STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185089	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF BOWLING GREEN	550 HIGH ST. BOWLING GREEN, KY 42101

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 0279 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policy, and review of the Resident Assessment Instrument (RAI) Manual 3.0 Version, it was determined the facility failed to ensure a comprehensive care plan was developed for each resident that included measurable objectives and timetables to meet the resident's medical and nursing needs that were identified in the comprehensive assessment for one (1) of five (5) sampled residents (Resident #3). Resident #3's Comprehensive Care Plan was not developed related to toilet use, although the Minimum Data Set (MDS) triggered for that area. Resident #3 was assessed by staff as a high fall's risk, and required two (2) staff for transfers. The resident also utilized a chair alarm due to unassisted transfers; however, the resident was not care plan related to toileting. On 09/29/14, Resident #3 was left on the commode in his/her bathroom unattended by Licensed Practical Nurse (LPN) #1. Resident #3 fell off the commode and sustained a left distal radius fracture, left boxer's fracture and comminuted intertrochanteric [MEDICAL CONDITION] hip. Resident #3 required surgical intervention to repair the fractures on 09/30/14. The findings include: Review of the facility's policy titled, Care Plans-Comprehensive, last revised October 2010, revealed the facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative, would develop and maintain a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expected to attain. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to the MDS. Each resident's comprehensive care plan is designed to incorporate risk factors associated with identified problems; and, aid in preventing or reducing declines in the resident's functional status and/or functional levels. Review of the RAI Version 3.0 Manual (section 4.1) revealed the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. Further review of the RAI Manual (section 4.4) revealed facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs. The process focuses on evaluating the triggered care areas using the (Care Area Assessments) CAAs, but does not provide exact detail on how to select pertinent intervention for care planning. Interventions must be individualized and based on applying effective problem solving and decision-making approaches to all of the information available for each resident. Section 4.7 states, in selecting interventions and planning care, the key task would be to identify specific symptomatic and cause specific interventions for physical, functional, and psychosocial needs. Record review revealed the facility admitted Resident #3 on 04/03/14 with [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 09/08/14, revealed the facility assessed Resident #3's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of six (6), which indicated the resident was not interviewable. Further review revealed the facility assessed Resident #3's balance during transitions and walking as not steady, only able to stabilize with staff assistance. In addition, the facility assessed Resident #3's toilet use and transfer as the resident required extensive assistance with two (2) plus persons physical assist. Review of Resident #3's Comprehensive Care Plan, dated 05/06/14, and the Certified Nurse Aide (CNA) Assignment Sheet, printed 09/14/14, revealed the resident was at risk for complications related to self-care deficit; and required staff assist of one (1) with transfers even though the MDS assessment indicated the resident required the extensive assistance of two (2) staff for transfers. Further review revealed no documented evidence to address the amount of staff assistance needed for the resident's toilet use even though the MDS assessment identified Resident #3's balance during transitions and walking was not steady, and the resident was only able to stabilize with staff assistance. In addition, the Care Plan revealed the resident required a chair alarm when up in the chair due to unassisted transfers. Review of a Situation, Background, Assessment, Response (SBAR) Communication Form, dated 09/29/14 at 6:50 PM, revealed Resident #3 was found sitting on the floor, legs straight, leaning against the door frame by LPN #1. Further review revealed a head to toe assessment was completed by LPN #1 with no injuries identified. Resident #3 complained of left hip pain and was sent to the local emergency room for evaluation and treatment at 7:10 PM. Further review of the SBAR revealed the facility was notified at 10:50 PM that the resident had sustained a left femur fracture; the greater trochanter was broken into the socket; and, the resident was being admitted to the hospital. Review of an Operative Report, dated 09/30/14, revealed Resident #3 sustained a comminuted intertrochanteric [MEDICAL CONDITION] hip, an angulated [MEDICAL CONDITION] metacarpal neck on the left hand with a nondisplaced [MEDICAL CONDITION] radius requiring surgical repair. The resident required trochanteric nailing of the left hip along with closed reduction and casting of the left boxer's fracture and distal radius. Interview with LPN #1, on 10/08/14 at 3:15 PM, revealed on 09/29/14, she assisted Resident #3 to the bathroom and placed him/her on the commode, and left him/her unattended and went back to the Nurses' Station. She stated she was giving the resident some privacy and gave him/her the call light to call when he/she was ready to get up. LPN #1 stated approximately five (5) minutes later, the resident's call light came on and she found the resident on the floor. She stated she thought the resident had fallen in the past but she was not sure if he/she was care planned as high risk for falls. Interview, on 10/08/14 at 3:30 PM, with Certified Nursing Assistant (CNA) #2, who was responsible for Resident #3 the day of the fall, revealed on the evening of 09/29/14, the South Unit staff consisted of five (5) CNAs, two (2) LPNs and one (1) Certified Medication Aide (CMA). She stated she was assisting in the dining room during mealtime at the time of the fall. CNA #2 stated the other South Unit staff helped with her assignment while she was in the dining room. She stated Resident #3 had already fallen off the toilet when she arrived in the room. CNA #2 stated Resident #3 had a history of [REDACTED]. She stated the resident used a chair and bed alarm because he/she would attempt to get up unassisted. She stated she would never leave Resident #3 unattended on the toilet. Interview with CNA #4, on 10/09/14 at 2:20 PM, revealed if a resident has an alarm they should not be left unattended on the commode. Interview with CNA #5, on 10/09/14 at 3:35 PM, revealed Resident #3 had a care plan in place with interventions which included the assistance of one (1) staff member with transfers. CNA #5 stated Resident #3 self-propelled in the wheelchair. CNA #5 revealed she stayed with the residents when she assisted them to the bathroom if they had a bed or chair alarm in place. Interview with the MDS Coordinator, on 10/09/14 at 9:00 AM, revealed she completed MDS assessments based on information from staff and direct observations. She stated the completion of the MDS generated the comprehensive care plan and the Unit Manager was expected to update care plans and create CNA care plans based on observation of the resident's needs. The MDS Coordinator stated the care plan and MDS assessment were not always the same. She stated the MDS was a snap shot of the seven (7) day look back period, and she used the information the nurses gave her, and made observations to make sure the information was accurate. She stated if the resident required the assistance of two (2) for transfer for only one episode during the look back period, she was required to code it as requiring the assistance of (two). Interview with the Unit Manager (UM) of the South and Reflections Units, on 10/08/14 at 5:00 PM, revealed the MDS

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

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F 0279 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) Coordinator generated the care plan. The UM stated she no longer had MDS access, as the MDSs were stored in a file cabinet. She stated it was her responsibility to modify the care plan when changes occurred. The UM stated unless the plan of care was specific about restrictions nursing staff could use their own judgement if it was safe to leave a resident alone in the bathroom. She stated her expectation was that if two (2) staff were required to assist with transfers and the resident was considered a fall's risk and had chair alarms, staff should stay with the resident during toileting. Interview with the Director of Nursing (DON), on 10/09/14 at 3:05 PM, revealed she expected nurses to use their judgment to determine if it was safe for the resident to be left alone in the bathroom. She stated residents should have toilet use as part of the care plan. The DON stated staff should use the transfer assist care plan which stated the resident required the assistance of one (1) for transfers if there was not a toilet use care plan because the resident could change from day to day. The DON stated that resident fall risk was noted on the CNA assignment form and she expected nurses to tell the CNAs which residents were cognitively impaired. The DON stated they should know the resident's behavior. If they have a bed or chair alarm they should go with what they have as a guide in toileting. She also stated the nurses were responsible to inform the nurse aides during shift report about each resident's cognitive status and make that decision each shift. She stated the residents were not care planned on whether to leave unattended on the toilet or not because the residents' needs could change daily. She revealed she had not really considered if residents who had been assessed as needing an alarm to alert staff of unassisted transfers should be left on the commode with no supervision.
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 observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to provide adequate supervision and assistance devices to prevent accidents related to a fall with injuries for one (1) of five (5) sampled residents (Resident #3). Record review revealed the facility assessed the resident as a high fall risk and required a chair and bed alarm due to unassisted transfers. On 09/29/14, Resident #3 was left on the commode in his/her bathroom unattended by Licensed Practical Nurse (LPN) #1. The resident fell off the commode and sustained a left distal radius fracture, left boxer's fracture and comminuted intertrochanteric fracture of the left hip. Resident #3 required surgical intervention to repair the fractures on 09/30/14. The findings include: Review of the facility's Fall Policy, dated 04/2012, revealed it was the intent of the facility to provide residents with assistance and supervision in an effort to minimize the risk of falls and fall related injuries. All residents should have a comprehensive fall risk assessment on admission, quarterly, and with significant change of condition. Appropriate care plan interventions would be implemented and evaluated as indicated by the assessment. A comprehensive care plan should be implemented based on the fall risk evaluation score with an individualized goal and interventions specific to each patient. The care plan should be reviewed following each fall, quarterly, annually, and with each significant change. Interventions should be revised as indicated by the assessment. Review of the facility's Resident Alarms policy, dated 12/2010, revealed resident alarms may be used for residents as a non-restraining device which alerts staff to a resident rising from a bed or chair without assistance. An alarm assists in providing mobility and ease of movement while promoting quality of life, dignity, and safety with emphasis on quality of care. The procedure to identify residents at risk for falls and those who would benefit from the use of an alarm device (frequent falls, confused residents, unsteady or weak in ambulation and/or bed rail climber). Record review revealed the facility admitted Resident #3 on 04/03/14 with [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 09/08/14, revealed the facility assessed Resident #3's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of six (6) indicating the resident was not interviewable. Further record review revealed Resident #3's balance during transitions and walking was unsteady, and the resident was only able to stabilize with staff assistance. In addition, Resident #3 required the extensive assistance of two (2) staff for transfers and toileting. Review of Resident #3's Fall Risk Assessment, dated 09/08/14, revealed the resident scored sixteen (16) which indicated the resident was at high risk for falls. Review of Resident #3's Comprehensive Care Plan, dated 05/06/14, revealed he/she was at risk for complications related to self-care deficit and required staff assist of one (1) with transfers even though the resident was assessed as needing two (2) staff assist for transfers. Further review revealed no interventions to address the amount of supervision needed for toileting. In addition, the Care Plan revealed the resident required a chair alarm when up in the chair due to unassisted transfers. Review of the Certified Nurse Aide (CNA) assignment sheet, printed 09/14/14 by Unit Manager (UM) of South Unit and the Reflections Unit, revealed documentation which included interventions for fall risk, one (1) assist transfer, alarm to the bed and wheelchair, non-skid socks while in the bed and raised toilet seat. However, there was no intervention to address supervision related to toileting even though the resident required a chair alarm and was assessed as unsteady for transfers and walking. Interview with LPN #1, on 10/08/14 at 3:15 PM, revealed on 09/29/14, she assisted Resident #3 to the bathroom and placed him/her on the commode, and left him/her unattended and went back to the Nurse's Station. She stated she was giving the resident some privacy and gave him/her the call light to call when he/she was ready to get up. LPN #1 stated approximately five (5) minutes later, the resident's call light came on and she found the resident on the floor. She stated she was not sure the resident was care planned for falls, but she knew the resident had fallen in the past. Review of the Communication Form, dated 09/29/14 at 6:50 PM, revealed Resident #3 was found sitting on the floor, legs straight and leaning against the door frame. A head to toe assessment was completed by LPN #1, with no injuries noted. The resident complained of left hip pain and was sent to the local emergency room for an evaluation and treatment at 7:10 PM. Review of an Situation, Background, Assessment, Response (SBAR), dated 09/29/14, revealed the facility was notified at 10:50 PM that the resident had sustained a left femur fracture and the greater trochanter was broken into the socket. Resident #3 was admitted to the hospital. Review of an Operative Report, dated 09/30/14, revealed Resident #3 sustained a comminuted intertrochanteric fracture of the left hip, and an angulated fracture of the small metacarpal neck on the left hand with a nondisplaced fracture of the distal radius requiring surgical repair. The resident required trochanteric nailing of the left hip along with closed reduction and casting left boxer's fracture and distal radius. Interview with CNA #2, who was responsible for Resident #3, on 10/08/14 at 3:30 PM, revealed when she entered the room, Resident #3 had already fallen off the toilet. She stated the resident was care planned for falls and required the assistance of two (2) staff for transfers and a bed and chair alarm due to unassisted transfers. Interview with CNA #4, on 10/09/14 at 2:20 PM, revealed if a resident had an alarm they should not be left unsupervised on the commode. Interview with CNA #5, on 10/09/14 at 3:35 PM, revealed she stayed with the residents when she assisted them to the bathroom if they had a bed or chair alarm in place. Interview with LPN #3, on 10/08/14 at 4:10 PM revealed Resident #3's mobility had decreased since the fall. Interview with the Physical Therapist (PT) on 10/09/14 at 9:10 AM, revealed Resident #3's mobility had declined and pain had increased since the fall. He stated Resident #3's plan of care included non-weight bearing and he/she required assistance of two (2) staff. The current PT goal for Resident #3 was to assist him/her to sit on the bedside. Interview with the Unit Manager (UM), on 10/09/14 at 11:15 AM, revealed she expected nursing staff to use their judgment when deciding if a resident required supervision while toileting. She stated if a resident was a high risk for falls then staff should not leave the resident unsupervised in the bathroom. Interview with the MDS Coordinator, on 10/09/14 at 9:00 AM, revealed she completed MDS assessments based on information from staff and direct observations. Upon MDS completion, the comprehensive care plan was generated and the UM was responsible for the CNA care plans and added updates to the comprehensive care plans based on observation of the resident needs. The MDS Coordinator stated the care plan and MDS assessment were not always the same. She stated she reviewed the MDS Supplemental Charting sheets completed by staff during the seven (7) day look back period and also made observations to ensure the information was accurate before documenting the information on the MDS. She stated she completed the assessments and generated the care plan for Resident #3. Interview with the Director of Nursing (DON), on 10/09/14 at 3:05 PM, revealed she expected nurses to use their judgment to determine if it was safe for the resident to be left alone in the bathroom. She stated residents should have toilet use as part of the care plan. The DON said staff should use the transfer assist care plan if there was not a toilet use care plan. Further interview with the DON revealed a resident's fall risk was noted on the CNA assignment form and she expected nurses to tell the CNAs which residents were cognitively impaired. The DON stated they should know the resident's behavior and if they had a bed or chair alarm they should go with what they had as a guide in toileting. She also stated the nurses were responsible to inform the nurse aides during shift report about each resident's cognitive status and make that decision each shift. She revealed she had not considered if residents who had

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) been assessed as needing an alarm to alert staff of unassisted transfers should be left unsupervised on the commode. Interview with the Administrator, on 10/09/14 at 8:30 AM, revealed that staff should not leave residents unsupervised on the commode if they had a BIMS of eight (8) or below. She stated privacy should be provided by staff standing at the door rather than going to the nurse's station.