STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185236**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/14/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OWENSBORO CENTER	**1205 LEITCHFIELD RD. OWENSBORO, KY 42303**

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 0280 **Level of harm -** Actual harm **Residents Affected -** Few	**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 revise the care plan for one (1) of four (4) sampled residents (Resident #1).

Resident #1 was care planned on 05/12/15 to remind him/her to use the call light when attempting to ambulate or transfer, even though the facility had assessed the resident's cognition as severely impaired. On 08/26/15, Resident #1 attempted to transfer and ambulate to the bathroom without calling for assistance. Resident #1 fell and sustained a compression [MEDICAL CONDITION] lumbar vertebral which resulted in the resident having to wear a back brace for approximately two (2) months. The facility revised the resident's care plan to address the resident continuing to get up without using the call light to ask for assistance on 09/08/15 with interventions to encourage resident to vent feeling/needs and document interventions and resident's response. However, the facility failed to develop an intervention to address the need for increased supervision to ensure staff would be aware if the resident attempted to get up in his/her room without assistance.

On 12/05/15, Resident #1 sustained another fall in the bathroom after ambulating to the bathroom without calling for assistance. The resident was hospitalized with a non-displaced left femoral head fracture which required surgical intervention. Further review of the Comprehensive Care Plan revealed there was still no revision to the care plan to address the resident's continued need for increased supervision to ensure staff would be aware if the resident attempted to get up in his/her room without assistance.

The findings include:

Review of the facility's Care Plan Policy, last revised 01/02/14, revealed a comprehensive, individualized care plan will be developed by the interdisciplinary team for each resident, and include measurable objectives to meet resident needs. Further review revealed a Practice Standard was to ensure the care plan was reviewed and revised a minimum of quarterly and, as needed to reflect response to care and changing needs and goals.

Record review revealed the facility admitted Resident #1 on 05/03/15 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/16/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of six (6), which indicated the resident was not able to make decisions and was not interviewable. In addition, the facility assessed Resident #1 as independent with transfers, ambulation and toilet use; and, his/her balance was steady when transferring from seated to standing, walking with assistive devices and moving on and off the toilet. The resident used a walker and was always continent of bowel and bladder.

Review of Resident #1's Comprehensive Care Plan, for at risk for falls due to decreased safety awareness/confusion, dated 05/12/15, revealed interventions included for staff to place the call light in reach at all times and remind the resident to use the call light when attempting to ambulate or transfer even though the facility had assessed the resident's cognition as severely impaired.

Review of the Nurse's Note, dated 08/26/15 at 10:54 PM, revealed Resident #1 was found on the floor of the bathroom and was assessed as having a scrape to his/her lower back and on 08/27/15 at 12:27 AM, the resident complained of lower back pain and was sent out to the hospital emergency room (ER). Review of a Hospital Discharge Summary, dated 08/29/15, revealed Resident #1 was diagnosed with [REDACTED].

Review of the Risk Management System (fall investigation), dated 08/26/15, revealed Resident #1 had an unwitnessed fall in the bathroom on 08/26/15 at 10:54 PM. The nurse determined the root cause of the fall was the walker was not in use at the time of the fall. Even though the facility assessed the resident to be cognitively impaired, the corrective action was to encourage the resident to use call light for assistance, which was already in place prior to the fall.

Review of a Significant Change MDS assessment, dated 09/07/15, revealed the facility assessed Resident #1's cognition as severely impaired with a BIMS score of five (5) which indicated the resident was still unable to make decisions. In addition, the facility identified the resident was totally dependent on two (2) plus staff for transfers and toilet use; and, the resident was not steady and was only able to stablelize with human assistance when transferring on and off the toilet and surface to surface. Further review of the Comprehensive Care Plan revealed the care plan was revised on 09/08/15, to address the resident's non-compliance with asking for help and not using the call light with interventions to encourage resident to vent feeling/needs and document interventions and resident's response. However, there were no interventions to address how the facility was going to ensure staff would be aware if the resident was attempting to get up in his/her room without assistance (increased supervision).

Review of Nurse's Note, dated 12/05/15 at 10:20 AM, revealed Registered Nurse (RN) #1 found Resident #1 on the floor of the bathroom and the resident had not called for assistance. On 12/05/15 at 8:23 PM, after the resident had complained of pain a mobile x-ray was completed. After the results were received, the physician gave an order to send the resident to the hospital ER.

Review of the facility's Advanced Practice Registered Nurse (APRN) Progress Note, dated 12/10/15, revealed Resident #1 was admitted to the hospital on [DATE] with a [DIAGNOSES REDACTED]. The surgical repair was completed and the resident returned to the facility on [DATE] with an incision on the left hip.

Review of the RMS Summary (fall investigation), dated 12/05/15, revealed Resident #1 was found in his/her bathroom on the floor on his/her left side. Further review revealed the immediate interventions were to conduct an assessment, complete neurological-checks, and the resident was placed in the lobby to be within the visual field of the nurse's station. However, review of the Comprehensive Care Plan revealed the care plan was still not revised to address the need for an intervention to address the resident's need for increased supervision when the resident was in his/her room to ensure staff would be aware if the resident attempted to get up in room without assistance.

Interviews on 01/12/16 with Unsampled Resident A (Resident #1's roommate) at 2:00 PM, with Certified Nurse Aide (CNA) #4 at 12:30 PM and CNA #3 at 11:30 AM, revealed Resident #1 would get up to use the restroom without calling for assistance and Unsampled Resident A would use the call light to call for staff. The CNAs stated Resident #1 was not steady on his/her feet and would get up approximately two (2) times a week. They stated the resident liked to stay in his/her room in bed. The CNAs stated they made rounds every two (2) hours.

Interview (Post Survey) with Licensed Practical Nurse (LPN) #2, on 01/25/16 at 9:25 AM, revealed Resident #1 had a significant change in cognition and functional decline during the summer. LPN #2 stated she thought Resident #1 was no longer capable of learning to use the call light even after repeated encouragement.

Interview with the C Wing Unit Manager, on 01/13/16 at 2:45 PM, revealed he as well as the licensed nurses were responsible

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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	185236	A. BUILDING ______ B. WING _____	**01/14/2016**

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F 0280 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) for updating the Care Plan and the Nurse Aide Kardex immediately after any fall or significant change of condition of a resident. He stated he knew Resident #1 was cognitively unable to learn to use the call light or to remember to ask for help even after repeated encouragement. He stated, We just were on higher watch and and aware (he/she) was at risk for falls. Interview with the Director of Nursing (DON) and the Administrator, on 01/14/16 at 10:30 AM, revealed they expected the licensed staff to update and revise the care plan after any re-admission and implement new interventions. They stated they felt they were between a rock and a hard place for this resident because the resident was not cognitively capable of using the call light but was still able to be mobile. When asked how they provided increased supervision for this resident they stated the facility had discontinued alarms at the facility but expected the staff to make rounds every two (2) hours and look into the resident's room every time they walked by.
F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	**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 interview, record review and review of the facility's policy it was determined the failed to have an effective system to ensure each resident receives adequate supervision to prevent accidents for one (1) of four (4) sampled residents (Resident #1). The facility care planned Resident #1 on 05/12/15, to remind him/her to use the call light when attempting to ambulate or transfer. However, the facility had assessed Resident #1's cognition on 05/12/15 as severely inpaired. On 08/26/15, Resident #1 sustained a fall in the bathroom after getting up without using the call light when attempting to ambulate. This fall resulted in a compression fracture of the lower lumbar vertebral; the resident had to wear a back brace for approximately two (2) months. On 09/08/15, the facility identified and care planned that the resident was continuing to get up without using the call light to ask for assistance. However, the facility failed to provide increased supervision to ensure staff would be aware if the resident attempted to get up without assistance in his/her room. On 12/05/15, Resident #1 sustained another fall in the bathroom when he/she ambulated to the bathroom without staff assistance or knowledge. This fall resulted in the resident being hospitalized with a non-displaced left femoral head fracture which required surgical intervention. The facility still failed to provide increased supervision to ensure staff would be aware if the resident attempted an unassisted transfer in his/her room. The findings include: Review of the facility's Falls Management Policy, last revised 05/15/14, revealed residents would be assessed for fall risks as part of the nursing assessment process and those determined to be at risk would receive appropriate interventions to reduce the risk and minimize injury. Further review revealed the facility's Practice Standards for when a resident falls included to document the accident/incident in the risk management system and on the change of condition note; to investigate using the appropriate tools in the Risk Management System (RMS); update care plan to include new interventions; conduct an interdisciplinary team meeting within seventy-two (72) hours of fall; and, for the Administrator and Director of Nursing (DON) to conduct a post fall review. Record review revealed the facility admitted Resident #1 on 05/03/15 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/16/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of six (6), which indicated the resident was not interviewable. In addition, the facility assessed Resident #1 as independent with transfers, ambulation and toilet use; and his/her balance was steady when transferring from a seated to standing position, walking with assistive devices and moving on and off the toilet. The resident used a walker and was always continent of bowel and bladder. Review of the Comprehensive Care Plan for resident at risk for falls due to decreased safety awareness/confusion, dated 05/12/15, revealed interventions for staff to place the call light in reach at all times. Staff was to remind the resident to use the call light when attempting to ambulate or transfer, even though they had assessed the resident as having confusion, poor safety awareness and his/her cognition was severely impaired. Review of the Nurse's Note, dated 08/26/15 at 10:54 PM, revealed Resident #1 was found on the floor of the bathroom and was assessed as having a scrape to his/her lower back. The resident was assisted back to his/her bed by two (2) Certified Nurse Aides (CNA). Review of a Nurse's Note, dated 08/27/15 at 12:27 AM, revealed the resident complained of lower back pain and was sent out to the hospital emergency room (ER). Review of a Hospital Discharge Summary, dated 08/29/15, revealed Resident #1 was diagnosed with [REDACTED]. Review of the Risk Management System (fall's investigation), dated 08/26/15, revealed Resident #1 had an unwitnessed fall in the bathroom on 08/26/15 at 10:54 PM. The nurse determined the root cause of the fall was that the walker was not in use at the time of the fall. Further review revealed the corrective action was to encourage the resident to use the call light for assistance. However, this intervention was already in place, and the facility had assessed the resident to be severely cognitive impaired. Review of a Significant Change MDS assessment, dated 09/07/15, revealed the facility assessed Resident #1's cognition as severely impaired with a BIMS' score of five (5) which indicated the resident was unable to make decisions. In addition, the facility identified the resident was totally dependent on two (2) plus staff for transfers and toilet use; was not steady; and, was only able to stablelize with human assistance with transferring on and off the toilet and surface to surface. Review of the Comprehensive Care Plan revealed on 09/08/15, Resident #1's care plan was revised to include resident exhibits behavior: non-compliance with asking for help and using the call light. Further review revealed the interventions developed were to allow time for the resident to vent feelings and to document interventions and the resident's response. However, there were no interventions to address how they were going to ensure staff would be aware if the resident attempted to get up without assistance or an intervention to increase the resident's supervision. In addition, further review of the care plan revealed an intervention for the resident to ambulate with a walker with one (1) assist on 10/01/15. Review of Nurse's Note, dated 12/05/15 at 10:20 AM, revealed Registered Nurse (RN) #1 documented she found Resident #1 on the floor of the bathroom and the resident was identified to have an abrasion on the left elbow and complained of mild hip pain. The resident was assisted by two (2) CNAs back to bed and neurological (neuro) checks were initiated. Review of a Nurse's Note, dated 12/05/15 at 10:56 AM, revealed to continue to encourage resident to use call light. The resident complained of mild left hip pain and the On Call Physician was contacted with an order received to obtain a portable radiograph (x-ray). Further review revealed the On-Call Physician was called at 8:23 PM with the x-ray results. An order was received to send the resident to the hospital ER. Review of the Advanced Practice Registered Nurse (APRN) Progress Note, dated 12/10/15, revealed Resident #1 was admitted to the hospital with [REDACTED]. The surgical repair was completed and the resident returned to the facility on [DATE] with an incision on the left hip. Review of the RMS Summary (fall's investigation), dated 12/05/15, revealed Resident #1 was found in his/her bathroom on the floor on his/her left side. Further review revealed there was no documented evidence that the root cause of the fall was identified. The immediate interventions included to conduct an assessment and neuro-checks; and, the resident was placed in the lobby to be within the visual field of the nurse's station. Review of the Comprehensive Care Plan revealed the care plan was revised on 12/14/15 to include an intervention for the resident to ambulate with a walker with one (1) to two (2) assist with weight bearing as tolerated. Interventions on 12/18/15, included to encourage the resident to use call light for assistance from staff; and, on 12/21/15 to encourage resident to stay in common areas and participate in activities. However, further review revealed there were still no interventions to increase the resident's supervision, to ensure staff would be aware if the resident attempted to get up without assistance. Interview with Unsampled Resident A (Resident #1's roommate), on 01/12/16 at 2:00 PM, revealed he/she saw Resident #1 get up and go to the bathroom by himself/herself, then he/she heard the resident in the bathroom trying to get up and calling for help. Unsampled Resident A stated Resident #1 was always getting up without calling for assistance so he/she would use the call light to call the nurse.

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Interview (Post Survey) with Licensed Practical Nurse (LPN) #2, on 01/25/16 at 9:25 AM, revealed Resident #1 had been independent prior to the 08/26/15 fall but had required a lot more assistance since then. She stated Resident #1 had a significant change in cognition and functional decline after the first fall and he/she was no longer capable of learning to use the call light, even after repeated encouragement. Interview with Certified Nurse Aide (CNA) #4, on 01/12/16 at 12:30 PM; and, on 01/13/16 at 2:30 PM, revealed RN #1 and CNA #3 found Resident #1 on the floor in the bathroom on 12/05/15. CNA #4 stated the resident was not steady on his/her feet before he/she fell the first time (08/26/15). She stated the resident would get up without calling for assistance approximately two (2) times a week and his/her roommate would usually let them know. She stated the CNAs made rounds every two (2) hours. Interview with CNA #3, on 01/12/16 at 11:30 AM; and on 01/13/16 at 2:35 PM, revealed Resident #1 would get up by himself/herself and he/she wasn't supposed too. CNA #3 stated the resident did not remember to call for assistance and liked to stay in his/her room in bed. She stated the resident would get up without assistance approximately two (2) times a week and his/her roommate would usually let them know. Interview with RN #1, on 01/12/16 at 10:15 AM, revealed Resident #1 was found on the floor in the bathroom on 12/05/15 in the morning. She stated the resident ambulated with a little bit of an unsteady gait with the assistance of one (1) staff. RN #1 stated she immediately initiated to place the resident in direct view of the nurse's station for observation after the 12/05/15 fall. Review of a Interdisciplinary Team (IDT) Note, dated 01/13/16, revealed the team met to review the resident's history of falls. The Note stated Resident #1 had a fall on 08/26/15 ambulating self to restroom, and the resident was encouraged to use the call light but continues with non-compliance and attempting to maintaining independence. In addition, the Note stated the resident started to allow them (staff) to assist with transfers and the next fall did not occur until 12/05/15. The resident attempted to ambulate self to bathroom and fell resulting in fractured left hip. There was no documented evidence the IDT had identified there was no intervention in place to ensure staff would be aware the resident was attempting to get up without calling for assistance. Interview with the C Wing Unit Manager (IDT), 01/13/16 at 2:45 PM, revealed he, as well as the licensed nurses were responsible for updating the Care Plan and the Nurse Aide Kardex immediately after any fall or significant change of condition of a resident. He stated he knew Resident #1 was cognitively unable to learn to use the call light or to remember to ask for help even after repeated encouragement. He stated, We just were on higher watch and aware he/she was at risk for falls. Interview with the Assistant Director of Nursing (ADON), on 01/13/16 at 3:00 PM, revealed she knew Resident #1 was cognitively unable to learn to use the call light, or to remember to ask for help when getting out of bed. She stated she was aware Resident #1 was at high risk for falls and she expected staff to monitor the resident closely every time they passed by the room as well as conducting routine continence checks and toileting every two (2) hours. She stated the facility no longer used bed or chair alarms. Interview with the DON and Administrator, on 01/14/16 at 10:30 AM, revealed they felt they were between a rock and a hard place for this resident because the resident was not cognitively capable of using the call light but was still able to be mobile. They stated the IDT recommended Resident #1 be moved closer to the nurse's station after the fall on 08/26/15, but the resident refused. They stated they knew the resident was a high fall's risk and expected staff to conduct every two (2) hour rounds and to be on a higher alert with him/her by looking into his/her room anytime they walked by the door.