list any needed resident equipment repair in the maintenance department communication log kept at each nurses' station. The Maintenance Director stated his staff reviewed the books daily.</p> <p>Interview, on 01/08/15 at 2:26 PM, with the DON revealed there was not just one person designated to monitor the condition of resident equipment such as wheelchairs, but that all direct care staff had received instruction through in-service education to report necessary wheelchair repairs, and further, they had been made aware that damaged wheelchair arm rests could put residents at risk for skin tears and discomfort.</p> <p>2. Observation of Room #2, on 01/07/15 at 3:00 PM, revealed a television cable cord hanging out of a hole in the wall at lap level. The television cable cord hole was approximately two (2) inches in diameter and three (3) inches in circumference with an electrical receptacle adjacent [approximately two (2) inches] to the hole.</p> <p>Review for both of the residents living in Room #2 revealed each had a moderate to severe cognitive impairment and both were wheelchair bound.</p> <p>Interview with CNA #1, on 01/08/15 at 9:00 AM, revealed it was her responsibility to ensure the safety of the residents living at the facility and if she noticed something that needed repair she would tell the unit nurse or put it in the log book at the nursing station for the maintenance men to fix. CNA #1 stated she had been assigned to Room #2 last week, but had not noticed the</p>	F 323			



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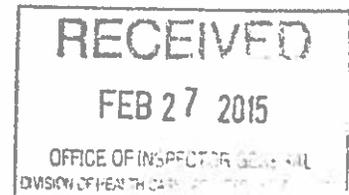
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F 323	<p>Continued From page 146</p> <p>television cable cord hanging out of the wall. CNA #1 stated neither resident in Room #2 had ever had a television to her knowledge.</p> <p>Interview with LPN #1, on 01/08/15 at 8:30 AM, revealed it was her responsibility to ensure the safety of the residents at the facility and if she saw something unsafe in the environment she would call one of the maintenance men or put the information in the log book at the nursing station. LPN #1 indicated she had not noticed the television cable cord hanging out of a hole in the wall of Room #2.</p> <p>Interview with the Maintenance Director, on 01/07/15 at 3:15 PM, revealed the maintenance department had not received a work order to replace the plate over the television cord hole in Room #2 and he had no idea how long the cord had been exposed in the hole in the wall. He indicated the plate was probably left off by the cable company man, but he did not know when the cable man had last been in the facility. The Maintenance Director stated he and no one in his department made routine rounds of the resident rooms or the building to look for environmental safety concerns. He indicated the Administrator would assign a staff person once a month to make rounds of the building and to focus on a certain number of rooms each month. He revealed he would fix those things brought to his attention by the Administrator or by the log book at each nursing station for work request orders.</p> <p>Interview with the Administrator, on 01/07/15 at 3:10 PM, revealed he did not know why the television cable cord did not have a plate over it as all of the cable cords had a cover over them to his knowledge and it must have been left off by</p>	F 323			



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F 323	Continued From page 147 the cable man. The Administrator indicated it was not a requirement of the facility for any of the maintenance workers to accompany the cable company workers when they were in the building unless they were going up into the attic of the building therefore, the cable man could have left the cable plate off. The Administrator stated he did assign a staff person to make rounds of the facility with focus on several resident rooms each month and that assigned staff was to turn in a report of their findings to him. The Administrator stated he would refer any concerns of things which needed to be fixed to the maintenance department brought to his attention from the audits. He stated he did not make any routine rounds of the building and resident rooms himself.	F 323			



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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1990 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III Unprotected, Mixed Construction. SMOKE COMPARTMENTS: Seven (7) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II, 100KW generator. Fuel source is Natural Gas. A Recertification Life Safety Code Survey was conducted on 01/06/15. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest deficiency identified at D level.	K 000	Preparation, submission, and implementation of this Plan of Correction does not constitute an admission or an agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

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

TITLE

(X6) DATE

[Signature]

X Administrator

X 02/18/2015

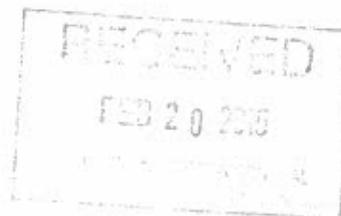
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

FEB 19 2015

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K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty-two certified beds and the census was one-hundred and ten (110) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/06/15 at 9:45 AM, with the Director of Maintenance and the Maintenance Assistant revealed boxes containing food, stored in the walk-in refrigerator located in the Kitchen, were stored within two (2) inches of the sprinkler head. A minimum of eighteen (18) inches of clearance is required from the sprinkler head.</p> <p>Interview, on 01/06/15 at 9:47 AM, with the Director of Maintenance and the Maintenance Assistant, revealed they were aware of the sprinkler head clearance requirement, but were not aware of boxes of food stored too close to the sprinkler head.</p>	K 062	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The boxes containing food, stored in the walk-in refrigerator located in the kitchen, that were stored within two (2) inches of the sprinkler head were removed by the Director of Maintenance and Dietary Manager on 01/06/15. Nothing remained stored within eighteen (18) inches from the sprinkler head.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>An inspection of the kitchen was completed by the Director of Maintenance and Dietary Manager on 01/06/15 to ensure a minimum of eighteen (18) inches of clearance as required from all the sprinkler heads in the kitchen. A complete inspection of every sprinkler head in the facility was conducted by the Director of Maintenance and Maintenance Assistant on 01/06/15 to ensure a minimum of eighteen (18) inches of clearance as required from all the sprinkler heads. All employees of the facility were provided training by the Staff Development Coordinator. The training was initiated on February 13, 2015. The training content addressed the requirement that there can be no obstructions to sprinkler discharge pattern development. Staff were instructed that there can be no continuous or non contiguous obstructions less than or equal to eighteen (18) inches below the sprinkler deflector that prevent the pattern from</p> <p>02/25/2015</p>



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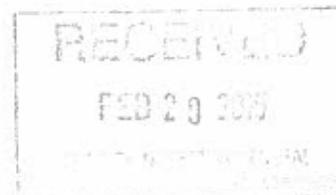
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K 062	<p>Continued From page 2</p> <p>The census of one-hundred and ten (110) was verified by the Administrator on 01/06/15. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 01/06/15.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development</p> <p>5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <p>(1) Wet pipe system</p> <p>(2) Light hazard or ordinary hazard occupancy</p> <p>(3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers</p>	K 062	<p>Continued from page 2 fully developing.</p> <p>3. Measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>The Dietary Manager will complete a visual inspection of all sprinkler heads in the kitchen and food storage areas on a daily basis the days she works. In her absence a Dietary employee will visually inspect all sprinkler heads in the kitchen and food storage areas. Documentation will be completed and signed by each individual visually inspecting the sprinkler heads to ensure a minimum of eighteen (18) inches of clearance. The Director of Maintenance and the Maintenance Assistant will visually inspect all sprinkler heads in the facility on a monthly basis.</p> <p>4. Facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>The Dietary Manager and Director of Maintenance will provide a written summary of findings of these inspections to the Quality Assessment and Assurance Committee on a monthly basis. The Quality Assessment and Assurance Committee will provide guidance and direct any action plans to ensure continued compliance with sprinkler head clearance requirements.</p>	



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K 062	Continued From page 3 are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. K 066 SS=D NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 062	02/25/15 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance, Maintenance Assistant, Administrator, Charge Nurse and Floor Tech picked up all cigarette butts off the ground around the generator on 01/06/15. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Maintenance and Maintenance Assistant did a complete inspection of the facility property on 01/06/15 picking up all cigarette butts. 3. Measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur.



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NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
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K 066	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, smoking policy review, and interview, it was determined the facility failed to ensure the facility was maintained as a smoke-free campus, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to effect each of the seven (7) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty-two (122) certified beds and the census was one-hundred and ten on the day of the survey. The findings include: Observation, on 01/06/15 at 9:55 AM, with the Director of Maintenance and the Maintenance Assistant revealed the area outside of the exit from the Kitchen, where the emergency generator is located, was being used as a smoking area. There were approximately fifty (50) cigarette butts on the ground around the generator. The facility was converted to a smoke-free campus in October of 2014, that required all smoking to be done outside of the facility's property. Interview, on 01/06/15 at 9:57 AM, with the Director of Maintenance and the Maintenance Assistant revealed the new smoke-free campus policy was not being strictly followed by some Staff members. The census of one-hundred and ten (110) was verified by the Administrator on 01/06/15. The findings were acknowledged by the Administrator	K 066	Continued from page 4 All employees were trained by the Staff Development Coordinator with training initiated on February 13, 2015. Content of training included a presentation of the smoke-free campus policy. A container has been placed at the front entrance for convenience of guests to properly discard cigarette butts. 4. Facility plans to monitor its performance to ensure that solutions are sustained. The Director of Maintenance and the Maintenance Assistant will pick up cigarette butts on the facility property Monday through Friday. The Director of Maintenance will report to the Administrator on a weekly basis the trends observed. The Administrator will direct Department Heads to provide education and counselling to their employees to ensure compliance with the smoke-free campus policy. The Director of Maintenance will provide a report to the Quality Assessment and Assurance Committee on a monthly basis reflecting his observations and his actions taken to include patterns and trends and his recommendations for staff education and/or counselling. The Quality Assessment and Assurance Committee will direct further action plans to ensure facility staff fully understand and comply with the smoke-free campus policy. The Administrator, Director of Nursing, Staff Development Coordinator,	

FEB 18 2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2015
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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
K 066	Continued From page 5 and verified by the Director of Maintenance at the exit interview on 01/06/15. Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available	K 066	Continued from page 5 and Director of Environmental Services will conduct weekly observations of the facility property and document findings and present findings to the Director of Maintenance and Department Heads on a weekly basis so further actions can be taken to ensure compliance.	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2015
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
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K 066	Continued From page 6 to all areas where smoking is permitted.	K 066		

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