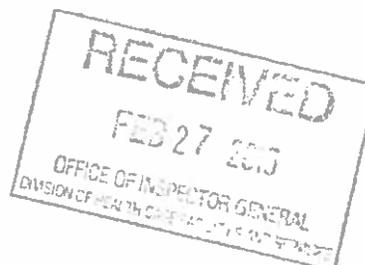


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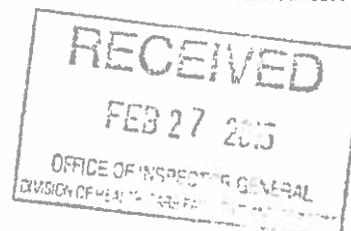
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185464 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>01/23/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN MEADOWS HEALTH CARE CENTER 1 |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>310 BOXWOOD RUN ROAD<br>MOUNT WASHINGTON, KY 40047                     |  |
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| F 280  | Continued From page 53<br>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.<br><br>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: 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 | F 280  |   |  |



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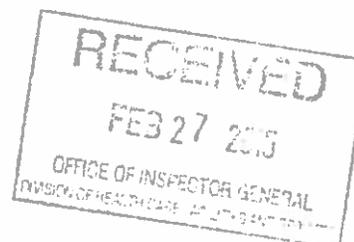
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| F 280  | <p>Continued From page 54</p> <p>Accidents and Incidents, policy on Falls Prevention, Neurological check protocol form and the form used for the Scheduled Toileting Program,</p> <p>8. The Administrator provided training to the Director of 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/revised 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 Manager and meets Monday-Friday.</p> <p>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</p> | F 280  |   |                      |  |



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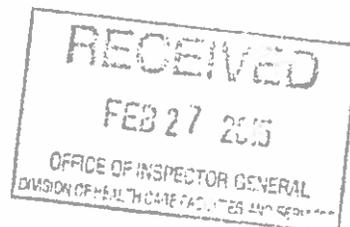
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| F 280  | <p>Continued From page 55</p> <p>the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of the toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee.</p> <p>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.</p> <p>13. The facility will utilize 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</p> | F 280  |   |                      |  |



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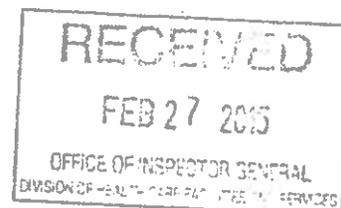
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| F 280  | <p>Continued From page 56</p> <p>audit information. These meetings will continue monthly for the next calendar year and will review the audit findings, assess the effectiveness of actions taken, revise action plans if necessary and continue 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> <ol style="list-style-type: none"> <li>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 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.</li> <li>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</li> </ol> | F 280  |   |  |



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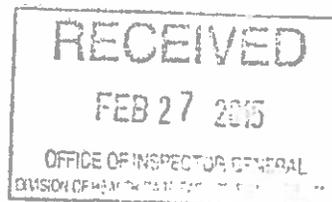
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| F 280  | <p>Continued From page 57</p> <p>physician/family notification, supervision and falls, care plan revisions and scheduled toileting programs). Further review of the Administrator's notes from telephone conversation with a Governing Body representative 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 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</p> | F 280  |   |                      |  |



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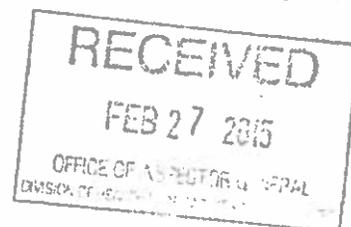
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| F 280  | <p>Continued From page 58</p> <p>audit on 01/10/15 with changes to reflect a time frame for toileting of 3:00 AM - 5:00 AM as the resident had fallen during those hours when attempting to self toilet.</p> <p>Interview with the DON on 01/23/15 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 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.</p> | F 280  |   |                      |  |



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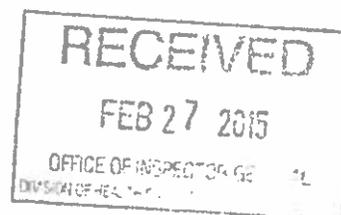
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| F 280  | <p>Continued From page 59</p> <p>Record review of one resident's individualized toileting program revealed it had been revised as a result of the audit on 01/10/15 with changes to reflect a time frame for toileting of 3:00 AM - 5:00 AM as 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 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</p> | F 280  |   |                      |  |



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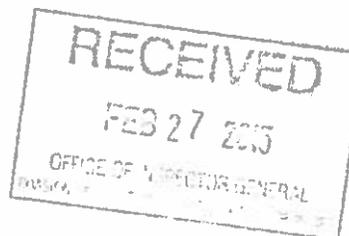
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| F 280  | <p>Continued From page 60</p> <p>review of Resident #27's record revealed the resident's alarm had been checked on the day shift per facility policy and was functioning.</p> <p>5. Review, on 01/23/15 at 10:13 AM, of the content for an inservice 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 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> | F 280  |   |                      |  |



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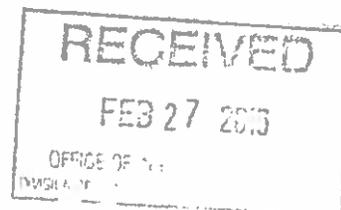
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| F 280  | Continued From page 61<br>Interview with the MDS Coordinator, on 01/23/15 at 3:44 PM, revealed she was involved in the Standards of Care meetings weekly, on 01/21/15 and in the review or revision of care plans for residents who had fallen.<br><br>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 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.<br><br>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 | F 280  |   |                      |  |



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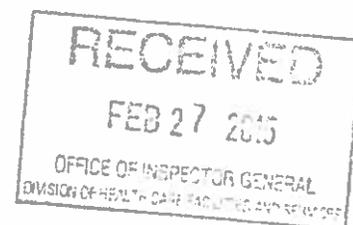
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| F 280  | <p>Continued From page 62</p> <p>a resident fall, care planning, event reports, scheduled toileting program/four (4) day bowel/bladder trending/proper documentation on 01/10/15 at 9:00 AM.</p> <p>Interview with CNA #11, on 01/23/15 at 1:50 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> <p>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.</p> <p>Interview with a Certified Occupational Therapy</p> | F 280   |   |  |



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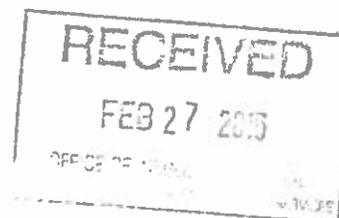
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| F 280  | <p>Continued From page 63</p> <p>Aide, on 01/23/15 at 4:50 PM, revealed he received an inservice about the Immediate Jeopardy, the Falls Prevention policy and root cause analysis among other resident falls concerns like the toileting program and all was presented by the Administrator.</p> <p>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.</p> <p>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.</p> <p>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 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</p> | F 280  |   |                      |  |



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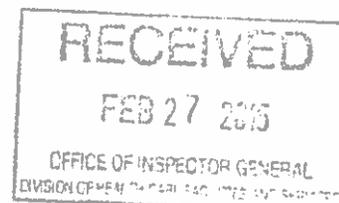
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| F 280  | <p>Continued From page 64</p> <p>the DON, on 01/10/15 at 9:00 AM, on physician/responsible party notification regarding a resident fall, care planning, event reports, and scheduled toileting program/four (4) day bowel/bladder trending/proper 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 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</p> | F 280  |   |  |



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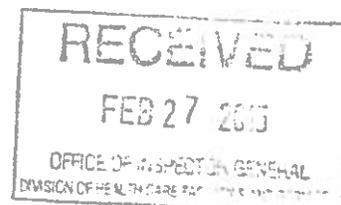
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| F 280  | Continued From page 65<br>January 2015 revealed the audit was started on 01/12/15 and was completed to 01/23/15.<br><br>13. Interview with the Administrator on 01/23/15 at 5:23 PM revealed the facility utilized the Quality Assessment and 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.<br><br>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. 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. | F 280  |   |                      |  |
| F 282<br>SS=G  | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of   | F 282  | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>Unit Manager responded to Resident #3's needs on 01/07/15. LPN #5 was provided | 02/25/15             |  |



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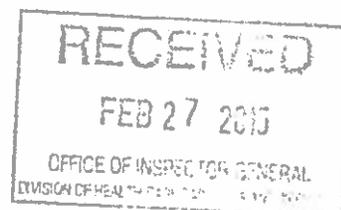
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| F 282  | Continued From page 66 care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record and policy review, it was determined the facility failed to have an effective system in place to ensure the comprehensive plan of care was implemented for two (2) of thirty-two (32) sampled residents (Resident #3 and Resident #16). The facility care planned Resident #3 to be turned and repositioned as needed due to pain, pressure and mobility. LPN #5 continued to pass medications and failed to respond to assist the resident to turn and reposition when he/she repeatedly cried out for someone to turn him/her because he/she was hurting.<br><br>In addition, the facility failed to ensure Resident #16's bed alarm was functioning as care planned at the time of the resident's fall. The nurse discovered that the batteries to the alarm were missing.<br><br>The findings include:<br><br>Review of the facility's policy titled Comprehensive Care Plan, dated July 2009, revealed the comprehensive care plan would include measureable objectives and timetables to meet the resident's medical, nursing, and psychological needs as identified in the comprehensive assessment. The care plan would include items or services ordered, provided, or withheld. In addition, the care plan should address prevention of avoidable decline in functional status, and the resident's care needs. | F 282  | Continued from page 66 education on the need to respond to resident care needs in a dignified and prompt manner and address their needs or delegate another staff member to address the resident's needs. Education was provided to LPN #5 by the Unit Manager on 01/07/15. LPN #5 was instructed to familiarize self with the residents' care plans and given direction on how and when to review and revise care plans as needed. Education was provided by the Restorative/Wound Care Nurse to CNA #5 on the process to ensure alarms have batteries and are functioning. All Nursing staff were provided training on the proper use and verification of proper function of alarms initiated on 01/10/14 and ended on 01/13/14 by the DON and Staff Development Coordinator (SDC). Licensed nurses were provided education on the proper action and documentation to be taken and made when an alarm is to be used to include who, how, and when the alarms are to be checked for functioning by the DON and SDC initiated on 01/10/14 and ended on 01/13/14. CNAs were provided training on their responsibility in the application and checking for functioning of alarms that are care planned for use on 01/10-13/15 by the DON and SDC.<br><br>2. How the facility will identify other residents having the potential to be affected by the same deficient practice? |                      |  |



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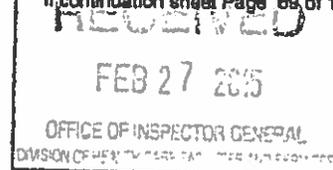
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| F 282  | <p>Continued From page 67</p> <p>1. Review of Resident #3's clinical record revealed the facility admitted the resident on 02/22/10 with diagnoses of Cerebral Palsy, Pressure Ulcer, Spina Bifida, Blindness, Seizures, and Urinary Tract Infection. Review of the Annual Minimum Data Set (MDS) Assessment, dated 03/21/14, and the Quarterly MDS Assessment, dated 11/14/14, revealed the facility assessed the resident as requiring extensive assistance with bed mobility, and as having one (1) or more pressure ulcers at Stage I or higher.</p> <p>Review of the Minimum Data Set (MDS), dated 11/14/14, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) with a score of twelve (12) reflecting minimal cognitive impairment.</p> <p>Review of the Comprehensive Care Plan for Resident #3 revealed the facility developed a care plan on 03/02/10, with an updated goal and target date of 02/14/15, for the problem of Potential for Pain or Discomfort related to staged pressure ulcers, immobility, and Spina Bifida. Interventions listed included to observe for quality, intensity, duration, and frequency of pain symptoms and to position the resident for comfort as needed.</p> <p>Continuous observations, on 01/07/15 from 7:50 AM to 8:13 AM, revealed Resident #3's pleas for help with repositioning went unanswered.</p> <p>Observation, on 01/07/15 at 7:50 AM, revealed Licensed Practical Nurse (LPN) #5 was at the medication cart near Resident #3's room. Resident #3 yelled from his/her room, "help me please, someone help, I don't like laying on this side, help, hey help." LPN #5 pushed the</p> | F 282  | <p>Continued from page 67</p> <p>All residents of the facility have the potential to be affected should the facility's system in place fail to ensure the comprehensive plan of care not be implemented for residents.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>All staff were educated to respond to resident's requests in an appropriate, timely and dignified manner. This education was provided by the Staff Development Coordinator on 02/13/15. The Risk Care Manager will observe staff's response to resident care needs once a day Monday through Friday on the 6:00 a.m. to 2:00 p.m. shift. The Director of Nursing will observe staff's response to resident care needs once a day on Monday through Friday on the 2:00 p.m. to 10:00 p.m. shift. The Administrator, in the DON's absence, will observe staff's response to resident care needs. The House Supervisor Licensed Nurse will observe staff's response to resident care needs on all three (3) shifts on the weekends. The House Supervisor Licensed Nurse will observe staff's response to resident care needs on Monday through Friday on 10:00 p.m. to 6:00 a.m. shift. Observation will include activated call lights, emergency call lights, and alarms. Staff's response will be observed and documented. Immediately, the observer will address concerns with the staff member being</p> |                      |  |



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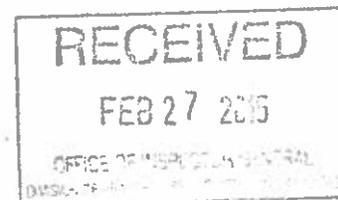
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| F 282  | <p>Continued From page 68</p> <p>medication cart down the hall and prepared medications to be administered. Resident #3 continued to yell, "Please will you do it, I don't want to, please help me, someone turn me over please."</p> <p>Observation, on 01/07/15 at 8:00 AM, revealed LPN #5 was at the end of the hall and Resident #3 yelled louder, "Please, please, I want to turn over, come on, please! Come on now. Please, not kidding when I say I want to turn over, please come on." LPN #5 continued with the medication pass. Resident #3 continued to yell, "Where you at? Hey, I'm not going to wait to turn over, please, please somebody." The resident could not turn them self or reposition.</p> <p>Observation, on 01/07/15 at 8:05 AM, revealed LPN #5 was beside Resident #3's room with the medication cart. Resident #3 yelled, "Please, please, I want to turn over please." LPN #5 continued to prepare medication for administration. At 8:10 AM, LPN #5 was observed in the room next to Resident #3. Resident #3 yelled, "Please turn me over, please come on now. Come on, I don't care. Please turn me over, I hurt. Please turn me over. Turn me over." Observation at 8:13 AM, revealed LPN #5 was outside of Resident #3's room and standing at the medication cart when the Unit Manager (UM) walked up to her. The UM was observed answering Resident #3 from the hallway and walked into the resident's room. LPN #5 continued past Resident #3's room without entering.</p> <p>Interview with Resident #3, on 01/07/14 at 8:15 AM, revealed the resident felt much better since he/she had been repositioned and was now on</p> | F 282  | <p>Continued from page 68</p> <p>observed and document such education. A total of twenty-five (25) observations per month per shift will be completed.</p> <p>Each resident who has an alarm being used will have their CNA care sheet documented to reflect the CNA is to check the alarm for proper functioning each shift. A listing of residents with alarms will be created and maintained by the Risk Manager. This listing of residents with alarms is used to determine audits and review during Standards of Care meeting. Administrator will assign Department Heads and Administrative Staff the responsibility of observing the provision of care, record review and staff and resident interviews based on specific problems/needs, goals and targets and approaches from residents' plan of care seven (7) days a week. Five (5) assignments will be made each day. Staff assigned will document their findings and present to the Administrator during the Daily QAPI/IDT meeting the following day during the week and the next business day after a weekend. These observations will be ongoing. Identified concerns will be reviewed by the members of the QAPI/IDT team and action plans created and assignments of staff made to ensure actions are taken. Progress of actions plans will be reported to and reviewed by the QAPI/IDT team.</p> |                      |  |



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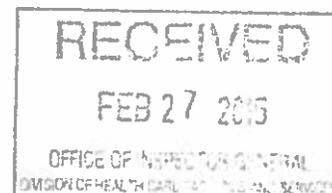
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| F 282  | <p>Continued From page 69 his/her back.</p> <p>Interview, on 01/07/15 at 11:00 AM, with LPN #5 revealed when she got near Resident #3's room to administer medication, she heard the resident call out, but she did not go into the room because the UM went into Resident #3's room to assist. Further interview with LPN #5 revealed she was not familiar with Resident #3's care plan. LPN #5 stated residents should be turned at least every two (2) hours by the Certified Nurse Aides (CNAs). LPN #5 stated she monitored the CNAs' turning of residents by comparing the residents' positions to how they were positioned the last time she observed them.</p> <p>Interview, on 01/07/15 at 11:55 AM, with the Orchard Unit Manager (UM), revealed she went to speak to LPN #5 regarding another resident and she heard Resident #3 call out for assistance. The UM stated when she went into Resident #3's room; the resident was laying on his/her side facing the door and the resident asked to be turned. She assisted by repositioning Resident #3 onto his/her back. The UM stated crying in pain and begging to be turned was not the usual behavior for the resident. The UM stated all staff was responsible for seeing to the needs of the residents. The UM further stated she attended all residents' care plan meetings with their families, but she did not know Resident #3's care plan off the top of her head.</p> <p>Interview, on 01/08/15 at 10:15 AM, with the Director of Nursing (DON), revealed he expected staff to answer resident's call lights within five (5) minutes, emergency lights within three (3)</p> | F 282  | <p>Continued from page 69</p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained?</p> <p>The Risk Care Manager will submit a report to the Quality Assessment and Assurance Committee reflecting the residents who have alarms, that they are care planned and placed on the C.N.A. care sheets and that five (5) audits of the alarms for proper functioning have been completed on a weekly basis with any necessary education and action having been taken. This report by the Risk Care Manager will be provided on a monthly basis for the remainder of the 2015 calendar year. Quality Assessment and Assurance Committee will monitor this report provided by the Risk Care Manager on a monthly basis for calendar year 2015.</p> |  |



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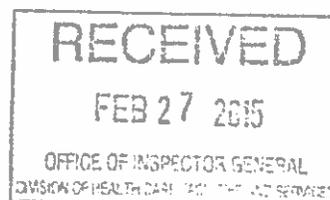
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| F 282  | <p>Continued From page 70</p> <p>minutes and a resident's call for help, immediately. The DON further stated twenty-three (23) minutes was too long for a resident's cry for assistance to go unanswered. The DON stated call light audits were completed monthly and if issues were noted, they were discussed with staff during in-services.</p> <p>2. 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 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 falls was a triggered care area. Review of the Comprehensive Care Plan, dated 02/20/14, revealed a care plan for falls with multiple interventions, which included a sensor pad/alarm to the resident's bed; however, it did not give direction as to who, how, or when the alarm was to be checked for function or to check the batteries.</p> <p>Review of the Nurses' Notes revealed it was documented that 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</p> | F 282  |   |                      |  |



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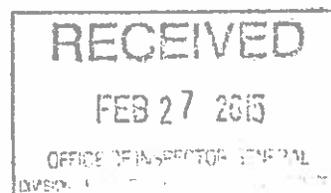
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185484 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>01/23/2015 |
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| F 282  | <p>Continued From page 71</p> <p>that morning at 10:40 AM and returned the call at 12:05 PM.</p> <p>Review of the facility's 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 Certified Nursing Assistant (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> <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. The facility's in-service instructed staff 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</p> | F 282  |   |                      |  |



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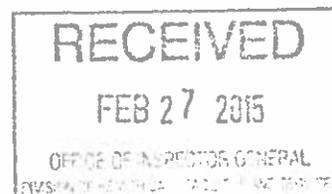
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| F 282  | Continued From page 72<br>responsible for caring for the resident was supposed to test the residents' alarms during his/her rounds at the beginning of the shift. CNA #5 stated she failed to check Resident #16's alarm for functioning.<br><br>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 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.<br><br>Interview, on 01/09/15 at 3:40 PM, with the Director of Nursing (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 that he, the shift supervisor, and each unit's licensed nurses, were 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, as care planned. | F 282  |   |                      |  |
| F 315<br>SS=J  | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive   | F 315  | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? | 02/25/15             |  |



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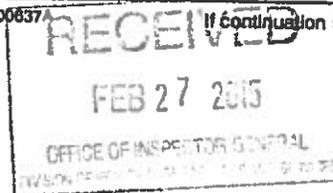
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| F 315  | <p>Continued From page 73</p> <p>assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure a toileting program was implemented, monitored and revised to meet the residents' individual incontinent needs for two (2) of thirty-two (32) sampled residents (Resident's #15 and #20).</p> <p>Review of Resident #20's toileting documentation revealed there was no completed assessment of urinary frequency, incontinence or continent episodes documented to determine if the toileting program was meeting the need of the resident or the goal to decrease the number of incontinent episodes. This resident sustained two falls with injury related to incontinence and trying to change soiled clothes. On 12/10/14 the resident was ambulating from the toilet to the wheelchair when they fell hit his/her head. On 12/14/14 the resident was found in the closet trying to change his/her clothing, the brief was around the ankles wet with urine and feces was found on the resident's buttocks. The resident fell and hit their head on the room mates foot board and sustained a hematoma. The resident was</p> | F 315  | <p>Continued from page 73</p> <p>The Medical Director was notified of Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday 01/08/15. 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. 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) 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)</p> |                      |  |



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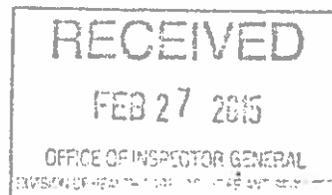
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| F 315  | <p>Continued From page 74</p> <p>transferred to the hospital for evaluation and expired on 12/16/14.</p> <p>Review of Resident #15's toileting program revealed inconsistent documentation of the program and the resident sustained three (3) falls with injury related to incontinence and attempting to take self to the toilet. On 11/17/14 the resident was taking self to the bathroom and fell receiving a laceration to left eyebrow. On 12/15/14 the resident was incontinent and fell with pain in the right shoulder. On 12/17/14 the resident was taking self to the bathroom and fell sustaining an abrasion to the back and a skin tear to the elbow.</p> <p>The facility's failure to have an effective system in place for implementing, monitoring and revising the toileting programs for residents has caused or is likely to cause serious injury, harm, impairment or death to resident. The Immediate Jeopardy was identified on 01/08/15 and determined to exist on 12/10/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 01/20/15 alleging the Immediate Jeopardy was removed on 01/14/15. The State Survey Agency validated the Immediate Jeopardy was removed on 01/14/15 as alleged, prior to exit on 01/23/15. The scope and severity was lowered to a "D" while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the a policy titles Bowel and Bladder and provided by the facility as the toileting program policy, dated September 2010, revealed</p> | F 315  | <p>Continued from page 74</p> <p>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. 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. The procedure for conducting neurological checks was reviewed by the DON and Staff 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</p> |                      |  |



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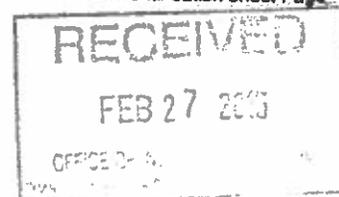
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| F 315  | <p>Continued From page 75</p> <p>every resident would be assessed and maintained at their highest level of continence. The toileting program would be individualized specific to a resident's incontinent pattern. The program would be implemented and noted on the plan of care.</p> <p>1. Review of the closed clinical record for Resident #20 revealed the facility admitted the resident on 05/21/14 with diagnoses of Deep Vein Thrombosis, Alzheimer's, and Gait Ataxia. Resident #20 also had a history of falls.</p> <p>Review of Resident #20's Quarterly Minimum Data Set (MDS) assessment, completed on 11/07/14, revealed the facility assessed the resident as not steady on his/her feet and requiring extensive assistance from staff to toilet, walk, and bathe. The MDS assessed Resident #20 as frequently incontinent of urine and was currently on a urinary toileting program. The facility conducted a Brief Interview for Mental Status (BIMS) during the assessment and the resident scored an eight (8) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Review of Resident #20's initial Plan of Care for Scheduled Toileting, dated 05/21/14 and the comprehensive care plan dated 05/29/14, revealed the goal was for the resident to have decreased episodes of incontinence. Interventions listed included; encourage resident to use the toilet in accordance with the program; evaluate the program quarterly and as needed; and, encourage the resident to request staff assistance with toileting at times other than scheduled toileting times.</p> <p>Review of the Behavioral Program form, dated</p> | F 315  | <p>Continued from page 75</p> <p>the DON on 01/12/15. The MDS Coordinator, MDS Nurse, DON and Risk Manager are responsible for ensuring care plans are completed/ revised in a timely/ accurate manner. A Falls Committee was initiated 01/12/15 to review fall interventions, to review reviewed/ revised 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 Services Representative, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services Manager or therapy representative and meets Monday through Friday. The MDS Coordinator, MDS Nurse, DON and Risk Care Manager are responsible for ensuring care plans are completed/ revised in a timely/ accurate manner. A Standards of Care meeting is led by the MDS Nurse and the MDS Coordinator. In attendance at that meeting are the Dietary, Risk Manager, Social Service 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. The DON and the Staff Development</p> |                      |  |



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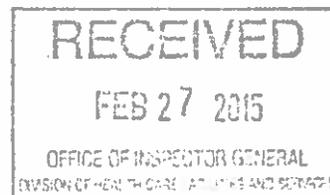
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| F 315  | <p>Continued From page 76</p> <p>05/29/14, revealed Resident #20 was placed on a scheduled toileting program with interventions to toilet at regular intervals that matched elimination patterns identified. However, the Four (4) Day Bowel and Bladder assessment form, used to determine Resident #20's elimination patterns, dated 05/23/14, revealed no documentation the resident was toileted, found wet or dry for an eight (8) hour time-frame, on 05/22/14 from 5:00 AM to 1:00 PM, and for a twenty-two (22) hour time-frame on 05/24/14 from 2:00 AM until 11:00 PM. Again on 05/25/14, there was no documentation for a fourteen (14) hour time-frame from midnight till 2:00 PM.</p> <p>Review of the Scheduled Toileting Program plans, dated June 2014 through December 2014, revealed staff was to document continent episodes on the form under headings labeled: Toilet as needed during the night, with morning care, after breakfast, after lunch; between 3:00 PM and 5:00 PM, after supper, at bedtime; and, between 10:00 PM and 12:00 PM. On the bottom portion of the form the staff was to document incontinent episodes every two hours. Continued review of the Scheduled Toileting program forms revealed numerous blanks, indicating staff did not document continent and incontinent episodes as required each month. Continued review of the documents revealed no revisions were made to Resident #20's scheduled toileting time-frames to indicate the staff was performing toileting at the time the resident would mostly likely need to toilet.</p> <p>Review of the Restorative Monthly Assessment form, dated 11/07/14, revealed staff documented the resident continued to frequently dribble urine and had a decrease in ambulation ability due to</p> | F 315  | <p>Continued from page 76</p> <p>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. All staff have been trained. The training to all licensed nurses and certified nursing assistants 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 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 Sheduled Toileting Program. The Administrator provided training to the Director of Nursing, the Risk Manager and the 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</p> |                      |  |



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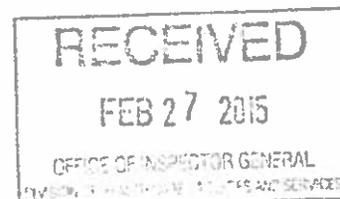
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| F 315  | <p>Continued From page 77</p> <p>knee pain. However, there was no documented assessment of urinary frequency, incontinence or continence episodes documented on the form to determine if the program was meeting the needs of the resident or the goal to decrease the number of incontinent episodes.</p> <p>Review of the Restorative Monthly Assessment form, dated 12/03/14, revealed staff documented Resident #20 had a significant decline in ambulation with complaints of bilateral leg pain and the resident remained on the scheduled toileting to decrease wetness along with unsafe transfers. However, there was no documented assessment to determine if the program was meeting the needs of the resident or the goal to decrease the number of incontinent episodes. The assessment forms further did not address the resident's falls sustained on 06/10/14, 06/11/14, 08/09/14, 09/08/14 and 10/20/14. On 12/10/14 and 12/14/14 that found the resident incontinent with each of these falls and received a head injury that required hospitalization and subsequent death.</p> <p>Interview with CNA #5, on 01/08/15 at 11:25 AM, revealed Resident #20 was only toileted every two (2) hours, the same as the other residents.</p> <p>Interview with CNA #7, on 01/08/15 at 10:55 AM, revealed she toileted the resident every two (2) hours and as needed. Resident #20 wanted to do it by him/herself and did not want to ask for help.</p> <p>2. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 08/19/13 with diagnoses of Dementia, Anemia, Osteoarthritis, and Bladder Disorder. Further review revealed Resident #15 had a history of</p> | F 315  | <p>Continued from page 77</p> <p>develop further actions to be taken. 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. 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. 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</p> |                      |  |



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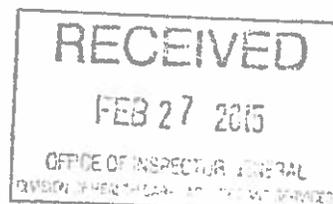
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185464 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br>01/23/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN MEADOWS HEALTH CARE CENTER 1 |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>310 BOXWOOD RUN ROAD<br>MOUNT WASHINGTON, KY 40047  |                      |  |
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| F 315  | <p>Continued From page 78</p> <p>falls and was receiving anti-depressant and anti-anxiety medications to treat symptoms of Depression and Anxiety.</p> <p>Review of Resident #15's quarterly Minimum Data Set (MDS) assessment, completed on 12/02/14, revealed the facility assessed the resident not steady on his/her feet and needed extensive assistance from staff to toilet, walk, transfer and bathe. The MDS further revealed staff could not conduct a Brief Interview for Mental Status (BIMS) due to the resident having short-term and long-term memory problems which affected his/her ability to make decisions and follow cues. The facility determined on the MDS the resident required supervision in daily decision making. The assessment further determined the resident was a candidate for a urinary toileting program.</p> <p>Review of the comprehensive care plan, dated 07/08/14, revealed the resident was on a Restorative Nursing Program scheduled toileting. Resident required restorative nursing scheduled toileting program related to decrease episodes of urinary incontinence and unsafe self transfers related to toileting needs. The undated interventions stated to observe skin for breakdown while toileting per individual schedule; encourage resident to use toilet in accordance with the program and as needed; evaluate restorative program quarterly and as needed; encourage resident to request staff assist to bathroom as needed at times other than scheduled toileting times. However, the comprehensive care plan did not provide direction to staff as to when to take the resident to the bathroom.</p> | F 315  | <p>Continue from page 78</p> <p>toileting program and her initials. On 01/12/15 the Restorative/Wound Care Nure 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. The facility will utilize 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</p> |                      |  |



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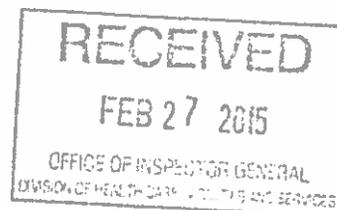
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| F 315  | <p>Continued From page 79</p> <p>Review of the Scheduled Toileting Program Plan revealed a flow sheet with a documentation key D-decline, V-toileted/voided, O-toileted-did not void, V/BM-toiled, voided and bowel movement. It further was divided into two sections one titled Continent Episodes only and Incontinent Episodes. The form contain a daily grid for each day and time noted as toilet prn during night; with AM care; after breakfast; after lunch; between 3P-6P, after supper; between 10P and 12A. The form further revealed it was not individualized, but toileting took place every two hours.</p> <p>Review of the Scheduled Toileting Program Plan, for Resident #15, dated June 2014, revealed nine (9) toileting times per day the resident was scheduled to be toileted. There were no entries made for one hundred and two (102) of the two hundred and seventy (270) toileting opportunities.</p> <p>Review of the Scheduled Toileting Program Plan, dated July 2014, revealed nine (9) toileting times per day the resident was scheduled. However, there was no entry made for fifty-five (55) of the two hundred seventy-nine (279) toileting opportunities.</p> <p>Review of the Scheduled Toileting Program Plan, dated August 2014, revealed nine (9) toileting times per day the resident was scheduled to be toileted. However, there were no entries made for sixty-eight (68) of the two hundred seventy-nine (279) toileting opportunities.</p> <p>Review of the Scheduled Toileting Program Plan, dated September 2014, revealed nine (9) toileting times per day the resident was scheduled to be toileted. However, there were no entries made for eighty-nine (89) of the one hundred sixty-two</p> | F 315  | <p>Continued from page 79 falls within the facility.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same practice?</p> <p>All residents of the facility have the potential to be affected should the facility's system to ensure a toileting program is implemented, monitored and revised to meet the residents' individual incontinent needs not be effective.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Licensed nurses and CNAs were provided training on the Scheduled Toileting Program by the Restorative/Wound Care Nurse, DON and SDC on 01/10-13/14 addressing the toileting program components including 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 forms and the toileting program as it relates to the prevention of falls. The Restorative/Wound Care Nurse developed an audit tool to audit the clinical documentation relative to the toileting program. The Restorative/Wound Care Nurse is auditing the toileting program on Monday through Friday. The Scheduled</p> |  |



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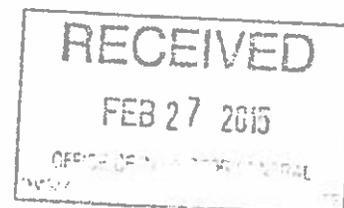
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| F 315  | <p>Continued From page 80</p> <p>(162) toileting opportunities between 09/01/14 and 09/18/14. No toileting documentation was completed on this sheet between 09/18/14 and 09/30/14.</p> <p>Review of the Scheduled Toileting Program Plan, dated October 2014, revealed nine (9) toileting times per day the resident was scheduled to be toileted. However, there were no entries made for one hundred and fifty-seven (157) of the two hundred and seventy-nine (279) toileting opportunities.</p> <p>Review of the Scheduled Toileting Program Plan, dated November 2014, revealed nine (9) toileting times per day the resident was scheduled to be toileted. However, there were no entries made for one hundred and fifty-four (154) of the two hundred and seventy (270) toileting opportunities.</p> <p>Review of the Scheduled Toileting Program Plan, dated December 2014, revealed nine (9) toileting times per day. There were no entries made for one hundred and seventeen (117) of the two hundred and seventy-nine (279) toileting opportunities.</p> <p>Continued review of Resident #15's program revealed it did not address the three (3) falls the resident sustained on 11/17/14, 12/15/14 and 12/17/14 with injury all associated with trying to self toilet. On 11/17/14 the resident was taking self to the bathroom and fell receiving a laceration to left eyebrow. On 12/15/14 the resident was incontinent and fell with pain in the right shoulder. On 12/17/14 the resident was taking self to the bathroom and fell sustaining an abrasion to the back and a skin tear to the elbow.</p> | F 315  | <p>Continued from page 80</p> <p>Toileting Audit form is used to determine all fields on forms are completed, identify any issues of concern, determine trends related to toileting and make updates to the program as needed. Identified concerns will be reported to the DON who will address with the appropriate staff through education. The Restorative/Wound Care Nurse is responsible for this auditing process to ensure it is completed and addresses the program's relation to falls prevention. The Restorative/Wound Care Nurse will report her findings to the Quality Assessment and Assurance Committee on a monthly basis for review and monitoring as well as provide direction.</p> <p><i>4. Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained?</i></p> <p>The Restorative/Wound Care Nurse will submit a report of findings to the Quality Assessment and Assurance Committee on a monthly basis for the remainder of calendar year 2015. The Quality Assessment and Assurance Committee will review and discuss the findings presented and evaluate the effectiveness of the actions and direct further action plans when needed.</p> |                      |  |



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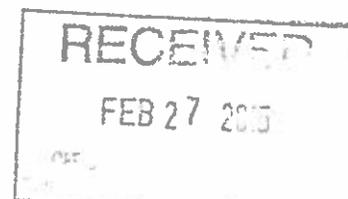
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| F 315  | <p>Continued From page 81</p> <p>Interview with Certified Nursing Assistant (CNA) #9, on 01/09/15 at 12:00 PM, revealed she would toilet residents on the toileting program every two hours. She stated if a resident did not void she left the box blank on the toileting form. The CNA stated she had been trained on the toileting program, and her preceptor was another CNA and she was told to leave the area blank if the resident did not void or was not incontinent.</p> <p>Interview with CNA #3, on 01/08/15 at 10:55 AM, revealed the residents on the toileting program were toileted every two hours and as needed.</p> <p>Interview with CNA #6, on 01/08/15 at 1:55 PM, revealed the residents on the toileting program were toileted every two hours and before and after meals.</p> <p>Interview with the Restorative/Wound Care Licensed Practical Nurse (LPN), on 01/09/15 at 2:30 PM, revealed the scheduled toileting program was not the same as a Restorative toileting program; however, it was documented on the same forms. She further stated there were twenty-seven (27) residents who were on the scheduled toileting program and only two (2) of those residents had a different schedule from the rest. She stated residents were assessed for four (4) days to determine if they met the requirements to be on the scheduled toileting program. She stated the Certified Nursing Assistants documented the resident's continent and incontinent episodes on the Scheduled Toileting Program form. She stated all areas on the forms should be filled in using the key at the top of the page and there should be no blanks. She stated a quarterly and monthly assessment was completed on each resident to determine if</p> | F 315  |   |                      |  |



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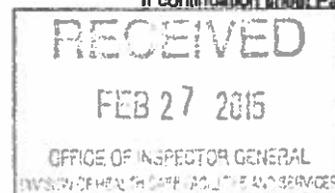
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| F 315  | <p>Continued From page 82</p> <p>the residents continued to qualify for the program. She stated she did not track or trend the information gathered regarding the residents toileting habits to determine if changes needed to be made to a resident's program to better meet their needs or to determine if the program was administered by nursing effectively. She stated the care plan for the toileting program was computerized and the computer automatically generated generic interventions for each resident's care plan.</p> <p>Interview with the Risk Manager, on 01/09/15 at 9:35 PM, revealed she had not completed any audits of the toileting program to determine if the program was effective or needed revisions.</p> <p>Interview with the Director of Nursing (DON) on, 01/09/15 at 3:00 PM, revealed the Restorative/Wound Care Licensed Practical Nurse, was responsible for assessing the toileting program to determine the program's effectiveness. But he was not aware there was documentation issues' occurring in regards to the toileting program until this week. He stated he thought it was important for her to tell him if there was a problem with the toileting program documentation sooner. The DON stated he did not know of any tracking and trending data completed by the Restorative/Wound Care LPN, in regards to the toileting program.</p> <p>Review of the Allegation of Compliance (AOC) revealed the facility implemented the following Immediate steps to remove the Immediate Jeopardy:</p> <p>1. The Medical Director was notified of</p> | F 315  |   |                      |  |



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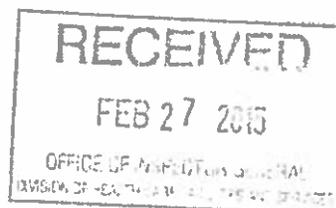
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| F 315  | <p>Continued From page 83</p> <p>Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday 01/08/15.</p> <p>2. A representative of the Governing Body provided the Administrator guidance and education on physician and family notification, supervision and investigation of falls, care plan revisions and scheduled toileting programs on 01/08/15 and 01/09/15.</p> <p>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) 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.</p> <p>4. The Medical Director met with the Director of</p> | F 315  |   |                      |  |



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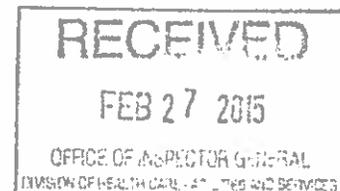
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| F 315  | Continued From page 84<br>Nursing (DON) on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting 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.<br><br>5. The procedure for conducting neurological checks was reviewed by the DON and the Staff 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.<br><br>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 | F 315  |   |                      |  |



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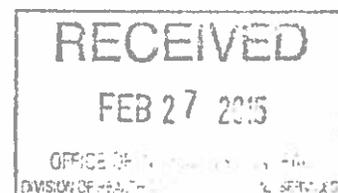
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| F 315  | Continued From page 85<br>Assessment and Assurance Committee monthly from January 2015 - December 2015.<br><br>7. The DON and the Staff Development Coordinator were provided training by the Administrator on 01/09/15 on physician and responsible 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: 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,<br><br>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 | F 315  |   |  |



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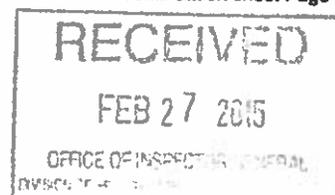
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| F 315  | Continued From page 86 taken.<br><br>9. Three (3) notifications of residents' who fell prior to 01/12/15 was made to the attending physicians and responsible party on 01/12/15 with one (1) physician and the responsible party notification of a fall which occurred on 01/13/15.<br><br>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 Manager and meets Monday-Friday.<br><br>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.<br><br>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. | F 315  |   |  |



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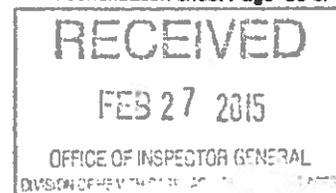
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| F 315  | <p>Continued From page 87</p> <p>The audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. On 01/12/15 the Restorative/Wound Care Nurse 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.</p> <p>13. The facility will utilize 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>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> | F 315  |   |                      |  |



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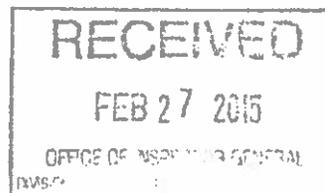
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| F 315  | <p>Continued From page 88</p> <p>1. Telephone interview with the Medical Director, on 01/26/15 at 2:30 PM, post survey due to lecture schedule and unavailability, revealed he was contacted by the Director of Nursing (DON) on 01/08/15 regarding 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 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</p> | F 315   |   |



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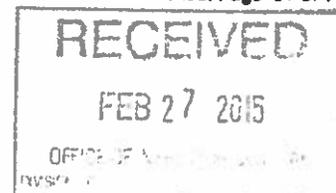
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| F 315  | <p>Continued From page 89</p> <p>falls and assurance audits are in place to ensure processes are being followed with concerns identified to be addressed in staff training.</p> <p>Interview with the Administrator, on 01/23/15 at 10:50 AM, 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 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</p> | F 315  |   |                      |  |



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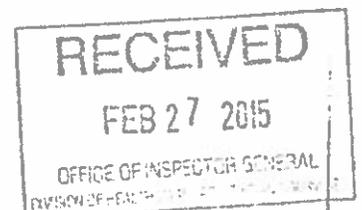
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| F 315  | <p>Continued From page 90<br/>plan updated at time of fall and any interventions added at time of audit.</p> <p>Interview with the Risk Manager, on 1/23/15 at 4:32 PM, revealed she was involved in the review of residents' falls for the past 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 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</p> | F 315  |   |                      |  |



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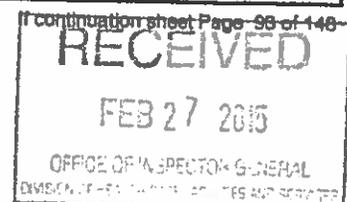
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| F 315  | <p>Continued From page 91</p> <p>of the policy, Falls Prevention, on 01/23/15 at 9:10 AM, revealed it had been revised to include the check of safety devices each shift to ensure they are in place and functioning properly.</p> <p>Interview 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 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</p> | F 315  |   |                      |  |



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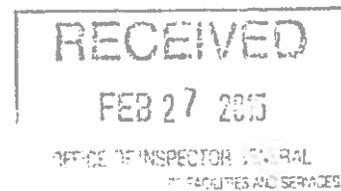
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| F 315  | <p>Continued From page 92</p> <p>crash carts. Review of two (2) medical supply company invoices on 01/23/15 revealed additional pen lights had been ordered by the Administrator for nurses to use during neurological checks.</p> <p>Observation 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 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</p> | F 315  |   |                      |  |



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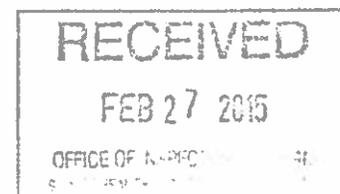
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| F 315  | <p>Continued From page 93</p> <p>all nursing staff training regarding the physician/responsible party notification after a resident's fall, and continued through 01/13/15. A review of in-service training records on 01/23/15 revealed one 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 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,</p> | F 315  |   |                      |  |



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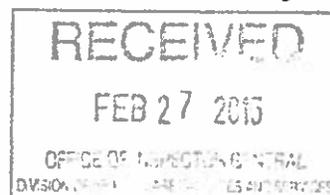
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| F 315  | <p>Continued From page 94</p> <p>revealed she had been trained on how to fill out the toileting program documentation, how to report any maintenance issues, the necessity to check alarms on any residents, to answer call lights timely and to report any concerns immediately.</p> <p>B. 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> <p>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.</p> <p>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.</p> <p>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</p> | F 315  |   |                      |  |



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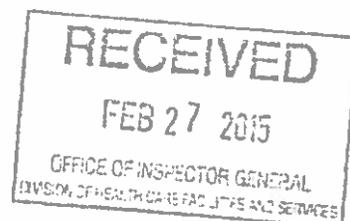
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| F 315  | <p>Continued From page 95</p> <p>physician and responsible party was notified on 01/13/15 of a fall which occurred on 01/13/15.</p> <p>Interview with the DON, on 01/23/15 at 2:19 PM, revealed three (3) residents were discovered on 01/12/15 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.</p> <p>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 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</p> | F 315  |   |                      |  |



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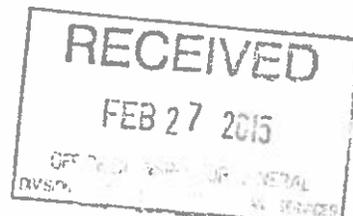
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| F 315  | <p>Continued From page 96</p> <p>Restorative Nurse signed a training record on 01/09/15 (no time), on 01/10/15 at 9:00 AM and on 01/12/15 (no time).</p> <p>12. Interview with the Restorative Nurse, on 01/23/15 at 3:55 PM, revealed she would 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 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</p> | F 315  |   |                      |  |



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| F 315  | Continued From page 97<br>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.<br><br>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. 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. | F 315  |   |                      |  |
| F 323<br>SS=K  | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and facility policy review, it was determined the facility failed to have an effective system in place to ensure adequate supervision and assistive   | F 323  | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>The Medical Director was notified of Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday 01/08/15. 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. Licensed nurses (DON, Staff Development Coordinator, Risk Care Manager, | 02/25/15             |  |



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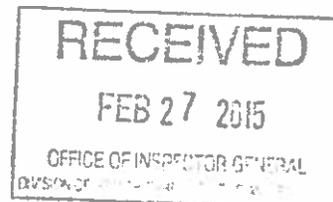
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| F 323  | <p>Continued From page 98</p> <p>devices to prevent accidents and to ensure the residents' environment was free of accident hazards. The facility failed to determine the root cause of resident falls and failed to assess its fall prevention processes to determine if they were implemented and effective in promoting a safe environment for six (6) of thirty-two (32) sampled residents, (Residents #8, #13, #15, #16, #17, and #20). (Refer to F157, F280 and F315)</p> <p>On 12/10/14 at 5:30 AM, Resident #20 sustained a fall with injury. The resident sustained a hematoma (localized swelling filled with blood caused by a break in the wall of a blood vessel) to the left side of the head that was dark purple in color and a hematoma to the right thumb. The facility did not complete a root cause analysis as to the cause of the fall. Resident #20 sustained a second fall on 12/14/14 at 11:55 PM, which resulted in a head injury and required transfer to the hospital for treatment where the resident subsequently expired on 12/16/14. Record review and interview revealed Resident #20 has sustained a total of seven (7) falls from 06/10/14 through 12/14/14 with no evidence the facility had revised interventions to prevent further falls.</p> <p>On 11/17/14 at 3:20 AM, Resident #15 had a fall and sustained a laceration to the left eyebrow. The facility failed to complete a root cause analysis and on 12/15/14 at 11:20 AM, Resident #15 fell again and sustained an injury to the right shoulder and hit his/her head. Resident #15 then fell on 12/17/14 at 9:15 AM and received an abrasion to the mid upper back and a skin tear to the right elbow.</p> <p>On 10/10/14, Resident #13 was found crawling on the floor mat beside the bed at 12:30 AM;</p> | F 323  | <p>Continued from page 98</p> <p>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) 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. 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</p> |  |

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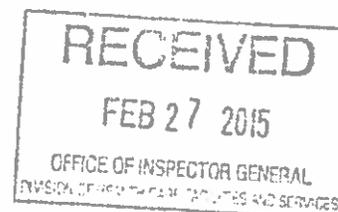
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| F 323  | <p>Continued From page 99</p> <p>found at 4:40 AM, crawling on the floor; and, again at 7:10 AM, the resident was found crawling on the floor with a small laceration to the back of the head. On 12/15/14 the resident sustained another fall at 1:00 PM and received a laceration and a hematoma the size of a golf ball above the right eyebrow. The facility applied steri-strips and a dry dressing to cover.</p> <p>Resident #17 sustained three (3) falls occurring on 06/19/14, 12/20/14 and 12/25/14. The resident required stitches with the 06/19/14 fall. The tab alarm was not attached to the resident during the December 2014 falls.</p> <p>On 12/28/14 at 9:25 PM, Resident #8 sustained a fall while in the bathroom and staff found the resident on the floor. The facility did not complete a root cause analysis to determined the resident's need for additional assistance. 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 revealed the resident had no apparent injuries, but neurological (neuro) checks were initiated by the facility's protocol. There was no root cause analysis completed for the fall.</p> <p>In addition, the facility failed to ensure one (1) of sixty-one (61) resident rooms (Room #2), with a missing electrical plate allowing residents access to the wires, was repaired to prevent potential injury, and failed to ensure wheelchair arm pads were replaced to prevent potential skin tears for ten (10) of seventy-eight (78) wheelchairs.</p> <p>The facility's failure to have an effective system in place to determine the root cause of falls and assess prevention processes to determined if they were implemented and effective in promoting</p> | F 323  | <p>Continued from page 99</p> <p>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. The procedure for conducting neurological checks was reviewed by the DON and the Staff 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. 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. Now that a Falls Committee has been initiated the care plans of resident who have fallen are being</p> |                      |  |



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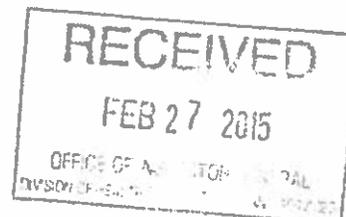
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| F 323  | <p>Continued From page 100</p> <p>a safe environment for residents at risk has caused or is likely to cause serious injury, harm, impairment or death to resident. The Immediate Jeopardy was identified on 01/08/15 and determined to exist on 12/10/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 01/20/15 alleging the Immediate Jeopardy was removed on 01/14/15. The State Survey Agency validated the Immediate Jeopardy was removed on 01/14/15 as alleged, prior to exit on 01/23/15. The scope and severity was lowered to an "E" while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Accidents and Incidents, dated March 2013, revealed it was the policy of the facility to have a safe and healthy environment. Therefore, all accidents or incidents occurring on facility premises must be reported and investigated. For reporting purposes, an accident/incident was defined as an occurrence with the potential of injury, illness, altercation, etc., or any single event that resulted in personal injury or illness to a resident. Regardless of how minor an accident or incident may be, it must be reported to the department supervisor, and an Event Documentation Form must be completed on the shift the accident or incident occurred. A falls scene investigation would be completed for residents with witnessed or suspected falls. The Staff/Charge Nurse must be informed of all accidents or incidents so that medical attention could be provided. Residents hitting their head when falling or any un-witnessed falls would be</p> | F 323  | <p>Continued from page 100</p> <p>reviewed Monday through Friday. The Standards of Care meeting continues once a week. In attendance in 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. Now the Standards of Care team, Falls Committee team and the QAPI/IDT team that meets as well Monday through Friday will work together to generate the same aforementioned report to the Quality Assessment and Assurance Committee. 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. All staff have been trained. The training to all licensed nurses and certified nursing assistants included: work order process, care plans, certified nursing assistant care sheets,</p> |                      |  |



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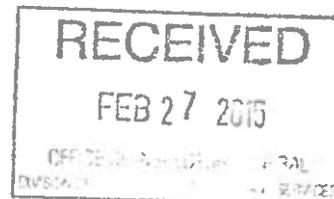
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| F 323  | Continued From page 101<br>monitored by routine neuro-check protocol; notify the Medical Director or the victim's attending physician and inform him or her of the accident or incident; make an entry in the resident's chart each time an attempt was made to contact the physician; provide care and transfer the resident, if necessary, as ordered by the physician or at the nurse's discretion; and, contact the resident's representative of the accident/incident or injury with 24 hours or immediately in emergency situations. The Director of Nursing would review all accidents or incidents discussing any concerns with the nurse responsible for the care. The Risk Manager or designee would be responsible for reviewing and analyzing all Event Documentation Forms for trending purposes and modifications to a resident's plan of care and forward all reports to the Administrator for review. Residents noted with multiple incidents would be reviewed as indicated at Resident Safety Committee to evaluate the plan of care. Nursing Services would be responsible for analyzing previous month's data for the Quality Assurance Committee.<br><br>1. Review of the closed clinical record for Resident #20 revealed the facility admitted the resident on 05/21/14 with diagnoses of Deep Vein Thrombosis, Alzheimer's, and Gait Ataxia. Resident #20 had a history of falls and was receiving Coumadin 5.5mg daily (blood thinning medication) to prevent a reoccurrence of Deep Vein Thrombosis.<br><br>A Falls Risk Assessment, completed on 05/21/14, revealed the resident had one-two falls in the past three months; the resident was chair bound; vision was poor; and, gait/balance the resident was unable to perform this function. Review of the initial care plan, dated 05/21/14, revealed the | F 323  | Continued from page 101<br>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. 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. 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. A Falls Committee was initiated 01/12/15 to review fall interventions, to review reviewed/revised care plans and to complete root cause analysis for falls during the meeting. The Falls Committee |                      |  |



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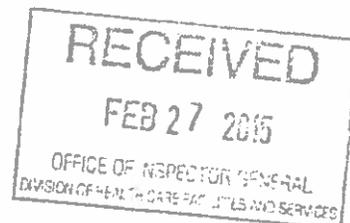
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| F 323  | <p>Continued From page 102</p> <p>staff were to keep the call light in reach; encourage use of the call light; orient the resident to the room; sensor alarm; appropriate foot wear; Physical Therapy evaluation; and transfer utilizing one person.</p> <p>Review of Resident #20's Admission Minimum Data Set (MDS), dated 05/28/14, revealed the facility assessed the resident with Brief Interview for Mental Status and determined the resident scored an eight (8) out of fifteen (15) moderate cognitive impairment. The facility further assessed the resident as extensive assistance with two plus persons for bed mobility; transfers; ambulation; and, locomotion. The resident's balance was not steady and was only able to stabilize with staff assistance. In addition, the resident sustained falls one month prior to admission. Review of the CAT worksheet for Falls, dated 05/28/14, revealed the resident had impaired balance during transitions and required human assistance for transitions. The resident had a diagnosis of Alzhiemers with cognitive impairment and Osteoarthritis and hard of hearing. These factors all increase risk for falls. The resident was also noted wandering throughout the facility. Under the notes section revealed sensor alarms were being utilized to alert the staff should resident attempt to rise unassisted.</p> <p>Review of the comprehensive care plan, dated 05/29/14, revealed a potential for falls related to a history of falls, medication use, cognition and immobility. Interventions included sensor alarm to bed and chair; notify appropriate parties if falls occur; verbal reminders to not ambulate or transfer without assistance; appropriate foot wear; and, environment free of clutter.</p> | F 323  | <p>Continued from page 102</p> <p>is comprised of the Administrator, the DON, a MDS Nurse, Social Service Representative, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services Manager and meets Monday through Friday. 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. 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</p> |                      |  |



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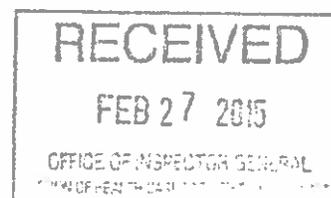
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| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN MEADOWS HEALTH CARE CENTER 1 |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>310 BOXWOOD RUN ROAD<br>MOUNT WASHINGTON, KY 40047   |  |
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| F 323  | <p>Continued From page 103</p> <p>Continued review of the comprehensive care plan, dated 05/29/14, revealed interventions added on 06/27/14 non-skid liner to wheelchair; 07/15/14 antitipper to back of wheelchair; and on 10/23/14 tab alarm with pin and clip to toilet; pommel cushion to wheelchair; and padding to wheelchair sides.</p> <p>Quarterly Minimum Data Set (MDS), dated 11/07/14 revealed the facility assessed the resident with a Brief Interview for Mental Status and determined the resident scored an eight (8) out of fifteen (15) moderate cognitive impairment. The facility further assessed the resident as requiring one person assist with locomotion and walking balance was only able to stabilize with staff assistance. The assessment further revealed the resident had prior falls.</p> <p>Review of Resident #20's toileting documentation revealed there was no completed assessment of urinary frequency, incontinence or continent episodes documented to determine if the toileting program was meeting the need of the resident or the goal to decrease the number of incontinent episodes. This resident sustained two falls with injury related to incontinence and trying to change soiled clothes.</p> <p>Review of the Fall Scene Investigation report, dated 12/14/14, revealed Resident #20 sustained a fall on 12/14/14 at 11:55 PM, and the physician was not notified of the fall until eight and one-half (8.5) hours later at 8:30 AM on 12/15/14. In addition, the facility did not notify the resident's responsible party of the fall on 12/14/14 until 8:40 AM on 12/15/14 when preparations were</p> | F 323  | <p>Continued from page 103</p> <p>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. The facility will utilize 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 audited 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</p> |  |



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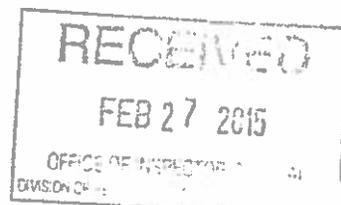
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| F 323  | <p>Continued From page 104<br/>underway to transfer the resident to the emergency room.</p> <p>Review of the Nursing Notes for Resident #20, dated 12/14/14 and timed at 11:55 AM, revealed Resident #20's door was found closed and the resident's bed alarm was heard faintly sounding from outside the door. When the nurse opened the door the resident was found standing behind the door and inside the closet. The nurse documented that opening the door had startled the resident and the resident tried to grab the door while it was opening and lost his/her balance, fell and hit his/her head on the foot board of the roommate's bed. The nurse noted Resident #20's brief was down around the ankles, and wet with urine. There was feces on the resident's buttocks. Nursing noted neuro-checks were started after the fall.</p> <p>However, review of the facility's Neurocheck Protocol document, dated 12/13/14, revealed the neuro-check block, timed at 8:55 AM, and the last one completed while the resident was in the facility, had a check mark in the box indicating findings were within normal limits. There was no documented evidence neuro-checks were completed after the 12/14/14 fall.</p> <p>Interview with Licensed Practical Nurse (LPN) #10, on 01/08/15 at 2:35 PM, regarding Resident #20's fall on 12/14/14, revealed she was in the hall when she heard a faint alarm sounding from inside Resident #20's room. She stated when she poked her head in the door, she startled Resident #20, causing him/her to fall and graze the back of the resident's head on the foot board of the bed. She stated she found the resident with feces on their bottom and a wet brief down around his/her</p> | F 323  | <p>Continued from page 104<br/>necessary and continue to monitor the specifics of all falls within the facility. The Director of Maintenance and Maintenance Assistant checked every wheelchair in the facility and replaced the arm rests that were cracked, frayed, and/or broken. Additional arm rests were purchased to have a supply available to replace arm rests as needed. The Maintenance Assistant repaired the wall in Room #2 and replaced the missing cable cover switchplate on 01/07/15 within 15 minutes of being identified.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same practice?</p> <p>All residents of the facility have the potential to be affected should the system to ensure adequate supervision and assistive devices to prevent accidents and to ensure the resident's environment is free of accident hazards, and should the facility fail to determine the root cause of resident falls and fail to assess its falls prevention processes to determine if they were implemented and effective in promoting a safe environment not be effective.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> |                      |  |



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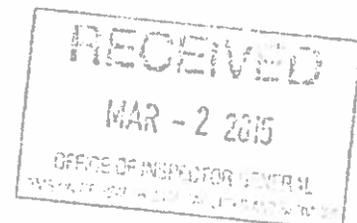
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| F 323  | <p>Continued From page 105</p> <p>ankles. She stated she discussed the incident with another LPN on duty to determine if the physician should be notified and the decision was made to wait until later in the morning when the physician was in the building to notify him of the fall. LPN#10 stated the neuro-checks were within normal limits. However, there was no documented evidence the neuro-checks were completed.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 01/08/15 at 10:55 AM, revealed CNA #3 and CNA #2 checked on Resident #20 around 6:30 AM on 12/15/14, during change of shift rounds, and found the resident breathing differently. She stated the resident's face was bruised and the bruising extended down the neck to the shoulder. The CNA stated the resident had the largest hematoma (localized swelling filled with blood caused by a break in the wall of a blood vessel) to the forehead she had ever seen; it protruded out about one to two inches. She stated she nudged the resident to wake him/her to try and see if he/she wanted to get up for breakfast. The CNA stated the resident did not seem like him/her self and she had not received information in report that the resident had experienced a change in condition. CNA #3 stated this was not reported to nurse at that time. She stated she just kept an eye on the resident and came back around 7:45 to 7:50 AM to deliver the breakfast tray. She stated again the resident still did not seem right and was lifeless. CNA #3 stated she reported this to the nurse and the nurse came to assess the resident.</p> <p>Interview with CNA #2, on 01/08/15 at 11:10 AM, revealed she and CNA #3 went into Resident #20's room around 6:00 to 6:30 AM to get the</p> | F 323  | <p>Continued from page 105</p> <p>The Director of Maintenance and Maintenance Assistant will check all wheelchairs in the facility on a monthly basis to ensure arm rests are in good repair, replacing as needed. The Director of Maintenance and Maintenance Assistant will check all cable cover switchplates and all electrical outlet plates throughout the facility on a monthly basis. The Room Audit form will reflect that staff members assigned room rounds check all cable cover switchplates and all electrical outlet plates. Staff will be assigned to ensure every resident room in the facility is audited once a month on an ongoing basis.</p> <p>The Standards of Care meeting held on a weekly basis, the Falls Committee Meeting held on Monday through Friday and the QAPI/IDT Meeting held on Monday through Friday will serve as the systemic changes put into place to ensure adequate supervision and assistive devices to prevent accidents and to ensure the residents' environment is free of accident hazards. These meeting will serve to determine the root cause of resident falls and assess the falls prevention processes to ensure they are implemented and effective in promoting a safe environment.</p> |                      |  |



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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>The purpose of the Standards of Care meeting is to Committee is to monitor care and services given to the resident to ensure quality and continuity of care is provided to all residents. The Standards of Care Committee will consist of Social Services, Activities, Dietary, Risk Care Manager and MDS Nurse. All residents will be seen on a quarterly basis, residents with restraints will be seen on a monthly basis and residents nutritionally at risk will be seen on a weekly basis. The Committee will meet weekly and discuss the following areas including but not limited to: Resident face sheet/allergies, physician orders, nurses notes, moods and behaviors, dietary (EFN, food consumption, weekly/monthly weights), PPD's, wounds/skin issues noted, care plans, C.N.A. care sheets, restorative/therapy (notes, screens, documentation). Any/all areas of concern will be discussed and addressed with appropriate department. A Standards of Care log is updated with each meeting The Standards of Care Committee is a Quality Assessment and Assurance subcommittee. Residents will be reviewed on either a weekly, monthly, or quarterly schedule. The DON and/or Administrator will review weekly updates. The DON has educated the members of the purpose and duties. Risk Care Manager oversees the Standards of Care Meeting.</p> |                      |  |



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| F 323  | <p>Continued From page 107<br/>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  | <p>Continued from page 107<br/>The Falls Committee is established to monitor the care and services to those residents who have fallen. The Falls Committee will consist of Social Services, MDS Nurse, Restorative/Wound Care Nurse, Clinical Documentation Review Nurse, Therapist, Director of Nursing and Administrator. The Committee will meet daily (Monday - Friday, excluding Holidays) and discuss any residents that have fallen since the previous meeting. The following areas will be reviewed including but not limited to: Physician orders, nurses notes, C.N.A. care sheets, Restorative/therapy (notes, screens, documentation), scheduled toileting program, falls scene investigation that includes appropriate notification of the MD/APRN and family, root cause analysis, update interentions, review care plans, all sections of forms completed. Any/all areas of concern will be discussed and addressed with appropriate department. The Falls Committee is a Quality Assessment and Assurance subcommittee. The DON and Administrator provided education to the members to the purpose and duties involved with the Falls Committee. The Clinical Documentation Review Nurse is responsible for oversight of the Falls Committee.</p> <p>The Quality Assurance Performance</p> |                      |  |

