STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185464**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/23/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREEN MEADOWS HEALTH CARE CENTER 1	**310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to have an effective system in place to ensure immediate notification of the attending physicians and resident representatives after a fall for three (3) of thirty-two (32) sampled residents (Resident's #13, #15, and #20). (Refer to F323) On [DATE] at 5:30 AM, Resident #20 sustained a fall with injury. The resident sustained [REDACTED]. The facility did not notify the physician or the responsible party of the injury until three and half (3.5) hours later at 9:00 AM on [DATE]. Resident #20 sustained another fall on [DATE] at 11:55 PM, and the physician was not notified of the fall until almost eight and one-half (8.5) hours later at 8:30 AM on [DATE]. In addition, the facility did not notify the resident's responsible party of the fall on [DATE] until 8:40 AM on [DATE] when preparations were underway to transfer the resident to the emergency room . The resident expired at the hospital at 6:00 AM on [DATE]. Record review and interview revealed Resident #20 had sustained a fall on [DATE] with no evidence the physician was notified and fell on [DATE] and [DATE] and the resident's physician was not notified timely. On [DATE] at 3:20 AM, Resident #15 sustained a fall which resulted in a laceration to the left eyebrow. The physician was not notified until seven and one-half (7.5) hours later. On [DATE] at 11:20 AM, Resident #15 fell and sustained an injury to the right shoulder and hit his/her head. The Nurse Practitioner was not notified until the next day. Resident #15 fell on [DATE] at 9:15 AM and received an abrasion to the mid upper back and a skin tear to the right elbow. The physician was not notified until the next day. On [DATE], Resident #13 was found crawling on the floor mat beside their bed at 12:30 AM; found at 4:40 AM, crawling on the floor; and, at 7:10 AM, was found again crawling on the floor with a small laceration to the back of the head. The resident's physician was not notified of the 12:30 AM or the 4:40 AM fall until after the 7:10 AM fall occurred. On [DATE] the resident sustained [REDACTED]. The facility's failure to have an effective system in place for notification of the physician and responsible party in a timely manner has caused or is likely to cause serious injury, harm, impairment or death to resident. The Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. An acceptable Allegation of Compliance (AOC) was received on [DATE] alleging the Immediate Jeopardy was removed on [DATE]. The State Survey Agency validated the Immediate Jeopardy was removed on [DATE] as alleged, prior to exit on [DATE]. 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. The findings include: Review of facility's policy Changes in a Resident's Condition or Status, dated [DATE], revealed the policy did not reflect timeframes to notify the physician or representative after a resident fall or change in condition/treatment. The policy stated nursing would notify the resident's attending physician and nursing or Social Services would notify the resident's representative when the resident was involved in any incident or accident; if there was a significant change in the resident's physical, mental, or psychosocial status; if there was a need to alter treatment significantly i.e. if the resident refused treatment or medications on a routine basis; or if the resident was discharged or transferred. All notifications would be documented in the resident's medical record. 1. Review of the closed clinical record for Resident #20 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Resident #20 also had a history of [REDACTED]. Review of Resident #20's Quarterly Minimum Data Set (MDS) assessment, completed on [DATE], revealed the facility assessed the resident as not steady on his/her feet and needed extensive assistance from staff to toilet, walk, and bathe. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored an eight (8) out of fifteen (15) indicating moderate cognitive impairment. Review of the Fall Scene Investigation Report, dated [DATE] at 5:30 AM, revealed Resident #20 sustained a fall with injury. The report stated the resident sustained [REDACTED]. The facility did not notify the physician or the responsible party of the injury until three and one-half (3.5) hours later at 9:00 AM on [DATE]. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #20 sustained a fall on [DATE] 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 [DATE]. In addition, the facility did not notify the resident's responsible party of the fall on [DATE] until 8:40 AM on [DATE] when preparations were underway to transfer the resident to the emergency room . Review of the nursing notes, dated [DATE] at 11:55 AM, revealed the resident lost his/her balance, fell and hit his/her head on the foot board of the roommate's bed. There was no evidence in the nurses notes that the physician or the responsible party were notified of the fall. Interview with Licensed Practical Nurse (LPN) #10, on [DATE] at 10:55 AM, revealed she consulted with another nurse regarding contacting the physician the night Resident #20 fell . The LPN stated due to the fall occurring at 11:55 PM and they knew the physician would be in the facility in the morning; the decision was made to notify the physician when he arrived that morning. Continued review of nursing documentation, dated [DATE] as a late entry, at 8:25 AM, revealed the resident was found by staff unresponsive, breathing irregularly and gurgling. The physician was noted to be in the facility at this time and was notified of the resident's change in condition. The physician ordered the resident to be sent to the emergency room of choice for evaluation on [DATE] at 8:30 AM. The facility notified the responsible party at 8:40 AM regarding the change in condition and their hospital of choice. Interview with Resident #20's Responsible Party (RP), on [DATE] 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. Review of Resident #20's emergency room record, dated [DATE] and timed at 9:51 AM, revealed the resident's eyes were assessed upon admission and the findings revealed the left pupil to be dilated (indicating neurological changes). An X-ray of the brain was ordered immediately and results communicated to the emergency room physician at 10:25 AM that revealed a large brain bleed. Further review of Resident #20's Fall Scene Investigation reports, revealed on [DATE] Resident #20 fell at 5:45 PM and the physician was not notified until two hours later with message left on the answering machine. There was no evidence the physician was ever made aware of the fall. On [DATE] the resident fell at 11:15 AM, the Advanced Practice Registered Nurse (APRN) was notified at 6:45 PM. The resident sustained [REDACTED]. per the nurses notes. On [DATE] the resident fell at 12:00 PM and the APRN was notified at 1:15 PM. Attempted interview with Resident #20's attending physician, on [DATE] at 1:55 PM, revealed he was unable to discuss the resident without looking at the chart. He further stated he was not available for interview. Interview, on [DATE] at 3:00 PM, with the Director of Nursing (DON) revealed he met with LPN #10 on [DATE] to discuss Resident #20's fall. He stated it was at that time he determined the physician was not notified timely of the resident's fall. His expectation was that the physician be notified promptly after Resident #20's fall. 2. Review of the clinical record revealed the facility admitted Resident #15 on [DATE] with [DIAGNOSES REDACTED]. Further record review revealed Resident #15 had a history of [REDACTED]. Review of Resident #15's quarterly Minimum Data Set (MDS) assessment, completed on [DATE], revealed the facility assessed the resident as 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) 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. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #15 fell on [DATE] at 3:20 AM. Facility staff reported Resident #15 was getting up from the recliner in the common area to go to the toilet when he/she fell . The Fall Scene Investigation report noted the resident fell face down onto the floor from the recliner and received a five-tenths (.5) centimeter (cm) laceration to the side of the left eyebrow which was swollen, raised and bruised. The Fall Scene Investigation report also noted Resident #15 reported the laceration was burning. Review of the nurse's notes for Resident #15, dated [DATE] at 1:40 PM, revealed the nurse informed the resident's physician of the resident's 3:20 AM fall, seven and one-half (7.5) hours after the fall. Further review of the note dated [DATE] at 2:25 PM revealed steri strips were applied at that time to a five-tenths (.5) centimeter (cm) laceration to Resident #15's left eyebrow. The nurse also noted on [DATE] at 2:25 PM the resident had a bruise on his/her left wrist. Review of the Fall Scene Investigation, dated [DATE], revealed Resident #15 fell on [DATE] at 11:20 PM. The resident reported hitting his/her head at the time of the fall and complained of pain in the right shoulder. The Fall Scene Investigation report indicated neurological checks were initiated but no other treatment given. Review of the nursing notes, dated [DATE] at 9:30 AM, revealed nursing staff notified the resident's Advanced Practice Registered Nurse (APRN) of the fall which had occurred at 11:20 PM on [DATE], ten (10) hours after the fall. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #15 fell on [DATE] at 9:15 AM. The fall report stated the resident was getting up to use the toilet and was incontinent of urine at the time of the fall. The resident received an abrasion to the mid upper back and a skin tear on the right elbow about 1.8 cm long. The Nursing notes, dated [DATE] at 10:40 AM, revealed Resident #15 complained of right side pain and the physician was notified at that time of the fall which had occurred at 9:15 AM on that date, one and one-half (1.5) hours. 3. Review of the clinical record for Resident #13 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's most recent Comprehensive Minimum Data Set (MDS) Assessment, dated [DATE], revealed the resident triggered as a falls risk and did not ambulate, but utilized a wheelchair for mobility. Review of the Quarterly MDS assessment, dated [DATE], revealed Resident #13 required the assistance of one (1) staff member for transfers. Review of Resident #13's Comprehensive Care Plan revealed interventions for falls prevention. Review of the Comprehensive Falls care plan revealed that prior to Resident #13's admission to the facility he/she had a history of [REDACTED]. Interview, on [DATE] at 12:05 PM, with LPN #5 revealed it was her understanding that prior to Resident #13's admission to the facility, he/she had crawled from chairs/furniture to the floor at home, as a means of getting around, and the resident had exhibited this behavior as a means of transfer/locomotion at the facility, as well. Review of the resident's clinical record (nurses' notes), revealed on [DATE] at 12:30 AM, Resident #13 was found by staff crawling on the floor mat beside his/her bed. At 4:40 AM, after the resident was transferred by staff, per wheelchair, to the sitting area on the Orchard Unit, the resident's wheelchair alarm sounded and he/she was found crawling on the floor. Further review of the nurses' notes revealed, on [DATE] at 7:10 AM, Resident #13 was again found on the floor of the unit's day room/sitting area. The resident was positioned on the floor between his/her wheel chair and another chair. The resident was assessed and a small laceration (,[DATE] centimeters) was found at the back of his/her head. Review of the falls reports, dated [DATE] at 12:30 AM, at 4:40 AM, and at 7:10 AM, did not reveal Resident #13's physician was immediately notified of the falls that occurred at 12:30 AM and 4:40 AM, but was notified at 7:10 AM after the third fall when a laceration was found on the back of the resident's head. Further review of Resident #13's Nursing Notes, dated [DATE] and timed at 1:00 PM, revealed the housekeeping supervisor called the nurse to Resident #13's room where she found the resident lying on the floor with a laceration above the right eyebrow and a hematoma about the size of a golf ball above the right eye. Nursing documented the physicians' call center was notified of the resident's fall at 2:00 PM, one (1) hour after the fall. Interview with Licensed Practical Nurse (LPN) #10, on [DATE] at 10:55 AM, revealed she was not sure what the facility policy directed them to do in regards to notifying the physician after a fall. Interview, on [DATE] at 3:00 PM, with the Director of Nursing (DON) revealed he had not conducted any recent audits to determine if there was a pattern in the facility of staff not notifying the physician timely. The DON stated no plans were made to conduct or re-educate staff. The DON stated he could not recall if not notifying physicians promptly was ever brought to the Quality Assurance Committee as an issue. He stated the importance of notifying the physician timely was to allow the physician the ability to direct the care of the resident. Review of the Allegation of Compliance (AOC) revealed the facility implemented the following immediate steps to remove the Immediate Jeopardy: 1. The Medical Director was notified of Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday [DATE]. 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 [DATE] and [DATE]. 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 [DATE] 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 [DATE] audit with changes to the timing of the toileting program based on his/her individualized needs. 4. The Medical Director met with the Director of Nursing (DON) on [DATE] to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program. Revisions were made to the policy, Accident and Incidents, for physician and responsible party notification to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Revision was made to the policy, Falls Prevention, to check safety devices each shift to ensure they are in place and functioning properly. 5. The procedure for conducting neurological checks was reviewed by the DON and the Staff Development Coordinator and all licensed nurses provided education on that process on [DATE] through [DATE]. 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 [DATE]. 6. The MDS Coordinator, MDS Nurse, DON and Risk Manager are responsible for ensuring care plans are completed/revised in a timely/accurate manner. The care plans of residents who have fallen would be reviewed weekly in a Standards of Care meeting led by the MDS Nurse and the MDS Coordinator. In attendance at that meeting are the Dietary Manager, Risk Manager, Social Services Representative and the Activity Director. A report would be generated in that meeting of all falls, the review/revision of the residents' care plans and any actions taken to address concerns which would include staff education, staff discipline and care plan revisions to the Quality Assessment and Assurance Committee monthly from [DATE] - [DATE]. 7. The DON and the Staff Development Coordinator were provided training by the Administrator on [DATE] on physician and responsible party notification. The DON and the Staff Development Coordinator initiated all licensed nurses' and Certified Nursing Assistants' (CNA) training on [DATE] and continued that training through [DATE]. A total of one hundred nineteen (119) staff had been trained by 9:30 PM on [DATE] 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. 8. The Administrator provided training to the Director of Nursing, the Risk Manager and therapy staff on [DATE] and [DATE] 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. 9. Three (3) notifications of residents' who fell prior to [DATE] was made to the attending physicians and responsible party on [DATE] with one (1) physician and the responsible party notification of a fall which occurred on [DATE]. 10. A Falls Committee was initiated [DATE] 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

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) Administrator, the DON, a MDS Nurse, Social Worker, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services Manager and meets Monday-Friday. 11. The DON provided training to the Restorative/Wound Care Nurse on [DATE], [DATE] and [DATE] addressing the facility's scheduled toileting program, the toileting program as it relates to falls, review of the four day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program form and the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of the toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee. 12. The Restorative/Wound Care Nurse would audit the toileting program using the Scheduled Toileting Audit tool. The toileting program documentation was to ensure accuracy and completeness of scheduled toileting programs. The audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. On [DATE] the Restorative/Wound Care Nurse audited twenty-nine (29) clinical records finding one (1) area of concern and on [DATE] she audited twenty-eight (28) clinical records finding one (1) area of concern. The Restorative/Wound Care Nurse is to report identified concerns with the toileting program to the DON and the Quality Assessment and Assurance Committee will review and monitor those findings. 13. The facility will utilize the Quality Assessment and Assurance Committee to review, 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. On [DATE], the State Survey Agency (SSA) validated the facility's AOC prior to exit through observation, interview and record review as follows: 1. Telephone interview with the Medical Director, on [DATE] at 2:30 PM, post survey due to lecture schedule and unavailability, revealed he was contacted by the Director of Nursing (DON) on [DATE] 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. 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 [DATE] 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 [DATE] 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. Interview with the Administrator, on [DATE] at 10:50 AM, revealed he had a telephone conversation with a Governing Body representative on [DATE] and [DATE] 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. 3. Review of the Resident Audit for Immediate Jeopardy [DATE] document revealed one hundred-eleven (111) residents (census of [DATE]) 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 [DATE] 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. Interview with the DON on [DATE] at 10:00 AM revealed he was involved in the audit of all residents' charts who were in the facility on [DATE] 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. Interview with the Risk Manager, on [DATE] 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 [DATE] 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. Interview with the Minimum Data Set nurse, on [DATE] at 3:44 PM, the Restorative/Wound Care Nurse, on [DATE] at 3:55 PM, two (2) Unit Managers on [DATE] at 4:45 PM, a Staff Nurse, on [DATE] at 5:05 PM, and the Staff Development Coordinator, on [DATE] at 5:30 PM, revealed they had all been involved in the audit of the facility residents on [DATE] 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 [DATE] 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. 4. Review of the policy, Accident and Incidents, on [DATE] 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 [DATE] 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. Interview with the Administrator and the DON, on [DATE] at 10:05 AM, revealed they had met with the Medical Director on [DATE] 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. Observation, on [DATE] at 10:40 AM, revealed Resident #25 had an alarm on the wheelchair as care planned and on [DATE] at 1:00 PM, Resident #25 was seated in the wheelchair with an alarm on the wheelchair. Observation of Resident #27, on [DATE] at 8:15 AM and 1:25 PM, revealed an alarm on the resident's wheelchair. 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. 5. Review, on [DATE] at 10:13 AM, of the content for an inservice to licensed nursing staff on [DATE] 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 [DATE] revealed additional pen lights had been ordered by the Administrator for nurses to use during neurological checks. Observation of a neurological check performed by Licensed Practical Nurse (LPN) #4 on Resident #26, on [DATE] at 12:30 PM, revealed proper technique per standards of nursing practice and followed the facility's retraining for nurses on neurological checks. Interview with LPN #4, on [DATE] 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 [DATE] by the Staff Development Coordinator and she knew pen lights were available in the facility on the crash carts. 6. Interview with the Activity Director, on [DATE] at 3:50 PM, revealed she had been present on [DATE] in a Standards of Care meeting and had been involved in the review and revision of care plans for residents who had fallen. Interview with the MDS Coordinator, on [DATE] at 3:44 PM, revealed she was involved in the Standards of Care meetings weekly, on [DATE] and in the review or revision of care plans for residents who had fallen. 7. Interview and record review with the DON, on [DATE] at 2:19 PM, revealed he was provided training by the Administrator on [DATE] on physician/responsible party notification after a resident's fall. He revealed he and the Staff Development Coordinator began on [DATE] an all nursing staff training regarding the physician/responsible party notification after a resident's fall, and continued through [DATE]. A review of in-service training records on [DATE] revealed one hundred nineteen (119) staff had been trained by 9:30 PM on [DATE] 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

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) process/form to be used and proper completion of the form. Th
F 0241 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure residents received care in a dignified manner for one (1) of thirty-two (32) sampled residents (Resident #3). Licensed Practical Nurse (LPN) #5 failed to respond to Resident #3's continuous calls for some one to assist him/her with repositioning for twenty-three (23) minutes while she passed medications next to and down the hall where Resident #3 lived. The findings include: The facility did not provide a policy regarding resident dignity. Review of Resident #3's clinical record revealed the facility admitted the resident on 02/22/10 with [DIAGNOSES REDACTED]. 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, range of motion limitation in lower extremities, and use of [MEDICAL CONDITION] medication. The resident was assessed to be at risk for falls. Review of the Comprehensive Care Plan for Resident #3 revealed the facility developed a care plan on 03/02/10, with updated goals and target dates for 02/14/15. Problems on the care plan included the Potential for Falls and Potential for Injury related to [MEDICAL CONDITION] medication use, [MEDICAL CONDITIONS], [MEDICAL CONDITIONS], and [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) with a score of twelve (12) reflecting minimal cognitive impairment. Observations on 01/07/15 from 7:50 AM to 8:13 AM, revealed LPN #5 did not provide adequate supervision for Resident #3 as evidenced by Resident #3 pleas for help went unanswered. Observation of Licensed Practical Nurse (LPN) #5 on 01/07/15 at 7:50 AM, revealed she 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 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. At 8:00 AM, LPN #5 was observed 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 medication pass. Resident #3 continued to yell, Where you at? Hey. I'm not going to wait to turn over, please. Please somebody. At 8:05 AM, LPN #5 was observed 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 Resident #3's room. LPN #5 continued past Resident #3's room without entering. Interview with LPN #5, on 01/07/15 at 11:00 AM, revealed when she got near Resident #3's room to administer medication, she heard the resident call out. LPN #5 stated did not go into the resident's room because the UM went into the resident's room to assist. LPN #5 stated she was not familiar with Resident #3's care plan. Interview with Orchard UM, on 01/07/15 at 11:55 AM, 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. The UM stated all staff was responsible for seeing to the needs of the residents. Further interview with the UM revealed crying out in pain and begging to be turned was not the usual behavior for the resident. Interview with the Director of Nursing (DON), on 01/08/15 at 10:15 AM, revealed he expected staff to answer resident's call lights within five (5) minutes, emergency lights within three (3) 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 done monthly and if issues were noted, they were discussed with staff during in-services.
F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide housekeeping and maintenance services.** Based on observation, interview, record review and policy review, it was determined the facility failed to provide the necessary maintenance and housekeeping services to maintain a sanitary, orderly and comfortable interior of the building as evidenced by the shower rooms on the Cherry and Maple Lanes. Observations revealed the shower stalls were in disrepair and had a dark substance in the grout work and wall seams. Random soiled items had been left in the shower stalls and on the floor of the Maple Lane shower room. In addition, scraped, gouged woodwork was observed on the door casings and baseboards in fourteen (14) of sixty-one (61) resident rooms throughout the facility. The findings include: Review of the facility's policy titled, Bathrooms, dated March 2009, revealed the bathrooms, including showers, commodes, etc., would be maintained in a clean and sanitary manner and would be cleaned daily and, also on an as needed basis. Review of a directive titled, Green Meadows Health Care: Response to Request for shower Room cleaning Schedule, dated 01/08/14, revealed employees of Green Meadows Environmental Services Department were to check both shower rooms between 7:00 AM and 8:00 AM daily for concerns that should be immediately addressed for the safety and comfort of the residents. Shower rooms were to be deep cleaned between 2:00 PM and 3:00 PM daily and the Certified Nursing Assistants (CNAs) were to inspect the shower rooms before taking a resident into the rooms. CNAs were to clean the shower rooms after use by each individual resident. Observation, on 01/06/15 at 2:02 PM, of the Maple Lane Shower Room, revealed three (3) wet, soiled wash cloths and an uncapped plastic disposable razor on the floor of shower stall #2. In addition, shower stall #1 had cracks in the flooring, and a dark brown/black substance was observed in the grout work of shower stall #1's floor. Observation, on 01/07/15 at 10:25 AM, revealed shower stall #2 in the Maple Lane Shower room had a dark black/brown substance in an opened area where the shower unit had separated from the shower room wall. In addition, a dark red color stained cotton ball was observed on the floor of the shower room. Observation, on 01/07/15 at 9:30 AM, revealed a soiled shower chair (a yellow stain and an orange substance) in the shower room on Cherry Lane. In addition, a black substance was observed within the grout/caulk on the shower stall floors. Interview, on 01/08/15 at 2:35 PM, during the environmental tour with the Facility's Administrator, the Maintenance Director, and the Environmental Services Director, revealed housekeeping staff was to perform a thorough, daily cleaning of each shower room. Further, the Environmental Services Director stated the exposed opening where the shower unit was separated from the wall would be difficult to clean and should be repaired to ensure the shower stall remained sanitary. In addition, the Administrator stated the cracked, damaged tiles must be repaired to prevent the growth and harborage of bacteria, and the grout work should be cleaned. The Administrator stated the direct care or housekeeping staff should have disposed of the used razor; and, the soiled wet wash cloths should have been picked up immediately as they posed a trip or accident hazard for the residents and/or the staff. In addition, the soiled wet cloths, the opened disposable razor, and the dark red color stained cotton ball posed a risk for blood borne pathogen transmission and cross contamination. Review of the facility's policy, titled Maintenance and Repairs, dated March 2009, revealed the facility was responsible for maintaining the interior and exterior of the building at all times. These responsibilities included maintaining the building in compliance with federal, state, and local laws, and among those responsibilities the maintenance staff would provide small scale remodeling and carpentry when required. Observation, on 01/07/15 from 4:00-4:20 PM, revealed gouged and dented areas with scraped off paint on the door casings and base boards in the following resident rooms: 2, 3, 8, 9, 13, 16, 23, 29, 35, 37, 50, 56, 57, and 58. Interview, on 01/08/15 at 2:30 PM, with the Administrator revealed lumber had been purchased in the fall of 2014 to replace/repair the damaged door casings and wood work in the residents' rooms. The Administrator stated the banged up/damaged woodwork in the residents' rooms was not ideal in appearance.
F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 care plans were individualized based on resident assessments and failed to ensure resident care plans were revised with interventions that prevented additional falls after sustaining falls for five (5) of

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NAME OF PROVIDER OF SUPPLIER **GREEN MEADOWS HEALTH CARE CENTER 1**	STREET ADDRESS, CITY, STATE, ZIP **310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) thirty-two (32) sampled residents. (Resident's #8, #13, #15, #17, and #20). (Refer to F323) Resident #20 had sustained a total of seven (7) falls from [DATE] through [DATE]. Review of the resident's Nursing Care Plan for falls, dated [DATE], revealed the pre-printed care plan interventions did not reflect the facility had provided direction to staff to increase Resident #20's supervision or provide assistive devices after Resident #20's falls. On [DATE] Resident #20 fell and sustained a hematoma to the head. The resident fell again on [DATE] and hit his/her head excerbating the injury received on [DATE]. The resident was transferred to the hospital after a decline in consciousness and subsequently expired on [DATE]. Resident #15's care plan was not revised with new interventions after the resident sustained [REDACTED]. Resident #13's care plan was not revised with new interventions after the resident was found crawling on the floor on [DATE] on three (3) separate occasions. Resident #17's care plan was not revised with new interventions after the resident sustained [REDACTED]. Resident #8's care plan was not revised after a fall on [DATE] with new interventions. The facility's failure to have an effective system in place for revising resident care plans to ensure safety after falls has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. An acceptable Allegation of Compliance (AOC) was received on [DATE] alleging the Immediate Jeopardy was removed on [DATE]. The State Survey Agency validated the Immediate Jeopardy was removed on [DATE] as alleged, prior to exit on [DATE]. 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. The findings include: Review of the facility's policy regarding Comprehensive Care Plans, dated July, 2009, revealed all care plans would be reviewed and updated quarterly or as needed by the interdisciplinary team. 1. Review of the closed clinical record for Resident #20 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Resident #20 also had a history of [REDACTED]. Review of Resident #20's Admission Minimum Data Set (MDS), dated [DATE], 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 [REDACTED]. Review of the CAT worksheet for Falls, dated [DATE], revealed the resident had impaired balance during transitions and required human assistance for transitions. The resident had a [DIAGNOSES REDACTED]. 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. Review of the comprehensive care plan for Resident #20, dated [DATE], revealed a potential for falls related to a history of falls, medication use, cognition and immobility. Interventions stated a sensor alarm to bed and chair as ordered; notify appropriate parties if fall occurs; give resident verbal reminders not to ambulate or transfer without assistance; properly fitting non-skid shoes for ambulation; and, environment free of clutter. Review of the Quarterly Minimum Data Set (MDS) assessment, completed on [DATE], revealed the facility assessed the resident as not steady on his/her feet and required extensive assistance from staff to toilet, walk, and bathe. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored an eight (8) out of fifteen (15) indicating moderate cognitive impairment. On [DATE], Resident #20 was in the closet, looking for a change of clothing with a brief around the ankles wet with urine and feces on the buttocks. The door to the room was shut. The nurse startled the resident upon entry to the room and caused the resident to fall and hit his/her head on the room mates foot board. Resident #20 sustained a decline in consciousness and was transferred to the hospital where he/she expired on [DATE]. Record review revealed Resident #20 had sustained six (6) falls prior to the fall on [DATE]. However, review of the resident's Nursing Care Plan for falls, dated [DATE], revealed the pre-printed care plan interventions did not reflect the facility had provided direction to staff to increase Resident #20's supervision or provide assistive devices after Resident #20's six (6) fall episodes on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. Review of the Fall Scene Investigation report, dated [DATE], revealed the resident slipped and fell after trying to ambulate alone. The report revealed the Director of Nursing (DON), Administrator (ADM) and Risk Manager (RM) did not meet regarding the fall until [DATE] (nine days later) and made no recommendations to change or revise Resident #20's plan of care. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #20's fall was due to non-compliance with care and the resident was experiencing intermittent confusion. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #20 fell reaching for a trash can. The DON, ADM and RM met on [DATE] regarding the falls on [DATE] and [DATE] but the resident's care plan was not revised to address these falls. Review of the Fall Scene Investigation report, dated [DATE], revealed the DON, ADM and RM met on [DATE] regarding the fall on [DATE] and there was no evidence on the form that the DON or ADM had made any additional recommendations or provided direction to change the plan of care. Review of Resident #20's previous Fall Scene Investigation report, dated [DATE], revealed the resident fell at 5:30 AM, and was found by staff on the floor with the bed alarm not sounding. The resident sustained [REDACTED]. The report stated staff witnessed the resident trying to silence the bed alarm after attempting an unsafe transfer earlier in the shift. Further review of the Fall Scene Investigation report revealed it did not indicate nursing had increased resident supervision to monitor for bed alarm manipulation or unsafe transfers prior to the fall. Continued review of the Fall Scene Investigation report, dated [DATE], revealed the root cause of the fall was the resident had attempted an unsafe transfer and turned off the alarm. Previously in the shift the resident attempted an unsafe transfer and tried to figure out how to turn off the alarm. The DON, ADM and Risk Manager RM met regarding the fall on [DATE] and there was no evidence on the form that the DON or ADM had made recommendations or provided direction to change the plan of care. 2. Review of the clinical record for Resident #15 revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. Further review revealed Resident #15 had a history of [REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment, completed on [DATE], revealed the resident was 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 the resident required supervision in daily decision making. Review of the Comprehensive Care Plan, dated [DATE], revealed a history of falls with potential for reoccurring falls related to medication use, cognition, immobility and advancing Dementia. Interventions, not dated, stated the staff was to notify appropriate parties if fall occurs; activity care plan for individual interests; sensor alarm; non-skid strips to bed side; verbal reminders not to ambulate or transfer without assistance; properly fitting non-skid soled shoes for ambulation; and, environment free of clutter. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #15 experienced a non-injury fall on [DATE] at 4:25 PM. The investigation report revealed the resident was trying to get up to go to the bathroom. Staff left blank the section of the investigation report titled Additional Care Plans/Care Sheet Updates. Review of Resident #15's Care Plan, dated [DATE], revealed the facility did not revise the plan of care after the fall. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #15 experienced a non-injury fall on [DATE] at 7:00 PM. The fall report stated the resident was attempting to self-ambulate out of the bathroom when the resident fell backward onto his/her buttocks. Staff entered a n/a (not applicable) in the section of the investigation report titled Additional Care Plans/Care Sheet Updates. Review of Resident #15's Care Plan, dated [DATE], revealed the facility did not revise the plan of care after the fall on [DATE] with interventions that addressed supervision or actions to meet the care needs of the resident. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #15 experienced a non-injury fall on [DATE] at 2:45 PM. The fall report stated staff had found the resident sitting on the floor in the resident's bedroom doorway without his/her wheel chair, walker, or alarms. Further review revealed the resident had a tab alarm to alert staff when rising. After the fall on [DATE], nursing staff ordered the tab alarm to be placed on the hand rail next to the toilet. No additional interventions were added to the Plan of Care for supervision of the resident while toileting or walking after the fall on [DATE]. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #15 fell on [DATE] at 3:20 AM. The staff reported the resident was getting up from the recliner in the common area to go to the toilet and landed face down on the floor. Resident #15 obtained a 0.5 cm laceration to the left eyebrow. The Additional Care Plans/Care Sheet Update section of the form stated staff would continue using alarms as ordered. Review of Resident #15's Care Plan, dated [DATE], revealed the facility did not revise the plan of care after the fall, on [DATE] with interventions that addressed supervision or actions to meet the care needs of the resident. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #15 fell on [DATE] at 9:15 AM. The fall report stated the resident was getting up to use the toilet. The resident received an abrasion to the mid upper back and a skin tear to the right elbow that was about 1.8 cm long. The resident was incontinent of urine at the time of the fall. The Additional Care Plans/Care Sheet Update part of the form was

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F 0280

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 5)
crossed through. Review of Resident #15's Care Plan, dated [DATE], revealed the care plan was not revised after the resident's fall on [DATE] to ensure the resident's toileting needs were met. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #15 fell on [DATE] at 10:55 AM. The fall report revealed Resident #15 was walking around the room, making the bed, and was also incontinent of urine at the time of the fall. The Additional Care Plan Update section of the form was crossed through. The Nurse's Notes for Resident #15, dated [DATE] at 10:55 AM, revealed a sensor alarm to the bed was found face down on the bed and was not sounding. Review of Resident #15's Care Plan, dated [DATE], revealed the staff did not revise the care plan after the resident's fall on [DATE] with interventions to increase supervision or that addressed toileting needs. Interview with the Risk Manager, on [DATE] at 9:30 AM, revealed the IDT had discussed leaving the resident alone on the toilet; however, the care plan was not revised after the meeting.
3. Review of the clinical record for Resident #13 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #13's Comprehensive Minimum Data Set (MDS) Assessment, dated [DATE], revealed the resident
triggered as at risk for falls and did not ambulate, but used a wheelchair for mobility. Review of the Quarterly MDS, dated [DATE], revealed Resident #13 required the assistance of one (1) staff member for transfers. Review of Resident #13's Comprehensive Care Plan, dated [DATE], revealed interventions for falls prevention included sensor alarm to bed and chairs as needed; mattress with raised edges; low bed with floor mats; however, it did not specify what the staff were to do when the resident crawled out the wheelchair onto the floor. The care plan stated that prior to the resident's admission to the facility he/she had a history of [REDACTED]. Interview, on [DATE] at 12:05 PM, with LPN # 5 revealed it was her understanding that prior to Resident #13's admission to the facility, the resident crawled from chairs/furniture in his/her home to the floor as a means of getting around, and at times, the resident had exhibited this behavior as a means of transfer/locomotion since he/she had been living at the facility. Review of Resident #13's nurses' notes, dated [DATE] at 4:40 AM, revealed on [DATE] at 12:30 AM, Resident #13 was found crawling on the floor mat beside his/her bed. The resident had defecated on the floor mat. Staff toileted the resident, and assisted him/her back to bed. At 4:40 AM, after the resident was transferred by staff via wheelchair to the Orchard Unit sitting area, the resident's chair alarm sounded and he/she was found crawling on the floor. Further review of the nurses' notes revealed on [DATE] at 7:00 AM, Resident #13 was again found on the floor of the unit's day room/sitting area. The resident was positioned on the floor between his/her wheelchair and another chair. The resident was assessed and a small laceration (,[DATE] centimeters) was found at the back of his/her head. Resident #13's physician was notified and the resident was transferred to a hospital emergency department for evaluation. Review of the comprehensive care plan for Resident #13, did not reveal new or additional interventions added or documented on the falls care plan after the resident had three (3) documented falls on [DATE] between 12:30 AM - 7:00 AM. Review, of the report of Resident #13's falls on [DATE], did not reveal new interventions were added under the Intervention to Prevent Further Falls/Ensure Safety section of the report. Instead, LPN #5 had written, continue with care plans currently in place. Interview, on [DATE] at 12:05 PM, with LPN #5 revealed the resident's tab alarm sounded both times when he/she left the wheelchair and was discovered on the floor of the dayroom on [DATE] at 4:40 AM and 7:00 AM, but LPN #5 further stated she did not think she updated the care plan after those falls. LPN #5 stated she thought the resident was care planned to be able to crawl from his/her wheelchair to the floor. Continued interview, on [DATE] at 12:05 PM, with LPN #5 revealed she thought Resident #13's care plan should have been updated to address the falls because it was not safe for the resident to crawl from a wheelchair to the floor. LPN #5 stated she could have met with the facility's Risk Management Nurse to decide on new or different interventions to protect the resident from further falls related to crawling from the wheelchair. Interview, on [DATE] at 2:40 PM, with the Unit Manager (UM) for the Orchard Unit, revealed Resident #13 was not care planned to crawl from one area to another on the Orchard Unit, such as from his/her wheelchair to the floor. The UM stated she had seen Resident #13 crawl out of his/her wheelchair, but further stated it was not safe for the resident to crawl out of the wheelchair. The Orchard UM stated Resident #13's falls care plan should have been updated after the resident fell two times on the floor of the Orchard Unit on [DATE]. The UM stated that after Resident #13's return from the hospital, he/she could have been evaluated by therapy to determine if any other safety interventions could have been appropriately implemented to protect the resident while seated in the wheelchair. 4. Review of the clinical record for Resident #17 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #17, dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of eleven (11), indicating cognitively intact. Review of the Comprehensive Care Plan, dated [DATE], revealed the potential for falls related to history of falls, medication use, immobility, Dementia, and incontinence. Interventions, not dated, stated a sensor alarm to bed and chair that was discontinued on [DATE] and a tab alarm to bed and chair was initiated on [DATE]; verbal reminders not ambulate or transfer with assistance; properly fitting non-skid soled shoes for ambulation; and, environment free of clutter. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #17 fell on [DATE] at 8:50 AM. The staff found Resident #17 on the floor in his/her room. The resident obtained a laceration to the forehead, along with skin tears to left forearm and right elbow. Resident #17 was sent to the emergency room for evaluation. The root cause portion of the document stated it appeared the resident fell asleep and fell out of the wheel chair head first, into the foot rail of the bed. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #17 experienced a non-injury fall on [DATE] at 5:45 PM. The investigation report indicated the staff found the resident on the floor in his/her room in front of his/her wheel chair. Review of the nurse's notes, dated [DATE] at 10:50 AM, revealed the alarm clip had slipped off the resident's shirt, preventing the alarm from sounding. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #17 experienced a non-injury fall, on [DATE] at 6:45 PM. The investigation forms revealed the resident was attempting to take shoes off when he/she slid out of the wheelchair. Review of the Nurse's Notes for Resident #17, dated [DATE] at 7:00 PM and [DATE] at 7:00 PM, stated the resident was observed sliding out of the wheelchair while attempting to remove his/her shoes and was educated to call for help when toileting or dressing. Review of Resident #17's Care Plan, dated [DATE], revealed the staff had not added new interventions to the falls section of the care plan after the resident fell on [DATE], [DATE], or on [DATE]. 5. Review of the clinical record for Resident #8 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored an eight (8) out of fifteen (15) indicating moderate cognitive impairment. Review of the Comprehensive Care Plan, dated [DATE], revealed a potential for falls related to history of frequent falls, unsteady gait, medication use, immobility, and cognition deficit.
Interventions, not dated, stated notify appropriate parties if falls occur; rear anti-tippers to wheel chair; anti-rollbars to wheel chair; mattress with raised edges; properly fitting non-skid sole shoes for ambulation; and, environment free of clutter. Review of the Nursing Notes, dated [DATE] and timed at 9:25 PM, revealed the nurse was standing outside Resident #8's room when she heard a loud sound and upon entering the resident's room she observed the resident sitting on the bathroom floor. The nursing notes stated the resident was brushing his/her teeth and the resident's legs became weak and the resident fell . Review of Resident #8's, Falls Nursing Care Plan, dated [DATE], revealed no revisions or updates were made after Resident #8's fall on [DATE] to promote safety and prevent additional falls. Review of Resident #8's Fall Scene Investigation Report, dated [DATE], revealed the root cause of the fall was the resident's legs became weak while standing. Nursing was to place the resident's name on the physicians list for review and to complete neuro-checks. The Summary of Meeting and Additional Care Plan Update sections were blank. Interview with the Advance Practitioner Registered Nurse (APRN) on, [DATE] at 2:15 PM, revealed she had not assessed the resident as of [DATE] in regards to the fall on [DATE]. The APRN said, according to her review of the physician's documentation in the medical record, Resident #8's physician had not performed an assessment to determine the cause of the fall as of [DATE]. She stated the physician would assess medication for potential causes of falls and look at the resident's [DIAGNOSES REDACTED]. Interview with the Risk Manager (RM), on [DATE] at 10:30 AM, revealed the root cause of Resident #8's fall was the resident's legs became weak while standing. The RM stated she did not complete her documentation under the Summary of Meeting where she would have met with the Administrator and the Director of Nursing to discuss the fall. She stated if the area under Additional Care Plan Update sections were blank there were none to document. Interview with the Director of Nursing on, [DATE] at 3:00 PM, revealed he had not provided direction to the Risk Manager regarding adding additional falls prevention interventions to Resident #8's plan of care. He stated he was not aware the physician had not assessed the resident since the fall on [DATE]. He stated he did not perform chart audits to determine if interventions were completed. Interview with the Risk Manager (RM), on [DATE] at 9:35 AM, revealed her responsibility was to ensure follow-up occurred after each resident fall, complete the documentation under the Falls Team Notes section of the Fall Scene Investigation report and report falls data/information to the Safety and Quality Assurance Committees. She stated it was nursing's responsibility to revise the care plan after a

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) fall. She stated after each fall she reviewed the Fall Scene Investigation form the nurses completed to ensure the care plan was revised after a fall, if indicated; however, did not actually check the care plan for the revision. She stated she would try and meet with the Director of Nursing and the Administrator at least every other week to discuss the findings of the fall but this was not a set time frame. Interview with the Director of Nursing on, [DATE] at 3:00 PM, revealed if a resident experienced a fall it was discussed in the morning meeting the day after the fall occurred. He stated the Administrator, Risk Manager and himself would meet to review a resident's fall. He stated he did not keep any record of the meetings and did not remember if he provided any direction to staff regarding the implementation of additional interventions for Resident #20. He stated it was his expectation that the nursing staff revise resident care plans after incidents occur. However, interview with LPN #8, on [DATE] at 9:55 AM, revealed the revision of the care plan after falls was to be completed by the RM. Interview with the Unit Manager, on [DATE] at 8:30 AM, revealed she was not sure about what interventions would be used to revise the care plan. Interview with the Administrator on, [DATE] at 5:25 PM, revealed he did not provide direction to the Director of Nursing or the Risk Manager regarding the care plan revisions for falls. Review of the Allegation of Compliance (AOC) revealed the facility implemented the following immediate steps to remove the Immediate Jeopardy: 1. The Medical Director was notified of Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday [DATE]. 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 [DATE] and [DATE]. 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 [DATE] 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 [DATE] audit with changes to the timing of the toileting program based on his/her individualized needs. 4. The Medical Director met with the Director of Nursing (DON) on [DATE] to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program. Revisions were made to the policy, Accident and Incidents, for physician and responsible party notification to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Revision was made to the policy, Falls Prevention, to check safety devices each shift to ensure they are in place and functioning properly. 5. The procedure for conducting neurological checks was reviewed by the DON and the Staff Development Coordinator and all licensed nurses provided education on that process on [DATE] through [DATE]. 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 [DATE]. 6. The MDS Coordinator, MDS Nurse, DON and Risk Manager are responsible for ensuring care plans are completed/revised in a timely/accurate manner. The care plans of residents who have fallen would be reviewed weekly in a Standards of Care meeting led by the MDS Nurse and the MDS Coordinator. In attendance at that meeting are the Dietary Manager, Risk Manager, Social Services Representative and the Activity Director. A report would be generated in that meeting of all falls, the review/revision of the residents' care plans and any actions taken to address concerns which would include staff education, staff discipline and care plan revisions to the Quality Assessment and Assurance Committee monthly from [DATE] - [DATE]. 7. The DON and the Staff Development Coordinator were provided training by the Administrator on [DATE] on physician and responsible party notification. The DON and the Staff Development Coordinator initiated all licensed nurses' and Certified Nursing Assistants' (CNA) training on [DATE] and continued that training through [DATE]. A total of one hundred nineteen (119) staff had been trained by 9:30 PM on [DATE] 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. 8. The Administrator provided training to the Director of Nursing, the Risk Manager and therapy staff on [DATE] and [DATE] 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. 9. Three (3) notifications of residents' who fell prior to [DATE] was made to the attending physicians and responsible party on [DATE] with one (1) physician and the responsible party notification of a fall which occurred on [DATE]. 10. A Falls Committee was initiated [DATE] 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. 11. The DON provided training to the Restorative/Wound Care Nurse on [DATE], [DATE] and [DATE] addressing the facility's scheduled toileting program, the toileting program as it relates to falls, review of the four day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program form and the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of the toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee. 12. The Restorative/Wound Care Nurse would audit the toileting program using the Scheduled Toileting Audit tool. The toileting program documentation was to ensure accuracy and comp
F 0282 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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. The findings include: 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. 1. Review of Resident #3's clinical record revealed the facility admitted the resident on 02/22/10 with [DIAGNOSES REDACTED]. 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. Review of the Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) with a score of twelve (12) reflecting minimal cognitive impairment. 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 [DIAGNOSES REDACTED]. Interventions listed included to observe for quality, intensity, duration, and frequency of pain symptoms and to position the resident for comfort as needed. 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. 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 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,

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NAME OF PROVIDER OF SUPPLIER **GREEN MEADOWS HEALTH CARE CENTER 1**	STREET ADDRESS, CITY, STATE, ZIP **310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0282 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 7) please help me, someone turn me over please. 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. 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. 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 his/her back. 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. 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. 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) 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. 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 REDACTED]. Continued review of Resident #16's clinical record revealed he/she received routine anticoagulation therapy ([MEDICATION NAME]) along with [MEDICATION NAME] and Aspirin for a [DIAGNOSES REDACTED].#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. 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 that morning at 10:40 AM and returned the call at 12:05 PM. 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. 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 insevice 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 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. 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. 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 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). 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 [REDACTED]. On [DATE] the resident was ambulating from the toilet to the wheelchair when they fell hit his/her head. On [DATE] 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 transferred to the hospital for evaluation and expired on [DATE]. Review of Resident #15's toileting program revealed inconsistent documentation of the program and the resident sustained [REDACTED]. On [DATE] the resident was taking self to the bathroom and fell receiving a laceration to left eyebrow. On [DATE] the resident was incontinent and fell with pain in the right shoulder. On [DATE] the resident was taking self to the bathroom and fell sustaining an abrasion to the back and a skin tear to the elbow. 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 [DATE] and determined to exist on [DATE]. An acceptable Allegation of Compliance (AOC) was received on [DATE] alleging the Immediate Jeopardy was removed on [DATE]. The State Survey Agency validated the Immediate Jeopardy was removed on [DATE] as alleged, prior to exit on [DATE]. 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. The findings include: Review of the a policy titles Bowel and Bladder and provided by the facility as the toileting program policy, dated [DATE], revealed every resident would be assessed and maintained at their highest level of continence. The toileting program would be individualized specific to a

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F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) resident's incontinent pattern. The program would be implemented and noted on the plan of care. 1. Review of the closed clinical record for Resident #20 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Resident #20 also had a history of [REDACTED]. Review of Resident #20's Quarterly Minimum Data Set (MDS) assessment, completed on [DATE], 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. Review of Resident #20's initial Plan of Care for Scheduled Toileting, dated [DATE] and the comprehensive care plan dated [DATE], 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. Review of the Behavioral Program form, dated [DATE], 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 [DATE], revealed no documentation the resident was toileted, found wet or dry for an eight (8) hour time-frame, on [DATE] from 5:00 AM to 1:00 PM, and for a twenty-two (22) hour time-frame on [DATE] from 2:00 AM until 11:00 PM. Again on [DATE], there was no documentation for a fourteen (14) hour time-frame from midnight till 2:00 PM. Review of the Scheduled Toileting Program plans, dated [DATE] through [DATE], 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. Review of the Restorative Monthly Assessment form, dated [DATE], revealed staff documented the resident continued to frequently dribble urine and had a decrease in ambulation ability due to knee pain. However, there was no documented assessment of urinary frequency, incontinence or continent 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. Review of the Restorative Monthly Assessment form, dated [DATE], 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 [DATE], [DATE], [DATE], [DATE] and [DATE]. On [DATE] and [DATE] that found the resident incontinent with each of these falls and received a head injury that required hospitalization and subsequent death. Interview with CNA #5, on [DATE] at 11:25 AM, revealed Resident #20 was only toileted every two (2) hours, the same as the other residents. Interview with CNA #7, on [DATE] 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. 2. Review of the clinical record for Resident #15 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Further review revealed Resident #15 had a history of [REDACTED]. Review of Resident #15's quarterly Minimum Data Set (MDS) assessment, completed on [DATE], 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. Review of the comprehensive care plan, dated [DATE], 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. 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-5P, after supper; between 10P and 12A. The form further revealed it was not individualized, but toileting took place every two hours. Review of the Scheduled Toileting Program Plan, for Resident #15, dated [DATE], 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. Review of the Scheduled Toileting Program Plan, dated [DATE], 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. Review of the Scheduled Toileting Program Plan, dated [DATE], 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. Review of the Scheduled Toileting Program Plan, dated [DATE], 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 (162) toileting opportunities between [DATE] and [DATE]. No toileting documentation was completed on this sheet between [DATE] and [DATE]. Review of the Scheduled Toileting Program Plan, dated [DATE], 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. Review of the Scheduled Toileting Program Plan, dated [DATE], 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. Review of the Scheduled Toileting Program Plan, dated [DATE], 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. Continued review of Resident #15's program revealed it did not address the three (3) falls the resident sustained [REDACTED]. On [DATE] the resident was taking self to the bathroom and fell receiving a laceration to left eyebrow. On [DATE] the resident was incontinent and fell with pain in the right shoulder. On [DATE] the resident was taking self to the bathroom and fell sustaining an abrasion to the back and a skin tear to the elbow. Interview with Certified Nursing Assistant (CNA) #9, on [DATE] 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. Interview with CNA #3, on [DATE] at 10:55 AM, revealed the residents on the toileting program were toileted every two hours and as needed. Interview with CNA #6, on [DATE] at 1:55 PM, revealed the residents on the toileting program were toileted every two hours and before and after meals. Interview with the Restorative/Wound Care Licensed Practical Nurse (LPN), on [DATE] 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 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. Interview with the Risk Manager, on [DATE] 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.

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F 0315

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 9)
Interview with the Director of Nursing (DON) on, [DATE] 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. Review of the Allegation of Compliance (AOC) revealed the facility implemented the following immediate steps to remove the Immediate Jeopardy: 1. The Medical Director was notified of Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday [DATE]. 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 [DATE] and [DATE]. 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 [DATE] 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 [DATE] audit with changes to the timing of the toileting program based on his/her individualized needs. 4. The Medical Director met with the Director of Nursing (DON) on [DATE] to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program. Revisions were made to the policy, Accident and Incidents, for physician and responsible party notification to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Revision was made to the policy, Falls Prevention, to check safety devices each shift to ensure they are in place and functioning properly. 5. The procedure for conducting neurological checks was reviewed by the DON and the Staff Development Coordinator and all licensed nurses provided education on that process on [DATE] through [DATE]. 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 [DATE]. 6. The MDS Coordinator, MDS Nurse, DON and Risk Manager are responsible for ensuring care plans are completed/revised in a timely/accurate manner. The care plans of residents who have fallen would be reviewed weekly in a Standards of Care meeting led by the MDS Nurse and the MDS Coordinator. In attendance at that meeting are the Dietary Manager, Risk Manager, Social Services Representative and the Activity Director. A report would be generated in that meeting of all falls, the review/revision of the residents' care plans and any actions taken to address concerns which would include staff education, staff discipline and care plan revisions to the Quality Assessment and Assurance Committee monthly from [DATE] - [DATE]. 7. The DON and the Staff Development Coordinator were provided training by the Administrator on [DATE] on physician and responsible party notification. The DON and the Staff Development Coordinator initiated all licensed nurses' and Certified Nursing Assistants' (CNA) training on [DATE] and continued that training through [DATE]. A total of one hundred nineteen (119) staff had been trained by 9:30 PM on [DATE] 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. 8. The Administrator provided training to the Director of Nursing, the Risk Manager and therapy staff on [DATE] and [DATE] 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. 9. Three (3) notifications of residents' who fell prior to [DATE] was made to the attending physicians and responsible party on [DATE] with one (1) physician and the responsible party notification of a fall which occurred on [DATE]. 10. A Falls Committee was initiated [DATE] 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. 11. The DON provided training to the Restorative/Wound Care Nurse on [DATE], [DATE] and [DATE] addressing the facility's scheduled toileting program, the toileting program as it relates to falls, review of the four day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program form and the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of the toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee. 12. The Restorative/Wound Care Nurse would audit the toileting program using the Scheduled Toileting Audit tool. The toileting program documentation was to ensure accuracy and completeness of scheduled toileting programs. The audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. On [DATE] the Restorative/Wound Care Nurse audited twenty-nine (29) clinical records finding one (1) area of concern and on [DATE] she audited twenty-eight (28) clinical records finding one (1) area of concern. The Restorative/Wound Care Nurse is to report identified concerns with the toileting program to the DON and the Quality Assessment and Assurance Committee will review and monitor those findings. 13. The facility will utilize the Quality Assessment and Assurance Committee to review, 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. On [DATE], the State Survey Agency (SSA) validated the facility's AOC prior to exit through observation, interview and record review as follows: 1. Telephone interview with the Medical Director, on [DATE] at 2:30 PM, post survey due to lecture schedule and unavailability, revealed he was contacted by the Director of Nursing (DON) on [DATE] 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. 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 [DATE] 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 [DATE] 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. Interview with the Administrator, on [DATE] at 10:50 AM, revealed he had a telephone conversation with a Governing Body representative on [DATE] and [DATE] 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. 3. Review of the Resident Audit for Immediate Jeopardy [DATE] document revealed one hundred-eleven (111)

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NAME OF PROVIDER OF SUPPLIER **GREEN MEADOWS HEALTH CARE CENTER 1**		STREET ADDRESS, CITY, STATE, ZIP **310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) residents (census of [DATE]) 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 [DATE] 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. Interview with the DON on [DATE] at 10:00 AM revealed he was involved in the audit of all residents' charts who were in the facility on [DATE] 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. Interview with the Risk Manager, on [DATE] 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 [DATE] 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. Interview with the Minimum Data Set nurse, on [DATE] at 3:44 PM, the Restorative/Wound Care Nurse, on [DATE] at 3:55 PM, two (2) Unit Managers on [DATE] at 4:45 PM, a Staff Nurse, on [DATE] at 5:05 PM, and the Staff Development Coordinator, on [DATE] at 5:30 PM, revealed they had all been involved in the audit of the facility residents on [DATE] 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 [DATE] 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. 4. Review of the policy, Accident and Incidents, on [DATE] 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 [DATE] 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. Interview with the Administrator and the DON, on [DATE] at 10:05 AM, revealed they had met with the Medical Director on [DATE] 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. Observation, on [DATE] at 10:40 AM, revealed Resident #25 had an alarm on the wheelchair as care planned and on [DATE] at 1:00 PM, Resident #25 was seated in the wheelchair with an alarm on the wheelchair. Observation of Resident #27, on [DATE] at 8:15 AM and 1:25 PM, revealed an alarm on the resident's wheelchair. 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. 5. Review, on [DATE] at 10:13 AM, of the content for an inservice to licensed nursing staff on [DATE] 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 [DATE] revealed additional pen lights had been ordered by the Administrator for nurses to use during neurological checks. Observation of a neurological check performed by Licensed Practical Nurse (LPN) #4 on Resident #26, on [DATE] at 12:30 PM, revealed proper technique per standards of nursing practice and followed the facility's retraining for nurses on neurological checks. Interview with LPN #4, on [DATE] 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 [DATE] by the Staff Development Coordinator and she knew pen lights were available in the facility on the crash carts. 6. Interview with the Activity Director, on [DATE] at 3:50 PM, revealed she had been present on [DATE] in a Standards of Care meeting and had been involved in the review and revision of care plans for residents who had fallen. Interview with the MDS Coordinator, on [DATE] at 3:44 PM, revealed she was involved in the Standards of Care meetings weekly, on [DATE] and in the review or revision of care plans for residents who had fallen. 7. Interview and record review with the DON, on [DATE] at 2:19 PM, revealed he was provided training by the Administrator on [DATE] on physician/responsible party notification after a resident's fall. He revealed he and the Staff Development Coordinator began on [DATE] an all nursing staff training regarding the physician/responsible party notification after a resident's fall, and continued through [DATE]. A review of in-service training records on [DATE] revealed one hundred nineteen (119) staff had been trained by 9:30 PM on [DATE] 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 u
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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) On [DATE] at 5:30 AM, Resident #20 sustained a fall with injury. The resident sustained [REDACTED]. The facility did not complete a root cause analysis as to the cause of the fall. Resident #20 sustained a second fall on [DATE] at 11:55 PM, which resulted in a head injury and required transfer to the hospital for treatment where the resident subsequently expired on [DATE]. Record review and interview revealed Resident #20 has sustained a total of seven (7) falls from [DATE] through [DATE] with no evidence the facility had revised interventions to prevent further falls. On [DATE] 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 [DATE] 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 [DATE] at 9:15 AM and received an abrasion to the mid upper back and a skin tear to the right elbow. On [DATE], Resident #13 was found crawling on the floor mat beside the bed at 12:30 AM; 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 [DATE] the resident sustained [REDACTED]. The facility applied steri-strips and a dry dressing to cover. Resident #17 sustained three (3) falls occurring on [DATE], [DATE] and [DATE]. The resident required stitches with the [DATE] fall. The tab alarm was not attached to the resident during the [DATE] falls. On [DATE] 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 [DATE] 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. 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. 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 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 [DATE] and determined to exist on [DATE]. An acceptable Allegation of Compliance (AOC) was received on [DATE] alleging the Immediate Jeopardy was removed on [DATE]. The State Survey Agency validated the Immediate Jeopardy was removed on [DATE] as alleged, prior to exit on [DATE]. 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. The findings include: Review of the facility's policy regarding Accidents and Incidents, dated [DATE],

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) 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 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. 1. Review of the closed clinical record for Resident #20 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Resident #20 had a history of [REDACTED]. A Falls Risk Assessment, completed on [DATE], 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 [DATE], revealed the 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. Review of Resident #20's Admission Minimum Data Set (MDS), dated [DATE], 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 [REDACTED]. Review of the CAT worksheet for Falls, dated [DATE], revealed the resident had impaired balance during transitions and required human assistance for transitions. The resident had a [DIAGNOSES REDACTED]. 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. Review of the comprehensive care plan, dated [DATE], 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. Continued review of the comprehensive care plan, dated [DATE], revealed interventions added on [DATE] non-skid liner to wheelchair; [DATE] antitipper to back of wheelchair; and on [DATE] tab alarm with pin and clip to toilet; pommel cushion to wheelchair; and padding to wheelchair sides. Quarterly Minimum Data Set (MDS), dated [DATE] 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. 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 [REDACTED]. Review of the Fall Scene Investigation report, dated [DATE], revealed Resident #20 sustained a fall on [DATE] 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 [DATE]. In addition, the facility did not notify the resident's responsible party of the fall on [DATE] until 8:40 AM on [DATE] when preparations were underway to transfer the resident to the emergency room . Review of the Nursing Notes for Resident #20, dated [DATE] 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. However, review of the facility's Neurocheck Protocol document, dated [DATE], revealed the neuro-check block, timed at 6:55 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 [DATE] fall. Interview with Licensed Practical Nurse (LPN) #10, on [DATE] at 2:35 PM, regarding Resident #20's fall on [DATE], 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 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. Interview with Certified Nursing Assistant (CNA) #3, on [DATE] at 10:55 AM, revealed CNA #3 and CNA #2 checked on Resident #20 around 6:30 AM on [DATE], 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. Interview with CNA #2, on [DATE] 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 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. Interview with the Unit Manager, on [DATE] at 11:20 AM, and review of the Nursing Notes, dated [DATE] 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 . Review of Resident #20's emergency room record, dated [DATE] 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 the results were communicated to the emergency room physician at 10:25 AM and revealed a large brain bleed. Continued review of Resident #20's hospital record revealed the Physician's clinical report, dated [DATE] 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 [DIAGNOSES REDACTED]. Continued review of the Physician's documentation revealed the care provider reviewed Resident #20's

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F 0323

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 12)
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 [DATE]. Interview with Resident #20's Responsible Party (RP), on [DATE] 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, history of blood clots in the leg, and arthritis. The RP stated the resident had a weak bladder causing frequent toileting, a bad knee and could not stand for long periods. The RP continued to say the resident was not experiencing any organ failure or decline and found it concerning that the resident was fine one day and unresponsive the next day. Further review of Resident #20's closed clinical record revealed the resident had fallen on [DATE] and sustained a head injury. Review of Resident #20's previous Fall Scene Investigation report, dated [DATE], revealed the resident fell at 5:30 AM and was found by staff on the floor with the bed alarm not sounding. The resident sustained [REDACTED]. The report stated staff witnessed the resident trying to silence the bed alarm after attempting an unsafe transfer earlier in the shift. Further review of documentation did not indicate whether nursing had increased resident supervision, to monitor for bed alarm manipulation or unsafe transfers prior to the fall. Continued review of the nursing documentation revealed Resident #20's physician was not notified of the fall with injury on [DATE] until 9:00 AM, three and half (3.5) hours later. Telephone interview with CNA #9, on [DATE] at 2:05 PM, regarding Resident #20's fall on [DATE], revealed she found the resident behind the door in his/her room. She stated no alarm was sounding to alert staff the resident was out of bed when she entered the resident's room. She stated it appeared the resident was trying to get into the closet, fell against the closet door, and sustained a goose egg injury to the forehead. She stated by the next day the bump on Resident 20's forehead had swollen tremendously and was purple in color. Telephone Interview with LPN #12, on [DATE] at 9:00 AM, regarding Resident #20's fall on [DATE], revealed she heard two CNAs yelling for assistance from Resident #20's room. She stated the resident was found in the floor behind the closed bedroom door by the closet door. She stated there was no alarm sounding at the time the resident was found. The LPN stated the resident was seen earlier in the shift fiddling with the alarm box. She stated the resident was assessed and found to have a hematoma to the left side of the forehead and right thumb. Further review of the Fall Scene Investigation report, dated [DATE], revealed the root cause of the fall was resident attempted unsafe transfer and turned off alarm. Previously in the shift the resident attempted an unsafe transfer and tried to figure out how to turn off the alarm. The Director of Nursing (DON), Administrator (ADM) and Risk Manager (RM) met regarding the fall on [DATE] and there was no documented evidence on the form that the DON or Administrator had made recommendations or provided direction to change the plan of care. Continued interview with Resident #20's Responsible Party (RP), on [DATE] at 4:05 PM, revealed the resident had fallen on [DATE] and had hit their head and sustained a hematoma to the forehead and bruise to the hand. The RP stated the resident was on blood thinning medication for the history of a blood clot in the leg, and this caused the increased bruising seen on the resident's face, neck and shoulder, after the fall on [DATE]. The RP stated they expected the facility to provide adequate supervision to prevent falls; however, the facility did not increase monitoring or rounding on the resident. Interview with the Risk Manager (RM), on [DATE] at 10:10 AM, revealed the root cause of Resident #20's fall on [DATE] was the resident attempted an unsafe transfer and turned off the bed alarm. She stated Resident #20 was on the facility toileting program; however, she had not reviewed the toileting program to determine if Resident #20's was effective and individualized or was the potential root cause for the resident's last two (2) falls. She stated she met with the DON and Administrator, to discuss the [DATE] and [DATE] falls on [DATE] (three days after Resident #20 passed). Telephone interview with the Medical Director, on [DATE] at 2:30 PM, revealed he was contacted by the DON on [DATE] regarding the Immediate Jeopardy. The Medical Director stated the facility had not done the right things in regard to the fall of Resident #20. Continued review of Resident #20's Fall Scene Investigation reports, revealed Resident #20 had sustained five (5) falls prior to the two (2) falls in December, 2014. The falls occurred on [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of the Fall Scene Investigation report, dated [DATE], revealed the root cause of Resident #20's fall was he/she slid out of the wheelchair with no injury. Review of Fall Scene Investigation report, dated [DATE], revealed the root cause of the fall was resident slipped and fell , next to the bed, while walking unassisted with no injury. However, there were no recommendations for care plan revisions written under the heading Additional Care Plan/Care Sheet Updates for the fall on [DATE] or [DATE]. In addition, the fall on [DATE] was not review by the DON, Administrator and RM until twenty (20) days later on [DATE]. The fall on [DATE] was not reviewed by the DON, Administrator and RM until nine (9) days after the fall on [DATE]. Further review of Resident #20's plan of care revealed a non-skid liner to the wheelchair was added to the wheelchair on [DATE], seventeen (17) days after the fall. Review of the Fall Scene Investigation report, dated [DATE], revealed the root cause of Resident #20's fall stated he/she was non-compliant with care and was experiencing intermittent confusion. The resident received no injury from the fall. The Fall Scene Investigation report, dated [DATE], revealed the root cause of Resident #20's fall stated the resident was reaching for a trash can. The fall did not result in any injury. The DON, Administrator and RM met on [DATE] regarding the falls on [DATE] and [DATE] and no recommendations for additional changes to the plan of care were documented as given by the DON or Administrator. Further review of Resident #20's plan of care revealed there was no revision to the interventions related to these two (2) falls. Review of the Fall Scene Investigation report, dated [DATE], revealed the root cause of the fall was it appeared the resident was ambulating from the toilet to the wheelchair unassisted, slipped and fell without injury. The DON, Administrator and RM met regarding the fall on [DATE] and there was no documented evidence on the form that the DON or Administrator had made recommendations or provided direction to change the plan of care. Further review of Resident #20's plan of care revealed a tab alarm pin/clip was added to the care plan on [DATE] to sit on the bar next to the toilet. Interview with LPN #5, on [DATE] at 9:20 AM, revealed she had placed Resident #20 on the toilet on [DATE], and left the resident unsupervised while she was completing tasks out in the resident's room. LPN #5 stated the resident was at high risk for falls, but believed it was safe to leave the resident unsupervised on the toilet. She stated she heard the resident fall and went to the bathroom to find the resident sitting crossed legged on the floor in front of the toilet. She stated the resident had a tab alarm to the bed and chair already and after the fall it was decided the alarm box would be placed on the hand rail next to the toilet. The LPN said that if the resident was left unsupervised again while toileting, it would alarm and notify staff the resident had raised from the toilet. She stated all staff know to supervise residents for safety, and that was done by rounding, which was done every two hours by the nursing assistants when they toileted and turned the residents. The LPN stated she did not provide additional direction to staff regarding increasing supervision of Resident #20 after the fall on [DATE]. She stated increased supervision was usually done only when a resident was exit seeking. Interview with the Risk Manager (RM), on [DATE] at 10:10 AM, revealed the determination of the root cause and interventions to prevent another fall was made by determining what the resident was doing at the time. She stated the root cause of an incident was not looked at in the manner that determined what facility systems or processes were not working properly. Interview with the Director of Nursing, on [DATE] at 3:00 PM, revealed he didn't remember if he provided any direction to the RM regarding implementing additional interventions for Resident #20. 2. Review of the clinical record for Resident #15 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Review of Minimum Data Set (MDS) for Resident #15, dated [DATE], revealed the facility was unable to assess Resident #15 utilizing the Brief Interview for Mental Status (BIMS) due to the resident was rarely/never understood. Review of the Falls care plan, dated [DATE], revealed a history of falls with potential for reoccuring falls related to medication use, cognition, immobility; and advancing Dementia. Interventions for the Falls care plan, not dated, revealed the staff was to notify the appropriate parties if a fall occured; see activity plan for individual interests; sensor alarm; non-skid strips to bed side; verbal reminders to not ambulate or transfer without assistance; properly fitting non-skid soled shoes for ambulation; and, clutter free environment. Review of Resident #15's medical record revealed the resident had fall episodes documented on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of the Fall Scene Investigation
report, dated [DATE], revealed Resident #15 fell on [DATE] at 4:25 PM. The staff reported witnessing the resident fall in the common area. The investigation report further revealed the resident had stated he/she was trying to get up to go to the bathroom. The resident did not obtain any injuries from this fall. The facility staff identified the root cause of this fall that the resident's foot slid when he/she was getting out of a recliner. The staff left blank the section of the investigation report titled Additional Care Plans/Care Sheet Updates. Review of the care plan revealed no changes, that were dated, were made to the care plan after the fall on [DATE]. Review of the Fall Scene Investigation, dated [DATE], revealed Resident #15 fell on [DATE] at 7:00 PM. The fall report stated the resident was attempting to self-ambulate out of the bathroom in the resident room when he/she fell backward onto his/her buttocks. The nurse noted no injuries on this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185464**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/23/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREEN MEADOWS HEALTH CARE CENTER 1	**310 BOXWOOD RUN ROAD** **MOUNT WASHINGTON, KY 40047**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) investigation. As the root cause, staff documented the resident was trying to get out of the bathroom. Staff entered n/a (not applicable) in the section of the investigation report titled Additional Care Plans/Care Sheet Updates. There were no changes, that were dated, added to the care plan after the fall on [DATE]. Review of the Fall Scene Investigation, dated [DATE], revealed Resident #15 fell on [DATE] at 2:45 PM. The fall report stated staff had found the resident sitting on the floor in the resident bathroom doorway without his/her wheel chair, walker, or alarms. The nurse noted no injuries on this Fall Scene Investigation report. As the root cause, staff documented the resident had an unsteady gait. The only notation found under interventions was on [DATE] ER followup fall-slipped to floor unwitnessed found at bathroom door, no injury. Review of the Fall Scene Investigation, dated [DATE], revealed Resident #15 fell , on [DATE] at 3:20 AM. The staff reported the resident was getting up from the recliner in the common area to go the toilet when the fall occurred. The resident fell face down onto the floor from the recliner. The resident had taken shoes off while sleeping in the recliner. The resident obtained a 0.5 cm laceration to the left eyebrow. The additional care plan section of the form stated staff to continue using alarms as ordered. The following notation was listed under interventions on [DATE] anti-rear tippers to wheelchair; and, anti-roll backs to wheelchair. However, the resident fell from a recliner and had no falls from the wheelchair. Review of the Fall Scene Investigation, dated [DATE], revealed Resident #15 fell on [DATE] at 11:20 PM. The fall report stated another resident reported to staff that he/she had heard someone fall. Staff went to Resident #15's room and found the resident attempting to get back into the bed. The resident had been incontinent of urine. The report further stated the resident had removed the sensor alarm from his/her bed and had placed it on the bedside table. The staff put an alarm in place. The resident hit his/her head and complained of pain in his/her right shoulder. The staff completed the additional care plan section of the form on [DATE] and indicated the facility would provide the resident with a mattress with raised edges to assist the resident to identify the edge of the bed. However, no interventions were put in place to address toileting needs or the removal of the sensor alarm from the bed. There were no changes made to the falls care plan after the [DATE] fall. Review of the Fall Scene Investigation, dated [DATE], revealed Resident #15 fell on [DATE] at 9:15 AM. The fall report stated the resident had stated he/she was getting up to use the toilet. The resident had been attempting to ambulate unattended in his/her room at the time of the fall. The resident received an abrasion on the mid upper back and a skin tear to the right elbow about 1.8 cm long. The resident was incontinent of urine at the time of the fall. The Additional Care Plan Update section of the form was crossed through. There were no changes made to the falls care plan after the [DATE] fall. Review of the Fall Scene Investigation, dated [DATE], revealed Resident #15 fell on [DATE] at 10:55 AM. The fall report revealed the resident had stated he/she was making the bed at the time of the fall. The resident had been attempting to ambulate unattended in his/her room and was incontinent of urine at the time of the fall. The Additional Care Plan Update section of the form was crossed through. There were no changes made to the falls care plan after the [DATE] fall. Interview with the DON, on [DATE] at 3:00 PM, revealed it was important to determine the root cause of incidents to ensure the appropriate corrective actions were put in place. He stated he had not provided any direction to staff to implement additional interventions for Resident #15. 3. Review of the clinical record for Resident #13 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #13's Comprehensive Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident utilizing the Brief Interview for Mental Status (BIMS) with a BIMS score of 9. The assessment further revealed the resident triggered at risk for falls due to a history of falls and did not ambulate, but used a wheelchair for mobility. Review of Resident #13's Comprehensive Care Plan, dated [DATE], revealed that prior to the resident's admission to the f