STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185456	A. BUILDING ______ B. WING _____	**11/25/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF SENECA PLACE	**3526 DUTCHMANS LANE LOUISVILLE, KY 40205**

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 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 interview, record review, and facility policy review, it was determined the facility failed to follow the care plan for one (1) of nineteen (19) sampled residents (Resident #6). The facility care planned Resident #6 for pain and Registered Nurse (RN) #1 failed to complete a prompt assessment and administer pain medication as care planned for Resident #6 after sustaining an injury and pain from a fall. The findings include: Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the facility did not have a policy on care plans; however, utilized the Resident Assessment Instrument (RAI) as their policy. Review of the RAI, Minimum Data Set (MDS) Manual, Chapter 4.7, page 4-1, #12 revealed the Interdisciplinary Team (IDT) identifies specific, individualized steps or approaches that will be taken to help the resident achieve his or her goals. These approaches serve as instructions for resident care and provide for the continuity of care by all staff. Precise and concise instructions help staff understand and implement interventions. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 08/26/15 with [DIAGNOSES REDACTED]. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment, completed on 09/02/15, revealed the facility assessed the resident as requiring one (1) person extensive assist to walk and one (1) person limited assist to complete activities of daily living (ADLs). The facility conducted a Brief Interview for Mental Status (BIMS) exam during the MDS assessment with a score of nine (9) out of fifteen (15) on the BIMS exam indicating the resident was moderately impaired. Review of Resident #6's care plan related to pain, dated 09/04/15, revealed the resident experienced the frequent presence of pain in his/her back due to a lumbar compression fracture after a fall at home prior to admission to the facility. Interventions included staff evaluating the location and intensity of the resident's pain. Staff was to administer pain medication as ordered, report any uncontrolled pain to the physician, and evaluate vital signs as needed. The staff was to observe for both verbal and nonverbal indicators of pain. Review of the Physician Orders, dated October 2015, revealed the physician ordered [MEDICATION NAME] 5-325 milligram (mg) tablet by mouth every six (6) hours as needed (PRN) for pain. The order also stated the facility must document pain level on a scale of one (1) to ten (10). Review of the Incident Log, printed 11/27/15 at 8:35 AM, revealed Resident #6 sustained a fall on the night of 10/28/15 or early morning of 10/29/15. The fall occurred in the resident's room at an unknown time. The report stated the resident sustained [REDACTED]. Interview with RN #1, on 11/24/15 at 6:10 PM, revealed Resident #6 complained of pain and had difficulty moving on the morning of 10/29/15. The RN stated she did not give the resident pain medication at the time and decided to monitor the resident for continued pain instead. She could not state why she did not give pain medication at that time as directed by the care plan and policy. Further interview with RN #1, on 11/25/15 at 2:58 PM, revealed RN #1 did not complete all assessments after Resident #6 reported a fall on 10/29/15. The nurse stated she did not remember if she assessed the resident's pain on 10/29/15 and did not document any pain assessment as directed by the care plan. Review of the Departmental Notes completed by RN #1, on 10/31/15 at 8:53 AM, revealed the RN completed a late entry pertaining to Resident #6's fall on 10/29/15. The note stated Resident #6 complained on Thursday morning, 10/29/15, of some difficulty moving his/her left leg, was grimacing, and complaining of pain. The note did not contain information indicating the resident's pain rating on the pain scale nor any interventions used to assist the resident to control pain, as directed by the plan of care. Review of the narcotic sheet for Resident #6's [MEDICATION NAME], dated 10/09/15, revealed the nursing staff signed as removing the medication from the narcotic drawer on 10/30/15 at 7:00 PM and on 10/31/15 at 1:00 AM. However, review of the Medication Administration Record [REDACTED]. Review of the facility's Departmental Notes, dated 10/27/15 through 10/31/15, revealed no documented evidence of pain assessments completed after Resident #6's reported fall as directed by the care plan. Interview with the Assistant Director of Nursing (ADON), on 11/25/15 at 11:10 AM, revealed that by not identifying and documenting Resident #6's injury as directed by the care plan, the resident's pain may have been prolonged and he/she was at increased risk of injury and pain. Further interview with the Director of Nursing (DON), on 11/25/15 at 9:00 AM, revealed the nurse should have completed and documented pain assessment per the care plan. Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the staff did not manage Resident #6's pain per the care plan and resulted in a delay in identifying the resident's fracture. Record review revealed the resident was diagnosed with [REDACTED].
F 0309 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, it was determined the facility failed to ensure staff provided care and services to meet the clinical needs for one (1) of nineteen (19) sampled residents (Resident #6). The staff failed to assess, monitor, and manage pain after Resident #6 sustained a fall and delayed the identification of an injury after Resident #6 experienced significant pain from the fall. The resident was diagnosed with [REDACTED]. The findings include: Review of the facility's Residents' Rights, not dated, revealed the residents had the right to receive adequate and appropriate care and services. Review of the facility's Care System Guideline for Pain Management, not dated, revealed the facility would complete a pain assessment upon admission, change of condition, and quarterly using a numeric rating scale or verbal descriptor scale. The facility would conduct a pain assessment after a resident fall or any acute change of condition where pain was suspected. The facility would then record the findings of the pain assessment in the clinical records including the evidence based rating or descriptor scale. Additionally, nursing would note ongoing monitoring and effectiveness of interventions in the medical record and progress notes. After a resident experienced a fall or other acute change, the Interdisciplinary Team (IDT) would then review the completed pain assessment and evaluate the effectiveness of the resident's pain management interventions. Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the facility used the Perry Potter Clinical Nursing

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

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NAME OF PROVIDER OF SUPPLIER **DIVERSICARE OF SENECA PLACE**		STREET ADDRESS, CITY, STATE, ZIP **3526 DUTCHMANS LANE LOUISVILLE, KY 40205**	

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) Skills and Techniques, Eighth (8th) Edition, as the facility's policy for assessing range of motion and for conducting musculoskeletal and neurologic assessments. Review of the Perry Potter Clinical Nursing Skills and Techniques, 8th Edition, revealed the facility would conduct a neurological assessment and musculoskeletal assessment when a resident reported pain or impairment. The facility would complete the assessments to determine the nature, extent, location, duration, and severity of the resident's reported pain. The assessments would include asking the resident to describe recent falls and to describe the type, location, and severity of the pain. The assessments also would include observing the resident for a change in Range of Motion (ROM) and other functioning. The steps for implementing the assessments included observing the resident's body for alignment while the resident was sitting, laying down, and in several other positions, inspecting gait as the resident walked, and asking the resident to move the major joints. Review of the facility's Care System Guideline for Falls, not dated, revealed the facility would physically assess a resident for injuries and render medical attention as needed after a resident fall. The facility would then notify the physician and resident's responsible party. Review of the facility's Incident Report Checklist, dated 12/24/13, revealed the information the facility would include in the nurse's note pertaining to a resident fall and the steps nursing staff would taken to complete an incident investigation. The form stated what information the nurse's note must entail which included: injury description; pain level; neuro checks for any head injury or unwitnessed fall; and range of motion. The checklist would include places for staff to document they completed a head to toe assessment and if they initiated neuro checks. Interview with the Director of Nursing (DON), on 11/25/15 at 9:00 AM, revealed nursing staff was required to use the Incident Report Checklist with each resident fall. Interview with Resident #6, on 11/23/15 at 4:30 PM, revealed the resident had fallen in his/her room a couple of weeks prior and that he/she needed increased assistance with transfers in and out of the bed since that fall. The resident stated he/she had first come to the facility after suffering a fall in the home that resulted in a broken backbone. However, the resident fell again while at the facility and suffered a broken hip. Resident #6 stated he/she got out of the bed in the night and tripped on a chair in the room. He/she bumped his/her head on the chair on the way to the floor and landed on his/her knee on the floor. Resident #6 stated he/she was unclear on the amount of time that passed between the fall and going to the hospital. The resident was unclear about any details regarding reporting the fall to the staff or any assessments or treatments following the fall. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 08/26/15 with [DIAGNOSES REDACTED]. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment, completed on 09/02/15, revealed the facility assessed the resident as requiring one (1) person extensive assist to walk and one (1) person limited assist to complete activities of daily living (ADLs). The facility conducted a Brief Interview for Mental Status (BIMS) exam during the MDS assessment with a score of nine (9) out of fifteen (15) on the BIMS exam indicating the resident was moderately impaired. Review of Resident #6's care plan related to pain, dated 09/04/15, revealed the resident experienced the frequent presence of pain in his/her back due to a lumbar compression fracture after a fall at home prior to admission to the facility. Interventions included the staff was to evaluate the location and intensity of the resident's pain. The staff was to administer pain medication as ordered, report any uncontrolled pain to the physician, and evaluate vital signs as needed. The staff was to observe for both verbal and nonverbal indicators of pain. Review of the Physician Orders, dated October 2015, revealed on 08/26/15 the physician ordered [MEDICATION NAME] 5-325 milligram (mg) tablet by mouth every six (6) hours as needed (PRN) for pain. The order also stated the facility must document the pain level on a scale of one (1) to ten (10). Review of the Incident Log, printed 11/27/15 at 8:35 AM, revealed Resident #6 sustained a fall on the night of 10/28/15 or early morning of 10/29/15. The fall occurred in the resident's room at an unknown time. The report stated the resident sustained [REDACTED]. Review of the Resident Incident Report, dated 10/30/15 at 12:11 AM, revealed Registered Nurse (RN) #1 created an incident report in the facility's medical records. The narrative explained the resident reported he/she had gotten out of bed, tripped on something, and fell forward hitting his/her head on a chair in the room. The resident then reported he/she went back to bed. The narrative continued to state the resident had a bruise on the top of his/her head, bruises on his/her left rib cage, and an abrasion on his/her left leg. The RN documented she placed steri strips on the resident's open areas. The incident report did not contain vital signs or report of pain assessment or if nursing completed any range of motion assessments as stated in their policy. Interview with Certified Nursing Assistant (CNA) #2, on 11/25/15 at 10:55 AM, revealed the resident reported pain and difficulty moving his/her left leg on the morning of 10/29/15. CNA #2 stated she was providing morning care to Resident #6 and asked the resident to straighten his/her leg. The resident stated he/she was unable to put the leg down due to pain in the leg and rubbed the inside of his/her leg. The CNA stated she noticed bruising on the inside of the leg. Resident #6 then told the CNA that he/she had gotten up in the night and fell over the chair in the room. CNA #2 stated because of the resident's increased confusion at that time, she was unsure at that time if the resident had really fallen or if he/she had dreamed they had fallen. However, the CNA stated she did report the possible fall to the nurse, RN #1. The CNA witnessed RN #1 asking the resident what had happened and the resident stated he/she had fallen. Interview with RN #1, on 11/24/15 at 6:10 PM, revealed Resident #6 complained of pain and acted as though he/she had difficulty moving on the morning of 10/29/15. RN #1 stated Resident #6 had been experiencing a lot of confusion since his/her return from the hospital on [DATE]. On the morning of 10/29/15, the resident reported pain and difficulty moving. Resident #6 reported he/she had fallen in the room and hit the chair. The RN stated she did not give the resident pain medication at the time and decided to monitor the resident for continued pain. She could not state why she did not give pain medication at that time. The nurse stated she looked at the resident and did not see any bruising on the resident nor see abnormalities with the resident's leg at that time. RN #1 did not take vitals after learning of the fall. She stated she did not feel they were necessary because the resident had fallen on a prior shift. She stated later in the afternoon the resident denied any pain. She stated she was off for a couple days following the incident and she made a note of the incident in the Departmental Notes a few days later when she returned to work. Further interview with RN #1, on 11/25/15 at 2:58 PM, revealed RN #1 did not initiate neurological checks on the resident because the fall happened prior to her shift. She stated she was unsure of how long before her shift the fall had taken place, but that she felt it was unnecessary to conduct neurological checks on the resident when the fall had taken place on a previous shift and some time had already passed. The nurse stated she did not remember if she assessed the resident's pain on 10/29/15, and that she did not know if she documented any pain assessment as directed by the policy. RN #1 stated she completed a head to toe assessment of the resident, but was not sure if she touched the resident during the assessment. She stated the head to toe assessment revealed the resident had some scratches on his/her rib cage. RN #1 stated the scratches on the resident's rib cage were not unusual. Review of the Departmental Notes completed by Licensed Practical Nurse (LPN) #1, on 10/29/15 at 12:19 AM, revealed Resident #6 was in bed with periodic wakefulness. LPN #1 documented she did not observe Resident #6 attempting to get out of bed. Review of the Departmental Notes completed by RN #1, on 10/31/15 at 8:53 AM, revealed the RN completed a late entry. RN #1 documented Resident #6 complained on Thursday morning, 10/29/15, of some difficulty moving his/her left leg and was grimacing and complaining of pain. The note stated the nurse asked the resident about his/her pain through the day. The resident reported pain one additional time that morning and then reported no pain to the nurse the remainder of the day. However, review of the Medication Administration Record [REDACTED]. Review of Departmental Notes completed by LPN #1, on 10/30/15 at 10:16 PM, revealed Resident #6 complained of pain to left leg and was unable to lay leg flat. The LPN documented she called the Nurse Practitioner and obtained an order for [REDACTED]. Review of the MAR indicated [REDACTED]. However, there was no documented evidence LPN #1 assessed resident's level of pain or effectiveness of the PRN pain medication she administered per the MAR. Interview with LPN #1, on 11/24/15 at 4:55 PM, revealed Resident #6 reported pain to the nursing staff on 10/30/15. LPN #1 stated Resident #6 experienced a lot of confusion at the time he/she reported pain to her on 10/30/15. She stated the

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F 0309 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) resident also had a UTI at the time and had increased confusion. LPN #1 stated she was assisting with getting the resident ready for bed when he/she reported having leg pain. The LPN conducted a pain assessment and visually inspected the resident's leg. She stated the resident's leg had some outward rotation and she called for an order for [REDACTED]. Review of the Departmental Notes completed by LPN #1, on 10/31/15 at 12:52 AM, revealed the LPN received the x-ray results. The x-ray results were positive for a fracture involving the femoral neck with a lateral displacement two (2) days after the incident. LPN updated the POA and called the ambulance service to transport the resident to the emergency room . Review of the MAR indicated [REDACTED]. However, there was no documented evidence LPN #1 assessed the resident's level of pain or effectiveness of the PRN pain medication she administered per the MAR. Review of the Medication Administration Record [REDACTED]. Further review of the Departmental Notes, 10/27/15 through 10/31/15, revealed no evidence of post fall neurological checks, no recorded pain assessment rating scale, and no evidence of a ROM assessment completed after Resident #6's reported fall as directed by the policy. Interview with the DON, on 11/24/15 at 5:45 PM, revealed the DON kept a copy of notes she made during the investigation into Resident #6's fall and fracture. The investigation notes stated the fall took place after Tuesday, 10/27/15, as evidenced by staff interviews who reported no abrasions, bruises, or complaints of pain on that day (10/27/15). Interview with the Assistant Director of Nursing (ADON), on 11/25/15 at 11:10 AM, revealed the standard of care the nurses should have done after discovering a resident fall included a head to toe assessment, skin check, and neurological checks. The purpose of completing these assessments and checks was to determine if the resident sustained [REDACTED]. The nurse should have then documented the results of the assessments, along with vital signs, on the incident report. The DON then reviewed the incident reports. The ADON further stated that by not identifying Resident #6's fracture, the resident was at increased risk of injury and pain. Interview with the DON, on 11/24/15 at 5:45 PM, revealed the nursing staff did not inform her of the fall until she received a call from the nurse about the resident's confirmed fracture on 10/31/15. Further interview with the DON, on 11/25/15 at 9:00 AM, revealed the nurse should have completed and documented vitals, a ROM assessment, and a pain assessment. The DON reviewed the incident report and stated based on the report it did not appear the nurse complete a pain assessment, vitals, range of motion check, or initiate neurological checks. The Incident Report Checklist directs staff to complete a head to toe assessment. Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the staff did not follow facility policy which resulted in a delay in identifying the resident's fracture. Nursing staff did not conduct the appropriate assessments after the resident fell and the nurse's notes were sketchy. The lack of assessments was concerning and indicated a lackadaisical approach to nursing care. This could have put the resident in pain for longer than necessary. Interview with the Director of Clinical Operations, on 11/25/15 at 9:00 AM with the DON, revealed per the documentation after Resident #6 fell , the nurse did not complete vitals, conduct neuro checks, and complete a range of motion assessment. The staff did not report the incident to the DON. As a result, the DON, Administrator, and Director of Clinical Operations were unaware of the resident's fall until after LPN #1 was notified of the fracture on 10/31/15. Review of the Weekly Event Report Summary, dated 11/05/15, revealed the Director of Clinical Services recorded the resident had increased pain to his/her left hip on 10/30/15 and was assessed by the nurse. The nurse noted the hip was bruised and obtained an order for [REDACTED]. The resident had reported he/she fell earlier in the week. The facility discharged the resident to the hospital for surgical repair of the fracture. Review of the hospital discharge packet, dated 11/03/15 at 9:01 AM, revealed the hospital admitted the resident on 10/31/15 and he/she underwent left hip replacement for his/her displaced, fractured left hip. The report further stated the resident developed severe left hip pain, limited range of motion, and an inability to bear weight after falling out of bed two (2) days prior to the date of admission, 10/31/15. The hospital reported the findings of the x-rays included a fracture through the femoral neck with a fifty percent (50%) displacement of the femoral shaft relative to the head.
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 facility policy review, it was determined the facility failed to complete a full Fall investigation for one (1) of nineteen (19) sampled residents (Resident #6). Resident #6 fell on [DATE]; however, Registered Nurse (RN) #1 failed to complete the fall assessment which would have included a head to toe assessment and assessing the resident's pain level. On 10/29/15 and 10/30/15 Resident #6 complained of pain to the left leg and was unable to lay leg flat. The resident was diagnosed with [REDACTED]. The findings include: Review of the facility's Care System Guideline, Falls, not dated, revealed the facility would conduct a fall huddle to investigate the circumstances around the resident's fall. Next, the facility would complete a Post Fall Investigation and include information to assist in choosing interventions to prevent future falls. The facility would then place the fall event and intervention on the twenty-four (24) hour report. Interview with the Director of Nursing (DON), on 11/25/15 at 9:00 AM, revealed nursing staff was required to use the Incident Report Checklist with each resident fall. Review of the facility's tool, Incident Report Checklist, dated 12/24/13, revealed the information the facility would include in the nurse's note pertaining to a resident fall and the steps nursing staff would take to complete an incident investigation. The form stated the nurse's note must include the following information: date and time; type of incident; location; title of individual reporting the incident; appearance or position of the resident when staff discovered the incident; injury description; treatment order; if staff used a lift; pain level; neuro checks for any head injury or unwitnessed fall; range of motion; notification of healthcare provider; notification of Power of Attorney (POA); notification of DON or Assistant Director of Nursing (ADON); and, any immediate interventions. The checklist also included places for staff to document they completed a head to toe assessment and if they initiated neuro checks. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 08/26/15 with [DIAGNOSES REDACTED]. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment, completed on 09/02/15, revealed the facility assessed the resident as requiring a one (1) person extensive assist to walk and one (1) person limited assist to complete activities of daily living (ADL). The facility conducted a Brief Interview for Mental Status (BIMS) exam during the MDS assessment. The resident scored a nine (9) out of fifteen (15) on the BIMS exam which meant the resident had a moderate cognition impairment. Review of the care plan related to falls, dated 09/04/15, revealed Resident #6 was at risk of falls due to a history of falls, decreased cognition, and impaired mobility. The facility included several interventions to prevent falls. The staff was to monitor Resident #6 for changes in condition that may have warranted increased supervision or assistance. The staff was to assist the resident with transfers and ambulation with the use of a walker. Additional interventions included staff reminding the resident to use the call light and ensuring the resident's bed was at the appropriate height, the call light was within the resident's reach, and the resident was to wear non-skid socks. Review of the Incident Log, printed 11/27/15 at 8:35 AM, revealed Resident #6 sustained a fall on the night of 10/28/15 or early morning of 10/29/15. The fall occurred in the resident's room at an unknown time. The report stated the resident sustained [REDACTED]. No in-house treatment or other disposition was recorded on this form. Review of the Resident Incident Report, dated 10/30/15 at 12:11 AM, revealed Registered Nurse (RN) #1 created an Incident Report in the facility's medical records. The narrative explained the resident reported he/she had gotten out of bed, tripped on something, and fell forward hitting his/her head on a chair in the room. The resident then reported he/she went back to bed. The narrative continued to state the resident had a bruise on the top of his/her head, a bruises on his/her left rib cage, and an abrasion on his/her left leg. The RN recorded she placed steri strips on the resident's open areas. However, record review revealed the Incident Report was not completed per the facility's policy and procedures. The

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) incident report did not contain vital signs or report of pain assessment. Nursing did not place the date and time of the incident on the form. In the narrative of the Resident Incident Report, the nurse failed to include information about who first discovered the incident, if nursing staff initiated neuro checks related to the resident reporting hitting his/her head, or if nursing completed any range of motion assessments. Additionally, the nurse did not include information pertaining to notification of the DON or ADON of the incident. Interview with Resident #6, on 11/23/15 at 4:30 PM, revealed the resident stated he had fallen in his/her room a couple of weeks prior and that he/she needed increased assistance with transfers in and out of the bed since that fall. Resident #6 stated he/she got out of the bed in the night and tripped on a chair in the room. He/she bumped his/her head on the chair on the way to the floor and landed on his/her knee on the floor. Interview with the DON, on 11/24/15 at 5:45 PM, revealed the DON kept a copy of notes she made during the investigation into Resident #6's fall. Review of the DON's investigation notes, not dated, revealed Certified Nursing Assistant (CNA) #2 reported on Thursday, 10/29/15, Resident #6 told her he/she fell . The CNA reported this to Registered Nurse (RN) #1 on Thursday morning, 10/29/15. The notes further stated the resident was not able to state what day the fall took place. RN #1 reported the fall to the MDS Coordinator. The investigation notes further revealed the fall took place after Tuesday, 10/27/15, as evidenced by staff report of no abrasions, bruises, or complaints of pain on that day. Interview with Certified Nursing Assistant (CNA) #2, on 11/25/15 at 10:55 AM, revealed she was providing morning care to Resident #6 on 10/29/15 and asked the resident to straighten his/her leg. The resident stated he/she was unable to put the leg down due to pain in the leg and rubbed the inside of his/her leg. The CNA stated she noticed bruising on the inside of the leg. Resident #6 then told the CNA that he/she had gotten up in the night and fell over the chair in the room. CNA #2 stated because of the resident's increased confusion at that time, she was unsure at that time if the resident had really fallen or if he/she had dreamed they had fallen. However, the CNA stated she did report the possible fall to the nurse, RN #1. CNA #2 stated per the policy, if a CNA sees or suspects a fall, the CNA was to report the incident to the floor nurse. The CNA witnessed RN #1 asking the resident what had happened and the resident stated he/she had fallen. Interview with RN #1, on 11/24/15 at 6:10 PM, revealed Resident #6 complained of pain and appeared to have some difficulty his/her leg on the morning of 10/29/15. Resident #6 reported he/she had fallen in the room and hit the chair. The nurse further stated the fall had happened prior to her coming on shift that day, and other staff did not appear aware of the fall. RN #1 did not take vitals after learning of the fall. She stated she did not feel they were necessary because the resident had fallen on a prior shift. RN #1 stated she initiated an incident report later that day. She stated she was off for a couple days following the incident and she made a note of the incident in the Departmental Notes a few days later when she returned to work. Further interview with RN #1, on 11/25/15 at 2:58 PM, revealed RN #1 did not initiate neurological checks on the resident because the fall happened prior to her shift. She stated she was unsure of how long before her shift the fall had taken place but that she felt it was unnecessary to conduct neurological checks on the resident when the fall had taken place on a previous shift and some time had already passed. The nurse stated she did not remember if she assessed the resident's pain on 10/29/15, and that she did not know if she documented any pain assessment. RN #1 stated she completed a head to toe assessment of the resident but was not sure if she touched the resident during the assessment. She stated the head to toe assessment revealed the resident had some scratches on his/her rib cage. RN #1 further stated she informed the MDS Coordinator of the fall. She stated the MDS Coordinator used to be the acting DON and when he was acting DON, nursing staff reported falls to him. RN #1 further stated nurses were supposed to report falls to the DON; however, she believed the DON was already aware of the fall and so she told the MDS Coordinator to get instruction. RN #1 was unable to state what led her to believe the DON knew of the fall. Interview with MDS Coordinator, on 11/25/15 at 10:32 AM, revealed on the morning of 10/29/15 RN #1 reported Resident #6 had fallen. She told the MDS Coordinator about the fall and asked what she should do since the nurse who worked third (3rd) shift had not put an incident report in the system. The MDS Coordinator advised the RN to generate an incident report. The MDS Coordinator also revealed the nurse should have informed the DON of the fall. He stated prior to the DON's employment, nursing staff did report falls to the MDS Coordinator. He stated he did not follow-up to ensure the nurse reported the fall to the DON and that he did not report the fall to the DON. After reviewing the Resident Incident Report, the MDS Coordinator stated the report was not completed per the facility's policy. Interview with the Staff Development Coordinator, on 11/24/15 at 5:15 PM, revealed the first employee to witness or discover an incident, such as a fall or injury of unknown origin, was responsible to report the incident to the floor nurse. The nurse should have then initiated the incident report as soon as they learned of the situation after ensuring the resident's safety. The nurse should have then notified the POA, physician, and the DON. The IDT should also have known about the incident. The Staff Development Coordinator also stated he was not employed at this facility at the time of the incident and could not speak to the incident itself. However, after reviewing the Resident Incident Report, he did state the report appeared incomplete. Interview with the ADON, on 11/25/15 at 11:10 AM, revealed nursing staff did not inform her of Resident #6's fall. The ADON stated the nursing staff should have reported the fall to the DON. She also the nurses should have completed a head to toe assessment, skin check, and neurological checks and documented the results of the assessments, along with vital signs, on the incident report. Per interview, the DON reviews the incident reports. Interview with the DON, on 11/24/15 at 5:45 PM, revealed the nursing staff did not inform the DON of the fall until 10/31/15. The DON stated she was off work ill on 10/29/15 when nursing discovered the resident had fallen. The resident reported the fall to CNA #2 on the morning of 10/29/15. The CNA reported the fall to the RN #1. RN #1 entered an incident report stating she had notified the physician and the POA on 10/29/15. RN #1 made a note in the medical record about the incident on 10/31/15. Further interview with the DON, on 11/25/15 at 9:00 AM, revealed the nursing staff did not complete and document the investigation per the facility's policy to ensure the resident's safety. The nurse should have completed and documented vitals, a ROM assessment, and a pain assessment. The DON reviewed the incident report and stated based on the report it did not appear the nurse complete a pain assessment, vitals, range of motion check, or initiate neurological checks. After the incident report was completed, the staff should have initiated an Incident Report Checklist and a huddle. The Incident Report Checklist instructs staff on what information to include in the documentation, such as date and time, type of incident, location, who reported it, appearance when found, injury description, treatment order, pain level, neuro checks, range of motion, notifications, and immediate interventions. The Incident Report Checklist directs staff to complete a head to toe assessment. The checklist further instructs staff to conduct a huddle to discuss the fall and interventions and includes a Resident Fall Analysis worksheet. The DON stated she was unable to find an Incident Report Checklist for Resident #6's fall reported on 10/29/15. Interview with the Director of Clinical Operations, on 11/25/15 at 9:00 AM with the DON, revealed the staff did not conduct the investigation and ensure the safety of the resident per the facility's standard. Per the documentation, after Resident #6 fell , the nurse did not complete vitals, conduct neuro checks, and complete a range of motion assessment. RN #1 reported the fall to the MDS Coordinator verbally and the MDS Coordinator informed the therapy department of Resident #6's fall verbally. Staff did not document this communication. Per interview, the RN notified the physician and the POA and documented this communication on the incident form. However, staff did not report the incident to the DON. As a result, the DON, Administrator, and Director of Clinical Operations were unaware of the resident's fall until 10/31/15. Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the staff did not manage Resident #6's fall per policy and resulted in a delay in identifying the resident's fracture. Nursing staff did not conduct the appropriate assessments after the resident fell . The lack of assessments were concerning and indicated a lackadaisical approach to nursing care.
F 0514 **Level of harm -** Actual harm **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, it was determined the facility failed to maintain an accurate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185456**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/25/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF SENECA PLACE	**3526 DUTCHMANS LANE LOUISVILLE, KY 40205**

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 0514 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) clinical record for one (1) of nineteen (19) sampled residents (Resident #6). Resident #6 fell on [DATE]; however, Registered Nurse (RN) #1 failed to complete the fall assessment which would have included a head to toe assessment and assessing the resident's pain level. On 10/29/15 and 10/30/15 Resident #6 complained of pain to the left leg and was unable to lay leg flat. The resident was diagnosed with [REDACTED]. (Refer to F309 and F323) The findings include: Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the facility did not have a policy regarding documentation or accuracy of the clinical record. Review of the facility's Care System Guideline for Pain Management, not dated, revealed the facility would complete a pain assessment after each resident's fall. The facility would then record the findings of the pain assessment in the clinical records including evidence based pain scales. Additionally, the facility would note the ongoing monitoring and effectiveness of pain interventions in the electronic medical record system and progress notes. After the pain assessment, the Interdisciplinary Team (IDT) would then evaluate the effectiveness of the resident's pain management after a fall or other acute change. Review of the facility's guideline for Falls, not dated, revealed the facility would physically assess a resident for injuries and render medical attention as needed after any resident experienced a fall. The facility would then notify the physician and responsible party. Review of the facility's Incident Report Checklist, dated 12/24/13, revealed the facility would include in the nurse's note the steps nursing staff would take when completing an incident investigation. The form stated the nurse's note must include the following information: date and time; type of incident; location; title of the individual reporting the incident; appearance or position of the resident when staff discovered the incident; injury description; treatment order; if staff used a lift; pain level; neuro checks for any head injury or unwitnessed fall; range of motion; notification of healthcare provider; notification of Power of Attorney (POA); notification of the Director of Nursing (DON) or Assistant Director of Nursing (ADON); and, any immediate intervention. The checklist also included places for staff to document they completed a head to toe assessment and if they initiated neuro checks and would become part of the medical record. Review of the Resident Incident Report, dated 10/30/15 at 12:11 AM, revealed Registered Nurse (RN) #1 created an incident report in Resident #6's medical record. The narrative explained the resident reported he/she had gotten out of bed, tripped on something, and fell forward hitting his/her head on the chair in the room. However, continued review of the Resident Incident Report revealed RN #1 did not record vital signs or pain level in the incident report. RN #1 did not place the date and time of the incident on the form and did not include who first discovered the incident had taken place. RN #1 also did not document if she initiated neuro checks related to the resident reporting he/she hit his/her head. RN #1 did not include if she completed any range of motion assessments. Additionally, the nurse did not note if she did or did not notify the DON or ADON of the incident as directed by policy. Interview with RN #1, on 11/24/15 at 6:10 PM, revealed it was her responsibility; however, she did not document the resident's level of pain using a pain scale. RN #1 stated she initiated an incident report later that day, but did not document vitals or neuro checks because she did not do them. She stated she did not make a note in the Departmental Notes until she returned to work a few days later. Interview with the Director of Nursing (DON), on 11/24/15 at 5:45 PM, revealed RN #1 entered an incident report after midnight on 10/30/15. RN #1 did not create a note in the medical record about the incident until 10/31/15. Review of the Departmental Notes completed by RN #1, on 10/31/15 at 8:53 AM, revealed the RN completed a late entry and documented Resident #6 complained on Thursday morning, 10/29/15, of some difficulty moving his/her left leg and was grimacing and complaining of pain. RN #1 did not record the resident's pain rating on the pain scale nor any interventions used to assist the resident to control the pain. Further interview with RN #1, on 11/25/15 at 2:58 PM, revealed she did not document the resident's pain level on 10/29/15 and did not remember if she assessed the resident's pain at that time. Review of Departmental Notes completed by Licensed Practical Nurse (LPN) #1, on 10/30/15, revealed Resident #6 complained of pain to the left leg and was unable to lay the leg flat. The nurse did not document in the Departmental Note the resident's pain scale rating, the intervention used to control the pain, nor the effectiveness of the pain medication administered. Review of the narcotic sheet for Resident #6's [MEDICATION NAME], dated 10/09/15, revealed the nursing staff signed as removing the medication from the narcotic drawer on 10/30/15 at 7:00 PM and on 10/31/15 at 1:00 AM. However, review of the Medication Administration Record [REDACTED]. Interview with LPN #1, on 11/24/15 at 4:55 PM, revealed Resident #6 reported having leg pain and stated the resident had reported pain to the nursing staff on 10/30/15. LPN #1 stated she had no knowledge of the resident having reported a fall the previous morning. She stated she did review the departmental notes and saw no notes pertaining to a fall. Interview with MDS Coordinator, on 11/25/15 at 10:32 AM, revealed on the morning of 10/29/15 RN #1 told the MDS Coordinator Resident #6 had fallen. She stated the nurse that work third (3rd) shift had not put an incident report into the system. The MDS Coordinator stated the RN should have completed the Resident Incident Report in the medical record per policy. Interview with the Assistant Director of Nursing (ADON), on 11/25/15 at 11:10 AM, revealed the standard of care the nurses should have done after discovering a resident fall included the completion and documentation of a head to toe assessment, Range of Motion (ROM) check, skin assessment, and neurological checks. The nurse should have then documented the results of the assessments, along with vital signs, on the incident report. The ADON reviewed the incident report and stated it was not completed. Further interview with the DON, on 11/25/15 at 9:00 AM, revealed the nursing staff did not complete the investigation and document to ensure the resident's safety per the facility's standard. The nurse should have completed and documented vitals, a skin assessment, a pain assessment, a range of motion check, and neurological checks. However, there was no documented evidence these assessments were completed. Additionally, after the incident report was completed, nursing should have initiated the Incident Report Checklist. The checklist instructed the nurse on what information to include in the documentation, such as date and time, type of incident, location, who reported it, appearance when found, injury description, treatment order, pain level, neuro checks, range of motion, notifications, and immediate interventions. However, the facility was unable to locate an Incident Report Checklist in the medical record for this resident's fall. She stated the nurse should have initiated a checklist to ensure all assessments were completed and documented in the medical record according to policy. Interview with the Director of Clinical Operations, on 11/25/15 at 9:00 AM with the DON, revealed the staff did not complete the required documentation in the medical record. After Resident #6 fell , the nurse did not complete vitals, conduct neuro checks, or complete a range of motion assessment. As a result, the DON, Administrator, and Director of Clinical Operations were unaware of the resident's fall until after LPN #1 discovered the fracture on 10/31/15. Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the nursing staff did not conduct or document the appropriate assessments after the resident fell and the nurse's notes were sketchy. The Administrator stated the lack of assessments were concerning.