

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

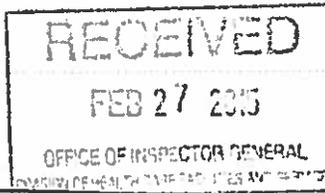
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 03/13/2015
NAME OF PROVIDER OR SUPPLIER  HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  Based upon an onsite revisit conducted on 03/13/15, the facility was deemed to be in compliance 02/25/15 as alleged.	{F 000}			

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.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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PRINTED: 02/08/2015  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/23/2015
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>A Recertification/Abbreviated Survey (KY22642) was conducted 01/08/15 through 01/09/15 and a partial/extended survey was conducted 01/22/15 through 01/23/15. The Division of Health Care substantiated KY22642 with Immediate Jeopardy (J) identified on 01/08/15 and was determined to exist on 12/10/14 at 42 CFR 483.10 Resident Rights (F157) at a scope and severity of a "K", 42 CFR 483.20 Resident Assessment (F280) at a scope and severity of a "K", 42 CFR 483.25 Quality of Care (F315) at a scope and severity of a "J", and 42 CFR 483.25 Quality of Care (F323) at a scope and severity of a "K". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 01/08/15.</p> <p>Interview and record review revealed the facility failed to have an effective system to determine the root cause of falls and implement interventions to prevent further falls. Resident #20 had a history of falls and sustained seven (7) falls between 05/21/14 through 12/14/14. On 12/10/14, Resident #20 fell and sustained a hematoma (localized swelling filled with blood caused by a break in the wall of a blood vessel) to the forehead and right thumb while attempting to change clothing after an incontinent episode. On 12/14/14 at 11:55 AM, Resident #20 again was incontinent and was attempting to change clothes after an incontinent episode, fell when startled, and hit their head on the end of the bed. Eight and one-half (8.5) hours later, at 8:25 AM on 12/15/14, nursing found the resident unresponsive to touch and verbal stimuli. The resident was transferred to the emergency room at 9:05 AM. Review of the Emergency Room</p>	F 000	Preparation, submission, and implementation of this Plan of Correction does not constitute an admission or an agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.		

Laboratory Directors or Provider/Supplier Representative's Signature

Title

(X6) Date

*[Signature]*

X Administrator

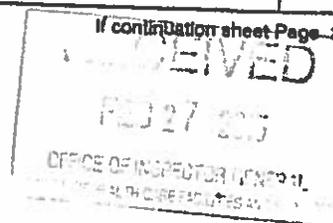
X 02/18/2015

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution provides 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 000	<p>Continued From page 1</p> <p>record, dated 12/15/14 and timed at 9:51 AM, revealed Resident #20's eyes were assessed upon admission and the findings revealed the left pupil was dilated (indicating neurological changes). An X-ray of the brain was ordered and results communicated to the emergency room physician at 10:25 AM revealed a large brain bleed. The resident expired 20 hours later at 6:00 AM on 12/16/14.</p> <p>Resident #15 sustained seven (7) falls between 06/29/14 through 12/24/14 all related to incontinence. However, the facility failed to address the root cause of the falls. On 11/17/14 the resident sustained a laceration to the left eyebrow; on 12/15/14 resident fell again and sustained an injury to the right shoulder and hit his/her head; and, on 12/17/14 the resident fell and received an abrasion to the mid upper back and a skin tear to the right elbow.</p> <p>Resident #13 fell three times on 10/10/14 and sustained an injury after a fall on 12/15/14. Resident #17 sustained three (3) falls between 06/19/14 through 12/25/14 and required stitches after the fall on 06/19/14.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 01/20/15 which alleged removal of the Immediate Jeopardy on 01/14/15. The SSA verified Immediate Jeopardy was removed on 01/14/15 as alleged prior to exit. The scope and severity was lowered to an "E" in 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.20 Resident Assessment (F280) and 42 CFR 483.25 Quality of Care (F323). The scope and severity was lowered to a "D" in 42 CFR 483.25 Quality of Care (F315) while the facility implements and monitors the Plan of Correction</p>	F 000			



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NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
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F 000	Continued From page 2 and for the effectiveness of systemic changes and quality assurance activities.  Additional deficiencies were cited as a result of the Recertification Survey at 42 CFR 483.15 Quality of Life (F253) at a scope and severity of a "E" and actual harm identified in 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.15 Quality of Life (F241) with the highest scope and severity of a "G".	F 000			
F 157 SS=K	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?  Licensed nurses (DON, Staff Development Coordinator, Risk Care Manager, Restorative/Wound Care Nurse, Minimum Data Set Nurse, House Supervisor, two (2) Unit Managers and a Staff Nurse) completed an audit on 01/10/15 for resident #13 and #15. Resident #20 is no longer a resident of the facility.  This audit included a review of the fall event document for root cause of the fall, interventions added to the care plan at the time of the fall, times of scheduled toileting program, alarms utilized, care plans, notifications made to the attending physician and resident's responsible party and interventions added after the audit was completed. Resident #13's MD and family were notified of resident being found on the floor on three (3) different times on 10/10/14 on 10/10/14 and being found on the floor on 12/15/14 on 12/15/14. Resident was toileted and care plan intervention was to add foot rests to the wheelchair. Resident #15's MD and family were notified of the fall of 11/17/14 on 11/17/14, the fall of 12/15/14 on 12/16/14 and the fall of 12/17/14 on 12/17/14. Interventions put into place on the care plan included; mattress with raised edges, non-skid socks when not wearing shoes and cranberry juice with meals.	02/25/15	

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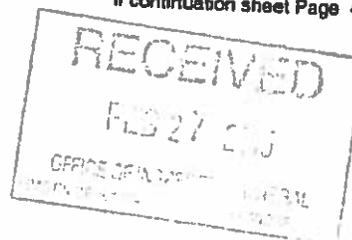
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F 157 SS=K	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?  Licensed nurses (DON, Staff Development Coordinator, Risk Care Manager, Restorative/Wound Care Nurse, Minimum Data Set Nurse, House Supervisor, two (2) Unit Managers and a Staff Nurse) completed an audit on 01/10/15 for resident #13 and #15. Resident #20 is no longer a resident of the facility.  This audit included a review of the fall event document for root cause of the fall, interventions added to the care plan at the time of the fall, times of scheduled toileting program, alarms utilized, care plans, notifications made to the attending physician and resident's responsible party and interventions added after the audit was completed.	02/25/15	

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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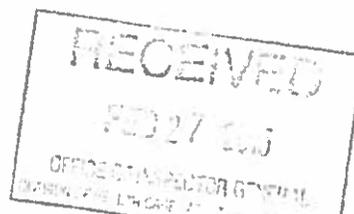
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F 157	<p>Continued From page 3 this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: 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)</p> <p>On 12/10/14 at 5:30 AM, Resident #20 sustained a fall with injury. The resident sustained a hematoma (localized swelling filled with blood caused by a break in the wall of a blood vessel) to the left side of the head that was dark purple in color and a hematoma to the right thumb. The facility did not notify the physician or the responsible party of the injury until three and half (3.5) hours later at 9:00 AM on 12/10/14. Resident #20 sustained another fall on 12/14/14 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 12/15/14. In addition, the facility did not notify the resident's responsible party of the fall on 12/14/14 until 8:40 AM on 12/15/14 when preparations were underway to transfer the resident to the emergency room. The resident expired at the hospital at 6:00 AM on 12/16/14. Record review and interview revealed Resident #20 had sustained a fall on 06/10/14 with no evidence the physician was notified and fell on 08/09/14 and 09/08/14 and the resident's</p>	F 157	<p>Continued from page 3</p> <p>2. How the facility will identify other residents having the potential to be affected by the same practice?</p> <p>Every resident of the facility has the potential to be affected should the facility's system to ensure immediate notification of the attending physician and resident representative after a fall not be effective.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Medical Director was notified of the Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday, 01/08/2015. 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 program on 01/08/15 and 01/09/15. The Medical Director met with the Director of Nursing (DON) on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program. Revisions</p>		



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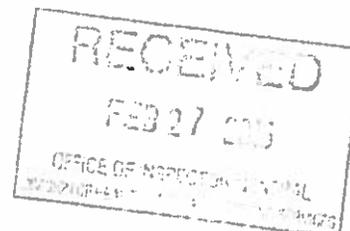
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F 157	<p>Continued From page 4 physician was not notified timely.</p> <p>On 11/17/14 at 3:20 AM, Resident #15 sustained a fall which resulted in a laceration to the left eyebrow. The physician was not notified until seven and one-half (7.5) hours later. On 12/15/14 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 12/17/14 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.</p> <p>On 10/10/14, 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 12/15/14 the resident sustained another fall at 1:00 PM and received a laceration and a hematoma the size of a golf ball above the right eyebrow and the physician was not notified until 2:00 PM.</p> <p>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 01/08/15 and determined to exist on 12/10/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 01/20/15 alleging the Immediate Jeopardy was removed on 01/14/15. The State</p>	F 157	<p>Continued from page 4 were made to the policy. Accidents and Incidents, for physician and responsible party notification to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Revision was made to the policy, Falls Prevention, to check safety devices each shift to ensure they are in place and functioning properly. The procedure for conducting neurological checks was reviewed by the DON and the Staff Development Coordinator and all licensed nurses were provided education on that process on 01/10/15 through 01/13/15. The DON and Staff Development Coordinator conducted the in-service training on neurological checks and additional pen lights (used to conduct the neurological checks) was ordered by the DON on 01/12/15. The MDS Coordinator, MDS Nurse, DON and Risk Manager are responsible for ensuring care plans are completed/revised in a timely/accurate manner. The care plans of residents who have fallen would be reviewed weekly in a Standards of Care meeting led by the MDS Nurse and the MDS Coordinator. In attendance at that meeting are the Dietary Manager, Risk Manager, Social Service Representative and the Activity Director. The DON and the Staff Development Coordinator were provided training by the Administrator on</p>		



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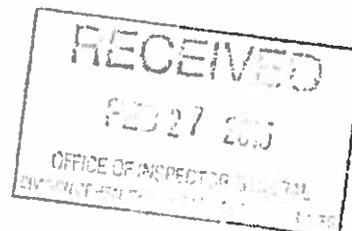
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F 157	<p>Continued From page 5</p> <p>Survey Agency validated the Immediate Jeopardy was removed on 01/14/15 as alleged, prior to exit on 01/23/15. The scope and severity was lowered to an "E" while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of facility's policy Changes in a Resident's Condition or Status, dated March 2009, 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.</p> <p>1. Review of the closed clinical record for Resident #20 revealed the facility admitted the resident on 05/21/14 with diagnoses of Deep Vein Thrombosis, Alzheimer's, and Gait Ataxia. Resident #20 also had a history of falls and continued to receive blood thinning medication to prevent a reoccurrence of a Deep Vein Thrombosis.</p> <p>Review of Resident #20's Quarterly Minimum Data Set (MDS) assessment, completed on 11/07/14, revealed the facility assessed the</p>	F 157	<p>Continued from page 5</p> <p>01/09/15 on physician and responsible party notification. The DON and the Staff Development Coordinator initiated all licenses nurses' and Certified Nursing Assistants' (CNA) training on 01/10/15 and continued that training through 01/13/15. All staff have been trained. The training to all licensed nurses and certified nursing assistants included: work order process, care plans, certified nursing assistant care sheets, proper use and types of alarms, the scheduled toileting program process/form to be used and proper completion of the form. The licensed nurse received training on: falls and proper process for notification of the resident's physician, the responsible party, the neurological check process, the proper completion of the Event Report Form, review/revision of care plans, root cause analysis process, policy and procedure on Accidents and Incidents, policy on Falls Prevention, Neurological check protocol form and the form used for the Scheduled Toileting program. The Administrator provided training to the Director of Nursing, the Risk Manager and therapy staff on 01/12/15 and 01/13/15 regarding the Immediate Jeopardy, policy and procedure revisions, Processes of Falls Committee Meeting, quality assessment and assurance committee role to ensure compliance and</p>		



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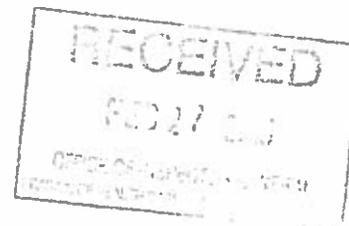
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F 157	<p>Continued From page 6</p> <p>resident as not steady on his/her feet and needed extensive assistance from staff to toilet, walk, and bathe. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored an eight (8) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Review of the Fall Scene Investigation Report, dated 12/10/14 at 5:30 AM, revealed Resident #20 sustained a fall with injury. The report stated the resident sustained a hematoma (localized swelling filled with blood caused by a break in the wall of a blood vessel) to the left side of the head that was dark purple in color and a hematoma to the right thumb. The facility did not notify the physician or the responsible party of the injury until three and one-half (3.5) hours later at 9:00 AM on 12/10/14.</p> <p>Review of the Fall Scene Investigation report, dated 12/14/14, revealed Resident #20 sustained a fall on 12/14/14 at 11:55 PM, and the physician was not notified of the fall until eight and one-half (8.5) hours later at 8:30 AM on 12/15/14. In addition, the facility did not notify the resident's responsible party of the fall on 12/14/14 until 8:40 AM on 12/15/14 when preparations were underway to transfer the resident to the emergency room.</p> <p>Review of the nursing notes, dated 12/14/14 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.</p> <p>Interview with Licensed Practical Nurse (LPN) #10, on 01/09/15 at 10:55 AM, revealed she</p>	F 157	<p>Continued from page 6</p> <p>develop further actions to be taken. A Falls Committe was initiated on 01/12/15 to review falls 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, an MDS Nurse, Social Worker, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services Manager and meets Monday - Friday. The DON provided training to the Restorative/Wound Care Nurse on 01/08/15, 01/10/15 and 01/12/15 addressing the facility's scheduled toileting program, the toileting program as it relates to falls, review of the four-day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program form and the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee. A Scheduled Toileting Audit tool was created to ensure accuracy and completeness of scheduled toileting programs. The audit would include completion of all fields on the</p>	



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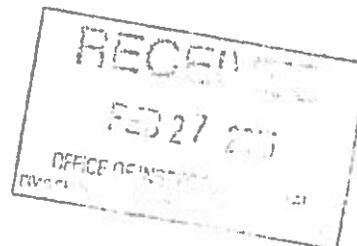
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F 157	<p>Continued From page 7</p> <p>consulted with another nurse regarding contacting the physician the night Resident #20 fell. The LPN stated due to the fall occurring at 11:55 PM and they knew the physician would be in the facility in the morning; the decision was made to notify the physician when he arrived that morning.</p> <p>Continued review of nursing documentation, dated 12/15/14 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 12/14/14 at 8:30 AM. The facility notified the responsible party at 8:40 AM regarding the change in condition and their hospital of choice.</p> <p>Interview with Resident #20's Responsible Party (RP), on 01/09/15 at 4:05 PM, revealed the facility did not contact them at the time of Resident #20's fall; it was not until the facility was in the process of transferring the resident to the emergency department were they notified of the fall.</p> <p>Review of Resident #20's Emergency Room record, dated 12/15/14 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.</p> <p>Further review of Resident #20's Fall Scene</p>	F 157	<p>Continued from page 7</p> <p>toileting program document, issues noted, trends noted, updates to the toileting program and her initials. The Restorative/Wound Care Nurse audited twenty-nine (29) clinical records on 01/12/15 finding one (1) area of concern and on 01/13/15 she audited twenty-eight (28) clinical records finding one (1) area of concern. Attendees of the Standards of Care weekly meeting and Daily Falls Committee meeting will sign a sheet reflecting the meeting has taken place. The Restorative/Wound Care Nurse will do an audit of the toileting program Monday through Friday excluding her approved days off work. Staff competency will be determined through observations of staff's performance and record review by the Administrator, DON, Staff Development Coordinator and Restorative/Wound Care Nurse. Record review will also be completed by the members of the Standards of Care and Falls Committee meeting members with actions taken to address any concerns identified that will include providing staff education.</p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained?</p>		



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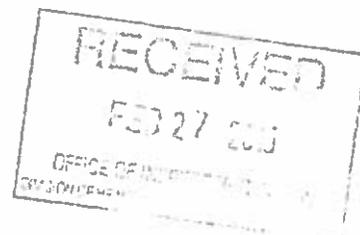
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F 157	<p>Continued From page 8</p> <p>Investigation reports, revealed on 06/10/14 Resident #20 fell at 5:45 PM and the physician was not notified until two hours later with message left on the answering machine. There was no evidence the physician was ever made aware of the fall. On 08/09/14 the resident fell at 11:15 AM, the Advanced Practice Registered Nurse (APRN) was notified at 6:45 PM. The resident sustained a fall on 09/08/14 at 7:25 AM and the physician was notified 2:45 PM. per the nurses notes. On 10/20/14 the resident fell at 12:00 PM and the APRN was notified at 1:15 PM.</p> <p>Attempted interview with Resident #20's attending physician, on 01/08/15 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.</p> <p>Interview, on 01/09/15 at 3:00 PM, with the Director of Nursing (DON) revealed he met with LPN #10 on 12/15/14 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.</p> <p>2. Review of the clinical record revealed the facility admitted Resident #15 on 08/19/13 with diagnoses of Dementia, Anemia, Osteoarthritis, and Bladder Disorder. Further record review revealed Resident #15 had a history of falls and was receiving anti-depressant and anti-anxiety medications to treat symptoms of depression and anxiety.</p> <p>Review of Resident #15's quarterly Minimum Data Set (MDS) assessment, completed on</p>	F 157	<p>Continued from page 8</p> <p>The members of the Falls Committee will generate a report of all falls, the review/ revision of residents' care plans and any actions taken to address concerns which include staff education, staff discipline and care plan revisions to the Quality Assessment and Assurance Committee monthly from January 2015 - December 2015. The Restorative/Wound Care Nurse is to report identified concerns with the toileting program to the DON and the Quality Assessment and Assurance Committee on a monthly basis. The Quality Assessment and Assurance Committee will review and monitor these findings. The facility will utilize the Quality Assessment and Assurance Committee to review, evaluate and monitor for compliance with the notification of physician/responsible party, revision of resident care plans, toileting program and accidents and supervision with the following documents to be utilized: audits for falls, audits of notification of residents' attending physician/responsible party, audits of care plans addressing falls and audits of the toileting program. The monthly meeting of the Quality Assessment and Assurance Committee to be held on February, 23, 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. The Director of Nursing will be responsible for the audits of falls and notifications of the</p>		



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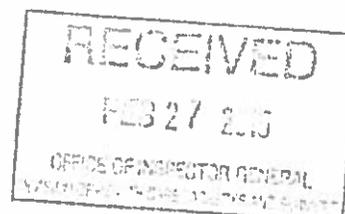
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F 157	<p>Continued From page 9</p> <p>12/02/14, revealed the facility assessed the resident as not steady on his/her feet and needed extensive assistance from staff to toilet, walk, transfer and bathe. The MDS further revealed staff could not conduct a Brief 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.</p> <p>Review of the Fall Scene Investigation report, dated 11/17/14, revealed Resident #15 fell on 11/17/14 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.</p> <p>Review of the nurse's notes for Resident #15, dated 11/17/14 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 11/17/14 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 11/17/14 at 2:25 PM the resident had a bruise on his/her left wrist.</p> <p>Review of the Fall Scene Investigation, dated 12/15/14, revealed Resident #15 fell on 12/15/14 at 11:20 PM. The resident reported hitting his/her</p>	F 157	<p>Continued from page 9</p> <p>resident's attending physician/responsible party. Audits of care plans addressing falls will be the responsibility of the Clinical Review Nurse. The Restorative/Wound Care Nurse will be responsible for the audits of the Toileting Program. The Director of Nursing will be responsible for making the determination of root cause analysis for falls during the Falls Committee Meetings that are held Monday through Friday. The Clinical Review Nurse will be responsible for tracking the root cause of falls. The Clinical Review Nurse will present the audit of root cause of falls to the Quality Assessment and Assurance Committee Meeting every month for the calendar year of 2015.</p>		



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F 157	<p>Continued From page 10</p> <p>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.</p> <p>Review of the nursing notes, dated 12/16/14 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 12/15/14, ten (10) hours after the fall.</p> <p>Review of the Fall Scene Investigation report, dated 12/17/14, revealed Resident #15 fell on 12/17/14 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 12/17/14 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.</p> <p>3. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 10/02/13 with diagnoses of Atrial Fibrillation, Arthritis, Hypertension, Seizures, Iron Deficiency Anemia, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Thrombocytopenia, a history of Deep Vein Thrombosis (DVT), a history of Falls, and Generalized Pruritus.</p> <p>Review of the resident's most recent Comprehensive Minimum Data Set (MDS) Assessment, dated 08/08/14, revealed the resident triggered as a falls risk and did not ambulate, but utilized a wheelchair for mobility.</p>	F 157			



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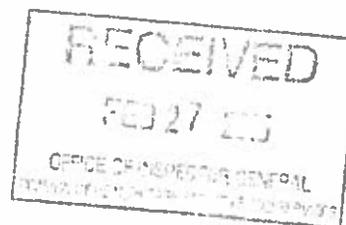
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F 157	<p>Continued From page 11</p> <p>Review of the Quarterly MDS assessment, dated 10/28/14, revealed Resident #13 required the assistance of one (1) staff member for transfers. Review of Resident #13's Comprehensive Care Plan revealed interventions for falls prevention.</p> <p>Review of the Comprehensive Falls care plan revealed that prior to Resident #13's admission to the facility he/she had a history of crawling out of his/her chair to the floor.</p> <p>Interview, on 01/09/15 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.</p> <p>Review of the resident's clinical record (nurses' notes), revealed on 10/10/14 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.</p> <p>Further review of the nurses' notes revealed, on 10/10/14 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 (1-2 centimeters) was found at the back of his/her head.</p> <p>Review of the falls reports, dated 10/10/14 at 12:30 AM, at 4:40 AM, and at 7:10 AM, did not</p>	F 157		



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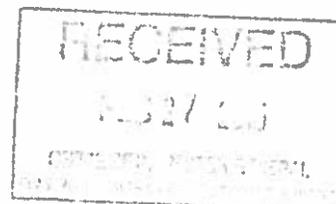
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F 157	<p>Continued From page 12</p> <p>reveal Resident #13's physician was immediately notified of the falls that occurred at 12:30 AM and 4:40 AM, but was notified at 7:10 AM after the third fall when a laceration was found on the back of the resident's head.</p> <p>Further review of Resident #13's Nursing Notes, dated 12/15/14 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.</p> <p>Interview with Licensed Practical Nurse (LPN) #10, on 01/09/15 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.</p> <p>Interview, on 01/09/15 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.</p> <p>Review of the Allegation of Compliance (AOC) revealed the facility implemented the following immediate steps to remove the immediate</p>	F 157			



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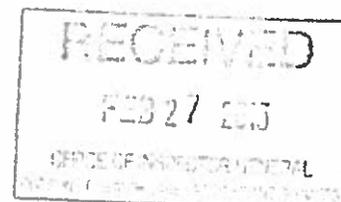
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F 157	Continued From page 13 Jeopardy:  1. The Medical Director was notified of Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday 01/08/15.  2. A representative of the Governing Body provided the Administrator guidance and education on physician and family notification, supervision and investigation of falls, care plan revisions and scheduled toileting programs on 01/08/15 and 01/09/15.  3. Licensed nurses (DON, Staff Development Coordinator, Risk Care Manager, Restorative/Wound Care Nurse, Minimum Data Set Nurse, House Supervisor, two (2) Unit Managers and a Staff Nurse) completed an audit on 01/10/15 for the one hundred eleven (111) residents currently in the facility. This included thirty (30) residents who had a fall in the past three (3) months, and eighty-one (81) residents who had no fall within the past three (3) months. The audit included a review of the fall event document for those who had fallen for root cause of the fall, interventions added to the care plans at the time of the fall, times of scheduled toileting program (if any), alarms utilized, care plans, notifications made to the attending physician and resident's responsible party and interventions added after the audit was completed. An action taken as a result of the audit included update/revision to care plans for eleven (11) residents. that included reachers; toileting in early morning hours; sensor pads; mattresses; and, non-skid strips to the floor. In addition, one resident's toileting program was addressed as a result of the 01/10/15 audit with changes to the timing of the toileting program based on his/her	F 157			



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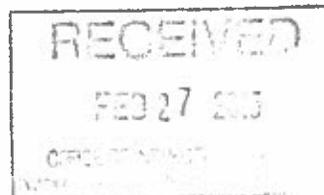
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F 157	Continued From page 14 individualized needs.  4. The Medical Director met with the Director of Nursing (DON) on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program. Revisions were made to the policy, Accident and incidents, for physician and responsible party notification to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Revision was made to the policy, Falls Prevention, to check safety devices each shift to ensure they are in place and functioning properly.  5. The procedure for conducting neurological checks was reviewed by the DON and the Staff Development Coordinator and all licensed nurses provided education on that process on 01/10/15 through 01/13/15. The DON and the Staff Development Coordinator conducted the inservice training on neurological checks and additional pen lights (used to conduct the neurological checks) were ordered by the DON on 01/12/15.  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	F 157			



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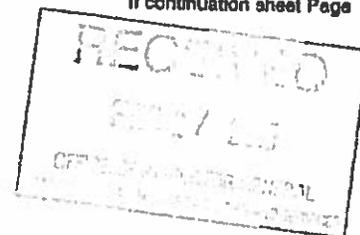
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F 157	Continued From page 15 plans and any actions taken to address concerns which would include staff education, staff discipline and care plan revisions to the Quality Assessment and Assurance Committee monthly from January 2015 - December 2015.  7. The DON and the Staff Development Coordinator were provided training by the Administrator on 01/09/15 on physician and responsible party notification. The DON and the Staff Development Coordinator initiated all licensed nurses' and Certified Nursing Assistants' (CNA) training on 01/10/15 and continued that training through 01/13/15. A total of one hundred nineteen (119) staff had been trained by 9:30 PM on 01/13/15 with one (1) remaining staff notified they must receive training by their supervisor prior to returning to work. The training to all licensed nurses and certified nursing assistants included: work order process, care plans, certified nursing assistant care sheets, proper use and types of alarms, the scheduled toileting program process/form to be used and proper completion of the form. The licensed nurses received training on: falls and proper process for notification of the resident's physician, the responsible party, the neurological check process, the proper completion of the Event Report Form, review/revision of care plans, root cause analysis process, policy and procedure on Accidents and Incidents, policy on Falls Prevention, Neurological check protocol form and the form used for the Scheduled Toileting Program.  8. The Administrator provided training to the Director of Nursing, the Risk Manager and therapy staff on 01/12/15 and 01/13/15 regarding the IJ, policy and procedure revisions, processes	F 157			



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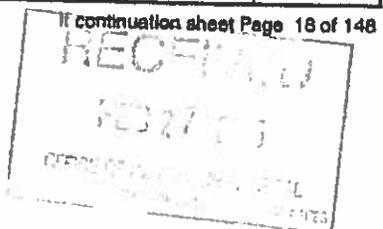
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F 157	<p>Continued From page 16 of Falls Committee Meeting, quality assessment and assurance committee role to ensure compliance and develop further actions to be taken.</p> <p>9. Three (3) notifications of residents' who fell prior to 01/12/15 was made to the attending physicians and responsible party on 01/12/15 with one (1) physician and the responsible party notification of a fall which occurred on 01/13/15.</p> <p>10. A Falls Committee was initiated 01/12/15 to review fall interventions, to review reviewed/revised care plans and to complete root cause analysis for falls during the meeting. The Falls Committee is comprised of the Administrator, the DON, a MDS Nurse, Social Worker, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services Manager and meets Monday-Friday.</p> <p>11. The DON provided training to the Restorative/Wound Care Nurse on 01/08/15, 01/10/15 and 01/12/15 addressing the facility's scheduled toileting program, the toileting program as it relates to falls, review of the four day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program form and the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of the toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee.</p> <p>12. The Restorative/Wound Care Nurse would audit the toileting program using the Scheduled</p>	F 157			



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F 157	<p>Continued From page 17</p> <p>Toileting Audit tool. The toileting program documentation was to ensure accuracy and completeness of scheduled toileting programs. The audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. On 01/12/15 the Restorative/Wound Care Nurse audited twenty-nine (29) clinical records finding one (1) area of concern and on 01/13/15 she audited twenty-eight (28) clinical records finding one (1) area of concern. The Restorative/Wound Care Nurse is to report identified concerns with the toileting program to the DON and the Quality Assessment and Assurance Committee will review and monitor those findings.</p> <p>13. The facility will utilize the Quality Assessment and Assurance Committee to review, evaluate and monitor for compliance with the notification of physician/responsible party, revision of resident care plans, toileting program and accidents and supervision with the following documents to be utilized: audits for falls, audits of notification of resident's attending physician/responsible party, audits of care plans addressing falls and audits of toileting program. The monthly meeting of the Quality Assessment and Assurance Committee to be held in February 2015 will be the initial meeting to review all of the audit information. These meetings will continue monthly for the next calendar year and will review the audit findings, assess the effectiveness of actions taken, revise action plans if necessary and continue to monitor the specifics of all falls within the facility.</p> <p>On 01/23/15, the State Survey Agency (SSA) validated the facility's AOC prior to exit through</p>	F 157			



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F 157	Continued From page 18 observation, interview and record review as follows:  1. Telephone interview with the Medical Director, on 01/26/15 at 2:30 PM, post survey due to lecture schedule and unavailability, revealed he was contacted by the Director of Nursing (DON) on 01/08/15 regarding the Immediate Jeopardy. The Medical Director revealed he and the DON discussed several issues in regard to the Immediate Jeopardy i.e. the cause of resident falls, toileting issues/toileting schedules, CNA education, review of residents' medications, use of non-skid socks/shoes (should always be available) and lighting. He also revealed he and the DON discussed revision of the residents' care plans as necessary and the revisions needed for facility policies; specifically Accidents/Incidents, Fall Prevention and the Toileting Program. The Medical Director indicated he told the DON the question should always be asked after a resident's fall where the facility failed and what should be done to prevent resident falls/accidents.  2. Review of the Administrator's notes from telephone conversation with a Governing Body representative revealed the representative retrained the Administrator on the need to ensure policies and procedures were in place (process of physician/family notification, supervision and falls, care plan revisions and scheduled toileting programs). Further review of the Administrator's notes from telephone conversation with a Governing Body representative on 01/09/15 revealed the representative addressed the process of root cause analysis which required intense and in-depth questioning, record review, and resident, staff and witness interviews. Also	F 157			



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F 157	<p>Continued From page 19 discussed during the 01/09/15 training of the Administrator by the Governing Body representative was tracking and trending of all falls and assurance audits are in place to ensure processes are being followed with concerns identified to be addressed in staff training.</p> <p>Interview with the Administrator, on 01/23/15 at 10:50 AM, revealed he had a telephone conversation with a Governing Body representative on 01/08/15 and 01/09/15 to include how to complete the process of physician/family notification when a resident had a fall, how to follow the facility policy regarding falls, care plan revisions, the scheduled toileting programs, and the process in-depth root cause analysis.</p> <p>3. Review of the Resident Audit for Immediate Jeopardy January 2015 document revealed one hundred-eleven (111) residents (census of 01/10/15) were reviewed for falls in the past three (3) months-date/time/root cause; interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit with signatures of nurses completing the audits. In addition, record review of Unsampled Resident C's individualized toileting program revealed it had been revised as a result of the audit on 01/10/15 with changes to reflect a time frame for toileting of 3:00 AM - 5:00 AM as the resident had fallen during those hours when attempting to self toilet.</p> <p>Interview with the DON on 01/23/15 at 10:00 AM revealed he was involved in the audit of all residents' charts who were in the facility on 01/10/15 to review all falls within the past three</p>	F 157		
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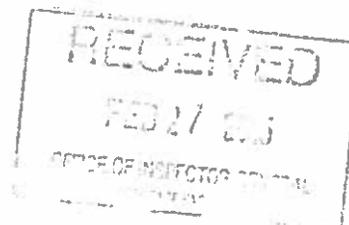
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F 157	<p>Continued From page 20</p> <p>(3) months in regard-date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit.</p> <p>Interview with the Risk Manager, on 1/23/15 at 4:32 PM, revealed she was involved in the review of residents' falls for the past three (3) months that included the current census of one hundred and eleven (111) residents on 01/10/15 and the review covered the date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit.</p> <p>Interview with the Minimum Data Set nurse, on 01/23/15 at 3:44 PM, the Restorative/Wound Care Nurse, on 01/23/15 at 3:55 PM, two (2) Unit Managers on 01/23/15 at 4:45 PM, a Staff Nurse, on 01/23/15 at 5:05 PM, and the Staff Development Coordinator, on 01/23/15 at 5:30 PM, revealed they had all been involved in the audit of the facility residents on 01/10/15 to review all falls within the past three (3) months in regard-date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit. Record review of one resident's individualized toileting program revealed it had been revised as a result of the audit on 01/10/15 with changes to reflect a time frame for toileting of 3:00 AM - 5:00 AM as the resident has fallen during those hours when attempting to self toilet.</p> <p>4. Review of the policy, Accident and Incidents, on 01/23/15 at 9:00 AM revealed it had been</p>	F 157			

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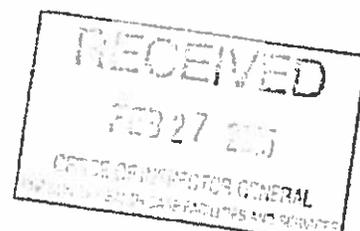
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F 157	<p>Continued From page 21</p> <p>revised to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Review of the policy, Falls Prevention, on 01/23/15 at 9:10 AM, revealed it had been revised to include the check of safety devices each shift to ensure they are in place and functioning properly.</p> <p>Interview with the Administrator and the DON, on 01/23/15 at 10:05 AM, revealed they had met with the Medical Director on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program and they made revisions to the Falls Prevention and the Accident and Incidents policies.</p> <p>Observation, on 01/22/15 at 10:40 AM, revealed Resident #25 had an alarm on the wheelchair as care planned and on 01/22/15 at 1:00 PM, Resident #25 was seated in the wheelchair with an alarm on the wheelchair. Observation of Resident #27, on 01/23/15 at 8:15 AM and 1:25 PM, revealed an alarm on the resident's wheelchair.</p> <p>Review of the record for Resident #25 revealed the resident's alarm had been checked on day shift per facility policy and was functioning and review of Resident #27's record revealed the resident's alarm had been checked on the day shift per facility policy and was functioning.</p> <p>5. Review, on 01/23/15 at 10:13 AM, of the content for an inservice to licensed nursing staff on 01/10/15 revealed the procedure for conducting neurological checks was reviewed by the Director of Nurses and Staff Development</p>	F 157			



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F 157	<p>Continued From page 22</p> <p>with the nurses and they were informed of additional pen lights (used during the neurological checks) being available in the facility on all of the crash carts. Review of two (2) medical supply company invoices on 01/23/15 revealed additional pen lights had been ordered by the Administrator for nurses to use during neurological checks.</p> <p>Observation of a neurological check performed by Licensed Practical Nurse (LPN) #4 on Resident #26, on 01/22/15 at 12:30 PM, revealed proper technique per standards of nursing practice and followed the facility's retraining for nurses on neurological checks.</p> <p>Interview with LPN #4, on 01/23/15 at 10:20 AM, revealed she had been retrained on neurological checks for residents with possible head injury during a training provided to all licensed nurses on 01/10/15 by the Staff Development Coordinator and she knew pen lights were available in the facility on the crash carts.</p> <p>6. Interview with the Activity Director, on 01/23/15 at 3:50 PM, revealed she had been present on 01/21/15 in a Standards of Care meeting and had been involved in the review and revision of care plans for residents who had fallen.</p> <p>Interview with the MDS Coordinator, on 01/23/15 at 3:44 PM, revealed she was involved in the Standards of Care meetings weekly, on 01/21/15 and in the review or revision of care plans for residents who had fallen.</p> <p>7. Interview and record review with the DON, on 01/23/15 at 2:19 PM, revealed he was provided training by the Administrator on 01/09/15 on</p>	F 157			



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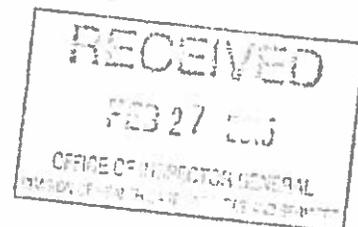
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F 157	<p>Continued From page 23</p> <p>physician/responsible party notification after a resident's fall. He revealed he and the Staff Development Coordinator began on 01/10/15 an all nursing staff training regarding the physician/responsible party notification after a resident's fall, and continued through 01/13/15. A review of in-service training records on 01/23/15 revealed one hundred nineteen (119) staff had been trained by 9:30 PM on 01/13/15 as cross-referenced with the facility human resource department staff roster. The training also included: work order process; care plans; certified nursing assistant care sheets; proper use and types of alarms; the scheduled toileting program process/form to be used and proper completion of the form. The licensed nurses received training on: falls and proper process for notification of the resident's physician; the responsible party; the neurological check process; the proper completion of the Event Report Form; review/revision of care plans; root cause analysis process; policy and procedure on Accidents and Incidents; policy on Falls Prevention; Neurological check protocol form and the form used for the Scheduled Toileting Program.</p> <p>Interview with LPN #1, on 01/23/15 at 1:40 PM and the Restorative Nurse, on 01/23/15 at 3:55 PM, revealed she had been trained on physician/responsible party notification regarding a resident fall, care planning, event reports, scheduled toileting program/four (4) day bowel/bladder trending/proper documentation on 01/10/15 at 9:00 AM.</p> <p>Interview with CNA #11, on 01/23/15 at 1:50 PM, revealed she had been trained on maintenance requests, CNA resident information sheets, resident alarms and the scheduled toileting</p>	F 157			



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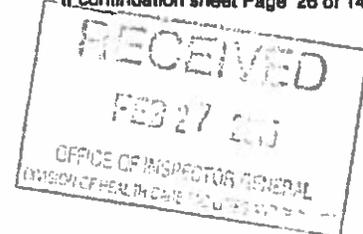
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F 157	<p>Continued From page 24 programs for residents on 01/12/15 at 10:45 PM.</p> <p>Interview with CNA #12, on 01/23/15 at 1:50 PM, revealed she had been trained on how to fill out the toileting program documentation, how to report any maintenance issues, the necessity to check alarms on any residents, to answer call lights timely and to report any concerns immediately.</p> <p>8. Review, on 01/23/15, of a therapy education attendance form and an administrative staff in-service training record each dated 01/13/15 revealed therapy staff and administrative staff had been trained by the Administrator on appropriate protocol to alert the maintenance department of safety issues and maintenance requests and a summary of the IJ received on 01/08/15.</p> <p>Interview with the Business Office Manager, on 01/23/15 at 5:10 PM, revealed she received an in-service regarding the Immediate Jeopardy notification and the ramifications of same. She stated the in-service included reporting maintenance concerns and how the facility was doing root cause analysis during the morning meeting.</p> <p>Interview with a Certified Occupational Therapy Aide, on 01/23/15 at 4:50 PM, revealed he received an inservice about the Immediate Jeopardy, the Falls Prevention policy and root cause analysis among other resident falls concerns like the toileting program and all was presented by the Administrator.</p> <p>9. Review of the nursing notes for Resident #23 and Unsampld Residents B, and C revealed the</p>	F 157			



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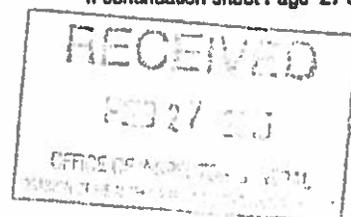
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F 157	<p>Continued From page 25</p> <p>attending physician and responsible party were notified on 01/12/15 of falls prior to that date and for Unsampled Resident D the attending physician and responsible party was notified on 01/13/15 of a fall which occurred on 01/13/15.</p> <p>Interview with the DON, on 01/23/15 at 2:19 PM, revealed three (3) residents were discovered on 01/12/15 to need physician/family notifications of falls which occurred prior to 01/12/15 and a physician/family notification was made on 01/13/15 regarding a fall on that date all due to implementation of a revised notification system.</p> <p>10. A Falls Committee meeting attendees sign-in sheet was reviewed on 01/23/15 which indicated the Administrator, the DON, the MDS Coordinator, Social Services #2, the Risk Care Manager and the Restorative/Wound Care Nurse were present at a meeting on 01/12/15 to review residents who had falls.</p> <p>Interview with the DON on 01/23/15 at 2:19 PM indicated the residents who were reviewed for falls at the 01/12/15 Falls Committee meeting were Resident #23 and Unsampled Residents B and C.</p> <p>11. Interview with the Restorative Nurse, on 01/23/15 at 3:55 PM, revealed she was trained by the DON, on 01/10/15 at 9:00 AM, on physician/responsible party notification regarding a resident fall, care planning, event reports, and scheduled toileting program/four (4) day bowel/bladder trending/proper documentation. She stated she had been made aware of the Immediate Jeopardy and the implications of the Immediate Jeopardy on 01/08/15, but she didn't remember if she signed an attendance sheet for</p>	F 157			



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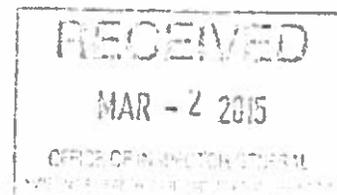
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/23/2015
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 26 that date on 01/12/15.</p> <p>Review of in-service training records revealed the Restorative Nurse signed a training record on 01/09/15 (no time), on 01/10/15 at 9:00 AM and on 01/12/15 (no time).</p> <p>12. Interview with the Restorative Nurse, on 01/23/15 at 3:55 PM, revealed she would use the Scheduled Toileting Audit tool to ensure accuracy and completeness of scheduled toileting programs Monday-Friday. She stated the audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. She indicated she had completed an audit of twenty-nine (29) clinical records on 01/12/15 finding one (1) area of concern and she audited twenty-eight (28) clinical records on 01/13/15 finding one (1) area of concern. The Restorative Nurse revealed she would report to the DON each morning Monday-Friday any concerns she had identified from the audits and he would follow-up on them. She stated she would also report her findings to the Quality Assessment and Assurance Committee monthly and the committee would review and monitor those findings.</p> <p>Review of the scheduled toileting audit for January 2015 revealed the audit was started on 01/12/15 and was completed to 01/23/15.</p> <p>13. Interview with the Administrator on 01/23/15 at 5:23 PM revealed the facility utilized the Quality Assessment and Assurance Committee to review, evaluate and monitor for compliance with the notification of physician/responsible party, revision of resident care plans, toileting program</p>	F 157			



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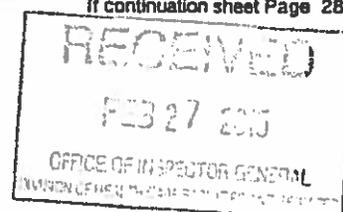
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F 1 57	Continued From page 27 and accidents and supervision with the following documents to be utilized: audits for falls, audits of notification of resident's attending physician/responsible party, audits of care plans addressing falls and audits 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.  Interview with the Director of Nursing, on 01/23/15 at 3:25 PM, revealed the Quality Assurance Committee met and discussed resident charts, care plans, falls, and risk factors. As an example, Resident #13 was reviewed, with changes made to the care plan for a Gerichair for comfort and safety, and an OT evaluation for falls.	F 157			
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: 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	F 241	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Unit Manager responded to Resident #3's needs on 01/07/15. An assessment for a turning schedule was completed, care planned and implemented on 09/08/14. LPN #5 was provided education on the need to respond to resident care needs in a dignified and prompt manner and address their needs or delegate another staff member to address the resident's needs. Education was provided to LPN #5 by the Unit	02/25/15	



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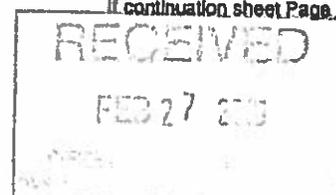


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F 241	<p>Continued From page 28</p> <p>residents (Resident #3). Licensed Practical Nurse (LPN) #5 failed to respond to Resident #3's continuous calls for some one to assist him/her with repositioning for twenty-three (23) minutes while she passed medications next to and down the hall where Resident #3 lived.</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding resident dignity.</p> <p>Review of Resident #3's clinical record revealed the facility admitted the resident on 02/22/10 with diagnoses of Cerebral Palsy, Pressure Ulcer, Spina Bifida, Blindness, Seizures, and Urinary Tract Infection. Review of the Annual Minimum Data Set (MDS) Assessment, dated 03/21/14, and the Quarterly MDS Assessment, dated 11/14/14, revealed the facility assessed the resident as requiring extensive assistance with bed mobility, range of motion limitation in lower extremities, and use of psychotropic medication. The resident was assessed to be at risk for falls.</p> <p>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 psychotropic medication use, Seizures, Blindness, Cerebral Palsy, Paraplegia, and Spina Bifida.</p> <p>Review of the Minimum Data Set (MDS), dated 11/14/14, revealed the facility assessed the resident with a Brief Interview for Mental Status</p>	F 241	<p>Manager and DON on 01/07/2015. LPN #5 was instructed to familiarize self with the residents' care plans and given direction on how to review and revise care plans as needed.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents of the facility have the potential to be affected should facility staff not respond appropriately to resident care needs in a timely and dignified manner.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>All staff were educated to respond to resident's requests in an appropriate, timely and dignified manner. This education was provided by the Staff Development Coordinator on 02/13/15.</p> <p>The Risk Care Manager will observe staff's response to resident care needs once a day Monday through Friday on the 6:00 a.m. to 2:00 p.m. shift. The Director of Nursing will observe staff's response to resident care needs once a day on Monday through Friday on the 2:00 p.m. to 10:00 p.m. shift. The</p>	



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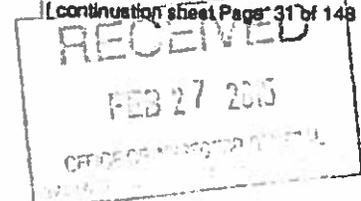
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F 241	Continued From page 29 (BIMS) with a score of twelve (12) reflecting minimal cognitive impairment.  Observations on 01/07/15 from 7:50 AM to 8:13 AM, revealed LPN #5 did not provide adequate supervision for Resident #3 as evidenced by Resident #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	F 241	Continued from page 29 Administrator in the DON's absence, will observe staff's response to resident care needs. The House Supervisor Licensed Nurse will observe staff's response to resident care needs on all three (3) shifts on the weekends. The House Supervisor Licensed Nurse will observe staff's response to resident care needs on Monday through Friday on the 10:00 p.m. to 6:00 a.m. shift. The observations will include activated call lights, emergency call lights and alarms. Staff's response will be observed and documented. Immediately the observer will address concerns with the staff member being observed and document such education. A total of twenty-five (25) observations per month per shift will be completed.  4. How the facility plans to monitor its performance to ensure that solutions are sustained?  Findings of these observations will be reported to the Quality Assessment and Assurance Committee on a monthly basis by the Risk Care Manager. The Quality Assessment and Assurance Committee will provide direction for any changes needed in response to observations/ audits and determine that staff education has been completed for any areas of concern identified.		

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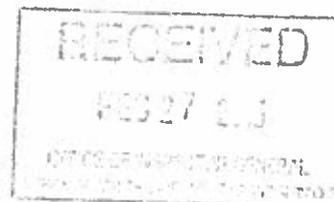
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F 241	<p>Continued From page 30</p> <p>observed answering Resident #3 from the hallway and walked into Resident #3's room. LPN #5 continued past Resident #3's room without entering.</p> <p>Interview with LPN #5, on 01/07/15 at 11:00 AM, revealed when 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.</p> <p>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.</p> <p>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.</p>	F 241			



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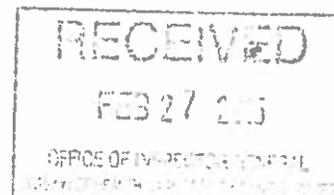
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F 253 SS-E	<p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: 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.</p> <p>The findings include:</p> <p>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.</p> <p>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</p>	F 253	<p>1. <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Shower rooms on Cherry and Maple were thoroughly cleaned on 01/06/15 and on 01/07/15 by the C.N.A.s and assigned Housekeepers. Shower stalls in Cherry and Maple were professionally cleaned and repairs made on 01/16/15. The cracks in the flooring of shower stall 1 have been repaired. Door casings in the fourteen (14) rooms identified have been repaired by the Director of Maintenance and Maintenance Assistant. Repairs to these fourteen (14) rooms was completed on 02/18/2015.</p> <p>2. <i>How the facility will identify other residents having the potential to be affected by the same deficient practice?</i></p> <p>All residents of the facility have the potential to be affected should the facility fail to provide the necessary maintenance and housekeeping services to maintain a sanitary, orderly and comfortable interior of the building.</p> <p>Inspection of the facility showers currently in use was completed by the Director of Maintenance and Director of Environmental Service on 01/08/2015. Areas needing attention were addressed</p>	02/25/15	



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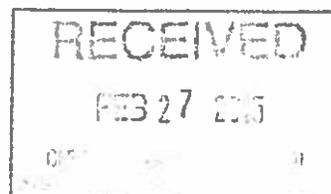
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F 253	<p>Continued From page 32</p> <p>check both shower rooms between 7:00 AM and 8:00 AM daily for concerns that should be immediately addressed for the safety and comfort of the residents. Shower rooms were to be deep cleaned between 2:00 PM and 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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,</p>	F 253	<p>Continued from page 32</p> <p>by the Director of Maintenance and Environmental Services Supervisor on 01/08/15.</p> <p>3. <i>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i></p> <p>The room audit form was reviewed and revised to reflect door casings and baseboards to be checked for proper repair. Room audits will be scheduled so that each resident room is audited at least once a month. An audit form was created for the shower rooms with Department Heads and Administrative staff assigned to audit the shower rooms on a weekly basis. Copies of the completed room and shower room audit forms will be given to the Director of Maintenance and Environmental Services Supervisor to address. Actions taken will be documented by the Director of Maintenance and Environmental Services Director. A schedule/plan has been created by the Director of Maintenance for completing repairs/replacements of all door casings and baseboards in resident rooms. All resident rooms will have damaged door casings repaired or replaced and baseboards painted by March 31, 2015.</p> <p>4. <i>How the facility plans to monitor its performance to ensure that solutions are sustained?</i></p> <p>The Director of Maintenance and</p>		



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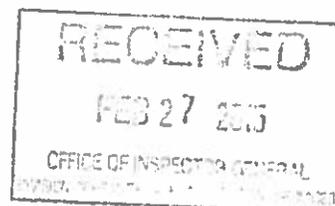
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F 253	<p>Continued From page 33</p> <p>daily cleaning of each shower room. Further, the Environmental Services Director stated the exposed opening where the shower unit was separated from the wall would be difficult to clean and should be repaired 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.</p> <p>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.</p> <p>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.</p> <p>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</p>	F 253	<p>Continued from page 33</p> <p>Environmental Services Supervisor will together create a report and present to the Quality Assessment and Assurance Committee which reflects actions that have been taken, tasks completed and a schedule of actions to be taken as a result of room audits completed. This report of audits will be presented once a month for the calendar year 2015. The Quality Assessment and Assurance Committee will provide guidance and ensure action plans are created as needed to ensure the facility's interior is maintained in a sanitary, orderly and comfortable environment.</p>		



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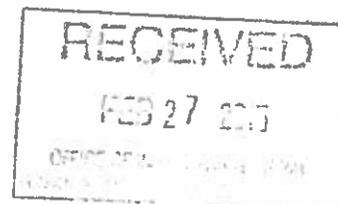
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F 253	Continued From page 34 damaged door casings and wood work in the residents' rooms. The Administrator stated the banged up/damaged woodwork in the residents' rooms was not ideal in appearance.	F 253			
F 280 SS=K	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: 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	F 280	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?  The Medical Director was notified of Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday, 01/08/15. A representative of the Governing Body provided the Administrator with guidance and education on physician and family notification, supervision and investigation of falls, care plan revisions and scheduled toileting program on 01/08/15 and 01/09/15. Licensed nurses (DON, Staff Development Coordinator, Risk Care Manager, Restorative/Wound Care Nurse, Minimum Data Set Nurse, House Supervisor, two (2) Unit Managers and a Staff Nurse) completed an audit on 01/10/15 that included the affected residents. 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 (if any), alarms utilized, care plans, notifications made to the attending physician and resident's	02/25/15	



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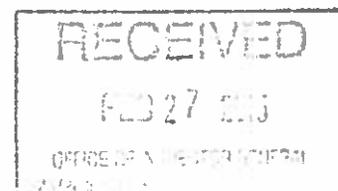
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F 280	<p>Continued From page 35</p> <p>interventions that prevented additional falls after sustaining falls for five (5) of thirty-two (32) sampled residents. (Resident's #8, #13, #15, #17, and #20). (Refer to F323)</p> <p>Resident #20 had sustained a total of seven (7) falls from 06/10/14 through 12/14/14. Review of the resident's Nursing Care Plan for falls, dated 05/21/14, 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 12/10/14 Resident #20 fell and sustained a hematoma to the head. The resident fell again on 12/14/14 and hit his/her head exacerbating the injury received on 12/10/14. The resident was transferred to the hospital after a decline in consciousness and subsequently expired on 12/16/14.</p> <p>Resident #15's care plan was not revised with new interventions after the resident sustained falls on 11/17/14, 12/15/14 and on 12/17/14.</p> <p>Resident #13's care plan was not revised with new interventions after the resident was found crawling on the floor on 10/10/14 on three (3) separate occasions.</p> <p>Resident #17's care plan was not revised with new interventions after the resident sustained falls on 06/19/14, 12/20/14, or on 12/25/14.</p> <p>Resident #8's care plan was not revised after a fall on 12/28/14 with new interventions.</p> <p>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</p>	F 280	<p>Contined from page</p> <p>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 and changes to the timing of the toileting program based on the resident's needs. The Medical Director met with the Director of Nursing (DON) on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program. Revisions were made to the policy, Accident and Incidents for physician and responsible party notification to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Revision was made to the policy, Falls Prevention, to check safety devices each shift to ensure they are in place and functioning properly. The procedure for conducting neurological checks was revised by the DON and the Staff Development Coordinator and all licensed nurses provided education on that process on 01/10/15 through 01/13/15. The DON and 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</p>		



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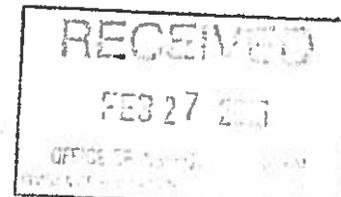
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F 280	<p>Continued From page 36</p> <p>serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 01/08/15 and determined to exist on 12/10/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 01/20/15 alleging the Immediate Jeopardy was removed on 01/14/15. The State Survey Agency validated the Immediate Jeopardy was removed on 01/14/15 as alleged, prior to exit on 01/23/15. The scope and severity was lowered to an "E" while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Comprehensive Care Plans, dated July, 2009, revealed all care plans would be reviewed and updated quarterly or as needed by the interdisciplinary team.</p> <p>1. Review of the closed clinical record for Resident #20 revealed the facility admitted the resident on 05/21/14 with diagnoses of Deep Vein Thrombosis, Alzheimer's, and Gait Ataxia. Resident #20 also had a history of falls and continued to receive blood thinning medication to prevent a reoccurrence of a Deep Vein Thrombosis.</p> <p>Review of Resident #20's Admission Minimum Data Set (MDS), dated 05/28/14, revealed the facility assessed the resident with Brief Interview for Mental Status and determined the resident scored an eight (8) out of fifteen (15) moderate cognitive impairment. The facility further assessed the resident as extensive assistance</p>	F 280	<p>Continued from page 36</p> <p>01/12/15. The MDS Coordinator, MDS Nurse, DON and Risk Manager are responsible for ensuring care plans are completed/revised in a timely/accurate manner. The care plans of residents who have fallen would be reviewed weekly in a Standards of Care meeting led by the MDS Nurse and the MDS Coordinator. In attendance at that meeting are the Dietary Manager, Risk Manager, Social Service Representative and the Activity Director. A report would be generated in that meeting of all falls, the review/revision of the residents' care plans and any actions taken to address concerns which would include staff education, staff discipline and care plan revisions to the the Quality Assessment and Assurance Committee monthly from January 2015 - December 2015. The DON and the Staff Development Coordinator were provided training by the Administrator on 01/09/15 on physician and responsible party notification. The DON and Staff Development Coordinator initiated all licensed nurses' and Certified Nursing Assistants' (CNA) training on 01/10/15 and continued that training through 01/13/15. All staff have been trained. The training to all licensed nurses and certified nursing assistants included: work order process, care plans, certified nursing assistant care sheets, proper use</p>		



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F 280	<p>Continued From page 37</p> <p>with two plus persons for bed mobility; transfers; ambulation; and, locomotion. The resident's balance was not steady and was only able to stabilize with staff assistance. In addition, the resident sustained falls one month prior to admission. Review of the CAT worksheet for Falls, dated 05/28/14, revealed the resident had impaired balance during transitions and required human assistance for transitions. The resident had a diagnosis of Alzheimer with cognitive impairment and Osteoarthritis and hard of hearing. These factors all increase risk for falls. The resident was also noted wandering throughout the facility. Under the notes section revealed sensor alarms were being utilized to alert the staff should resident attempt to rise unassisted.</p> <p>Review of the comprehensive care plan for Resident #20, dated 05/29/14, 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.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, completed on 11/07/14, revealed the facility assessed the resident as not steady on his/her feet and 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.</p>	F 280	<p>Continued from page 37</p> <p>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 forms used for the Scheduled Toileting Program. The Administrator provided training to the Director of Nursing, the Risk Manager and therapy staff on 01/12/15 and 01/13/15 regarding the IJ, policy and procedure revisions, process of Falls Committee Meeting, quality assessment and assurance committee role to ensure compliance and develop further actions to be taken. Three (3) notifications of residents' who fell prior to 01/12/15 was made to the attending physicians and responsible party on 01/12/15 with one (1) physician and the responsible party notification of a fall which occurred on 01/13/15. A Falls Committee was initiated 01/12/15 to review falls interventions to review reviewed/revise care plans and to complete root cause analysis for falls during the meeting. The Falls Committee is comprised of the</p>		

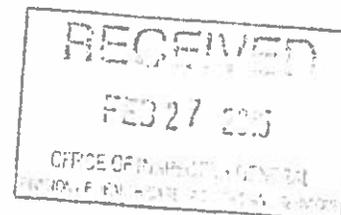


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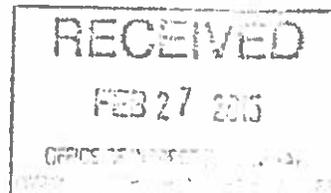
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F 280	<p>Continued From page 38</p> <p>On 12/14/14, Resident #20 was in the closet, looking for a change of clothing with a brief around the ankles wet with urine and feces on the buttocks. The door to the room was shut. The nurse startled the resident 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 12/16/14.</p> <p>Record review revealed Resident #20 had sustained six (6) falls prior to the fall on 12/14/14. However, review of the resident's Nursing Care Plan for falls, dated 05/21/14, 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 06/10/14, 06/11/14, 08/09/14, 09/08/14, 10/20/14 and 12/10/14.</p> <p>Review of the Fall Scene Investigation report, dated 06/11/14, 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 06/20/14 (nine days later) and made no recommendations to change or revise Resident #20's plan of care.</p> <p>Review of the Fall Scene Investigation report, dated 08/09/14, 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 09/08/14, revealed Resident #20 fell reaching for a trash can. The DON, ADM and RM met on 09/11/14 regarding the falls on 08/09/14 and</p>	F 280	<p>Continued from page 38</p> <p>Administrator, the DON, a MDS Nurse, Social Service Representative, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services Manager or Therapy Representative and meets Monday - Friday. The DON provided training to the Restorative/Wound Care Nurse on 01/08/15, 01/10/15 and 01/12/15 addressing the facility's scheduled toileting program, the toileting program as it relates to falls, review of the four-day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program form and the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of the toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee. The Restorative/Wound Care Nurse would audit the toileting program using the Scheduled Toileting Audit tool. The toileting program documentation was to ensure accuracy and completeness of scheduled toileting programs. The audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. On 01/12/15 the Restorative/Wound Care</p>	



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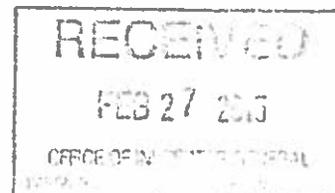
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F 280	<p>Continued From page 39</p> <p>09/08/14 but the resident's care plan was not revised to address these falls.</p> <p>Review of the Fall Scene Investigation report, dated 10/20/14, revealed the DON, ADM and RM met on 10/31/14 regarding the fall on 10/20/14 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.</p> <p>Review of Resident #20's previous Fall Scene Investigation report, dated 12/10/14, 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 a hematoma that was dark purple in color to the left side of the head and to the right thumb. 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.</p> <p>Continued review of the Fall Scene Investigation report, dated 12/10/14, 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 12/19/14 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.</p> <p>2. Review of the clinical record for Resident #15</p>	F 280	<p>Continued from page 39</p> <p>Nurse audited twenty-nine (29) clinical records finding one (1) area of concern and on 01/13/15 she audited twenty-eight (28) clinical records finding one (1) area of concern. The Restorative/Wound Care Nurse is to report identified concerns with the toileting program to the DON and the Quality Assessment and Assurance Committee will review and monitor these findings. The facility will utilize the Quality Assessment and Assurance Committee to review, evaluate and monitor for compliance with the notification of physician/responsible party, revision of resident care plans, toileting program and accidents and supervision with the following documents to be utilized: audit for falls, audits of notification of resident's attending physician/responsible party, audits of care plans addressing falls and audits of toileting program. The monthly meeting of the Quality Assessment and Assurance Committee to be held in February 2015 will be the initial meeting to review all of the audit information. These meetings will continue monthly for the next calendar year and will review the audit findings, assess the effectiveness of actions taken, revise action plans if necessary and continue to monitor the specifics of all falls within the facility.</p>		



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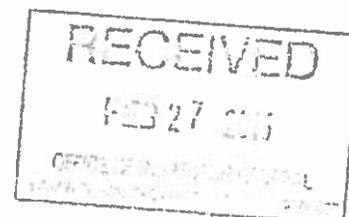
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F 280	<p>Continued From page 40</p> <p>revealed the facility admitted the resident on 08/19/13, with diagnoses of Dementia, Anemia, Osteoarthritis, and Bladder Disorder. Further review revealed Resident #15 had a history of falls and was receiving anti-depressant and anti-anxiety medications to treat symptoms of Depression and Anxiety.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, completed on 12/02/14, revealed the resident was not steady on his/her feet and needed extensive assistance from staff to toilet, walk, transfer and baths. 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.</p> <p>Review of the Comprehensive Care Plan, dated 07/15/14, 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.</p> <p>Review of the Fall Scene Investigation report, dated 06/29/14, revealed Resident #15 experienced a non-injury fall on 06/29/14 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</p>	F 280	<p>Continued from page 40</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents of the facility have the potential to be affected should the facility's system to ensure care plans were individualized based on resident assessments and revisions with interventions that could prevent additional falls after sustaining falls not be effective.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The facility has implemented a Falls Committee Meeting that is held Monday through Friday. The Falls Committee was initiated 01/12/15. The Falls Committee reviews the Event Report Document, reviews the resident's clinical record, the resident's care plan and the C.N.A. care sheet. Fall interventions are reviewed as is the reviewed/revised care plans and further root cause analysis for falls is completed during the meeting. The Falls Committee is comprised of the Administrator, the DON, a MDS Nurse, Social Service Representative, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services Manager.</p>		



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F 280	<p>Continued From page 41 Investigation report titled Additional Care Plans/Care Sheet Updates.</p> <p>Review of Resident #15's Care Plan, dated 07/18/14, revealed the facility did not revise the plan of care after the fall.</p> <p>Review of the Fall Scene Investigation report, dated 9/15/14, revealed Resident #15 experienced a non-injury fall on 9/15/14 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.</p> <p>Review of Resident #15's Care Plan, dated 07/18/14, revealed the facility did not revise the plan of care after the fall on 09/15/14 with interventions that addressed supervision or actions to meet the care needs of the resident.</p> <p>Review of the Fall Scene Investigation report, dated 10/31/14, revealed Resident #15 experienced a non-injury fall on 10/31/14 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 10/31/14, 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 10/31/14.</p> <p>Review of the Fall Scene Investigation report, dated 11/17/14, revealed Resident #15 fell on</p>	F 280	<p>Continued from page 41 Additionally the facility has initiated a Daily Quality Assessment Performance Improvement (QAPI)/Interdisciplinary Team (IDT) meeting that is held Monday through Friday where residents who are new admissions, hospitalizations, re-admissions, have had event reports, state reportables, significant changes in treatments and conditions have their clinical records, care plans and C.N.A. care sheets brought to the meeting to be reviewed and any areas of concern addressed during the meeting or an action plan is developed for further action to be taken. This team is comprised of the Administrator, Director of Nursing, Risk Care Manager, Clinical Care Specialist, Social Services Representative, Restorative/Wound Care Nurse, a MDS Nurse and if applicable the Rehab Services Manager or representative from the therapy department.</p> <p>The Standards of Care meeting continues to be held once a week led by an MDS Nurse. In attendance at that meeting are the Dietary Manager, Risk Manager, Social Service Representative and the Activity Director. Residents who have fallen are now reviewed by the Falls Committee rather than the Standards of Care meeting.</p>	

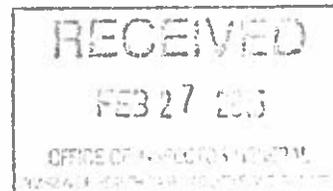


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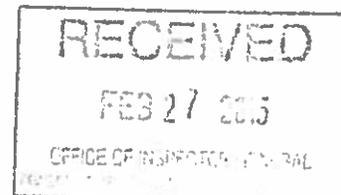
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F 280	<p>Continued From page 42</p> <p>11/17/14 at 3:20 AM. The staff reported the resident was getting up from the recliner in the common area to go to the toilet and landed face down on the floor. Resident #15 obtained a 0.5 cm laceration to the left eyebrow. The Additional Care Plans/Care Sheet Update section of the form stated staff would continue using alarms as ordered.</p> <p>Review of Resident #15's Care Plan, dated 07/18/14, revealed the facility did not revise the plan of care after the fall, on 11/17/14 with interventions that addressed supervision or actions to meet the care needs of the resident.</p> <p>Review of the Fall Scene Investigation report, dated 12/17/14, revealed Resident #15 fell on 12/17/14 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 crossed through.</p> <p>Review of Resident #15's Care Plan, dated 07/15/14, revealed the care plan was not revised after the resident's fall on 12/17/14 to ensure the resident's toileting needs were met.</p> <p>Review of the Fall Scene Investigation report, dated 12/24/14, revealed Resident #15 fell on 12/24/14 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.</p>	F 280	<p>Continued from page 42</p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained?</p> <p>Members of the Falls Committee, Daily QAPI/IDT Team and Standards of Care will work together to create a report to the Quality Assessment and Assurance Committee on a monthly basis. The reports to the Quality Assessment and Assurance Committee will be made monthly reflecting activities from January 2015 through December 2015.</p>	



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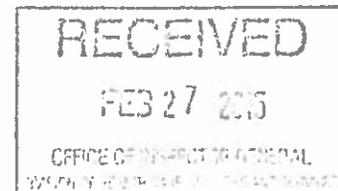
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F 280	<p>Continued From page 43</p> <p>The Nurse's Notes for Resident #15, dated 12/24/14 at 10:55 AM, revealed a sensor alarm to the bed was found face down on the bed and was not sounding.</p> <p>Review of Resident #15's Care Plan, dated 07/15/14, revealed the staff did not revise the care plan after the resident's fall on 12/24/14 with interventions to increase supervision or that addressed toileting needs.</p> <p>Interview with the Risk Manager, on 01/09/15 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.</p> <p>3. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 10/02/13 with diagnoses of Atrial Fibrillation, Arthritis, Hypertension, Seizures, Iron Deficiency Anemia, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Thrombocytopenia, and Generalized Pruritus.</p> <p>Review of Resident #13's Comprehensive Minimum Data Set (MDS) Assessment, dated 08/08/14, 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 10/28/14, revealed Resident #13 required the assistance of one (1) staff member for transfers.</p> <p>Review of Resident #13's Comprehensive Care Plan, dated 10/10/13, 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</p>	F 280			



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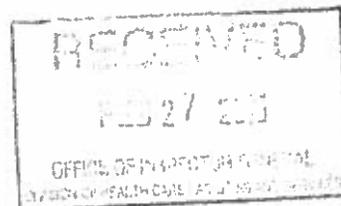
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F 280	<p>Continued From page 44</p> <p>resident crawled out the wheelchair onto the floor. The care plan stated that prior to the resident's admission to the facility he/she had a history of crawling from one place to another in his/her home.</p> <p>Interview, on 01/09/15 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.</p> <p>Review of Resident #13's nurses' notes, dated 10/10/14 at 4:40 AM, revealed on 10/10/14 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 10/10/14 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 (1-2 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.</p> <p>Review of the comprehensive care plan for Resident #13, did not reveal new or additional interventions added or documented on the falls</p>	F 280		



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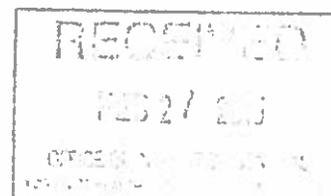
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F 280	<p>Continued From page 45</p> <p>care plan after the resident had three (3) documented falls on 10/10/14 between 12:30 AM - 7:00 AM.</p> <p>Review, of the report of Resident #13's falls on 10/10/14, did not reveal new interventions were added 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.</p> <p>Interview, on 01/09/15 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 10/10/14 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.</p> <p>Continued interview, on 01/09/15 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.</p> <p>Interview, on 01/09/14 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</p>	F 280			



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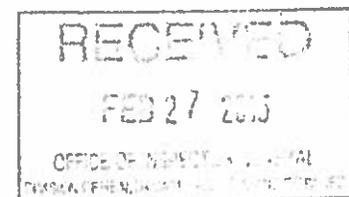
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F 280	<p>Continued From page 46</p> <p>wheelchair. The Orchard UM stated Resident #13's falls care plan should have been updated after the resident fell two times on the floor of the Orchard Unit on 10/10/14. The UM stated that after Resident #13's 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.</p> <p>4. Review of the clinical record for Resident #17 revealed the facility admitted the resident on 02/11/14 with diagnoses of Fractured Leg, Toxic Encephalopathy, Anemia, Heart Disease, Chronic Pulmonary Heart Disease, Hypertension, Atrial Fibrillation, Cardiac Murmurs, and Osteoarthritis.</p> <p>Review of the Minimum Data Set (MDS) for Resident #17, dated 01/06/15, revealed the resident had a Brief Interview for Mental Status (BIMS) score of eleven (11), indicating cognitively intact.</p> <p>Review of the Comprehensive Care Plan, dated 02/20/14, 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 03/06/14 and a tab alarm to bed and chair was initiated on 03/06/14; verbal reminders not ambulate or transfer with assistance; properly fitting non-skid soled shoes for ambulation; and, environment free of clutter.</p> <p>Review of the Fall Scene Investigation report, dated 06/19/14, revealed Resident #17 fell on 06/19/14 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</p>	F 280		



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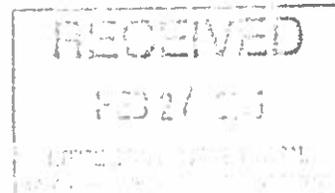
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F 280	<p>Continued From page 47</p> <p>skin tears to left forearm and right elbow. Resident #17 was sent to the emergency room for evaluation. The root cause portion of the document stated it appeared the resident fell asleep and fell out of the wheel chair head first, into the foot rail of the bed.</p> <p>Review of the Fall Scene Investigation report, dated 12/20/14, revealed Resident #17 experienced a non-injury fall on 12/20/14 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 12/21/14 at 10:50 AM, revealed the alarm clip had slipped off the resident's shirt, preventing the alarm from sounding.</p> <p>Review of the Fall Scene Investigation report, dated 12/25/14, revealed Resident #17 experienced a non-injury fall, on 12/25/14 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 12/25/14 at 7:00 PM and 12/26/14 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.</p> <p>Review of Resident #17's Care Plan, dated 02/20/14, revealed the staff had not added new interventions to the falls section of the care plan after the resident fell on 06/19/14, 12/20/14, or on 12/25/14.</p> <p>5. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 06/15/11 with diagnoses of Hypertension, Deep</p>	F 280			



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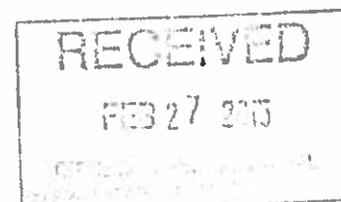
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F 280	<p>Continued From page 48</p> <p>Vein Thrombosis, Dementia, Schizophrenia and the resident had a history of falls. Review of the Quarterly Mlinimum Data Set (MDS) assessment, completed on 12/17/14, revealed the resident needed supervision when walking and transferring. 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 impalment.</p> <p>Review of the Comprehensive Care Plan, dated 06/29/11, 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.</p> <p>Review of the Nursing Notes, dated 12/28/14 and filmed 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.</p> <p>Review of Resident #8's, Falls Nursing Care Plan, dated 06/29/11, revealed no revisions or updates were made after Resident #8's fall on 12/28/14 to promote safety and prevent additional falls.</p> <p>Review of Resident #8's Fall Scene Investigation Report, dated 12/28/14, revealed the root cause of the fall was the resident's legs became weak while standing. Nursing was to place the</p>	F 280		



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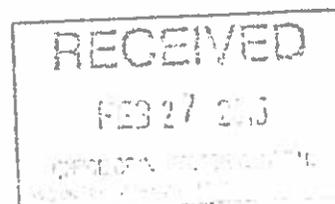
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F 280	<p>Continued From page 49</p> <p>resident's name on the physicians list for review and to complete neuro-checks. The Summary of Meeting and Additional Care Plan Update sections were blank.</p> <p>Interview with the Advance Practitioner Registered Nurse (APRN) on, 01/07/15 at 2:15 PM, revealed she had not assessed the resident as of 01/07/15 in regards to the fall on 12/28/14. 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 01/07/15. She stated the physician would assess medication for potential causes of falls and look at the resident's diagnoses to determine if there was a correlation.</p> <p>Interview with the Risk Manager (RM), on 01/07/15 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.</p> <p>Interview with the Director of Nursing on, 01/09/15 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 12/28/14. He stated he did not perform chart audits to determine if interventions were completed.</p>	F 280			



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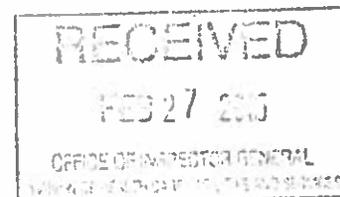
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F 280	<p>Continued From page 50</p> <p>Interview with the Risk Manager (RM), on 01/09/15 at 9:35 AM, revealed her responsibility was to ensure follow-up occurred after each resident fall, complete the documentation under the Falls Team Notes section 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 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.</p> <p>Interview with the Director of Nursing on, 01/09/15 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.</p> <p>However, interview with LPN #8, on 01/08/15 at 9:55 AM, revealed the revision of the care plan after falls was to be completed by the RM.</p> <p>Interview with the Unit Manager, on 01/08/15 at 8:30 AM, revealed she was not sure about what interventions would be used to revise the care plan.</p>	F 280			



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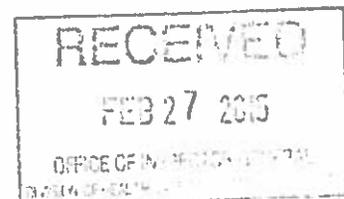
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F 280	<p>Continued From page 51</p> <p>Interview with the Administrator on, 01/09/15 at 5:25 PM, revealed he did not provide direction to the Director of Nursing or the Risk Manager regarding the care plan revisions for falls.</p> <p>Review of the Allegation of Compliance (AOC) revealed the facility implemented the following immediate steps to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> <li>1. The Medical Director was notified of Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday 01/08/15.</li> <li>2. A representative of the Governing Body provided the Administrator guidance and education on physician and family notification, supervision and investigation of falls, care plan revisions and scheduled toileting programs on 01/08/15 and 01/09/15.</li> <li>3. Licensed nurses (DON, Staff Development Coordinator, Risk Care Manager, Restorative/Wound Care Nurse, Minimum Data Set Nurse, House Supervisor, two (2) Unit Managers and a Staff Nurse) completed an audit on 01/10/15 for the one hundred eleven (111) residents currently in the facility. This included thirty (30) residents who had a fall in the past three (3) months, and eighty-one (81) residents who had no fall within the past three (3) months. The audit included a review of the fall event document for those who had fallen for root cause of the fall, interventions added to the care plans at the time of the fall, times of scheduled toileting program (if any), alarms utilized, care plans, notifications made to the attending physician and resident's responsible party and interventions.</li> </ol>	F 280		



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F 280	<p>Continued From page 52</p> <p>added after the audit was completed. An action taken as a result of the audit included update/revision to care plans for eleven (11) residents that included reachers; toileting in early morning hours; sensor pads; mattresses; and, non-skid strips to the floor. In addition, one resident's toileting program was addressed as a result of the 01/10/15 audit with changes to the timing of the toileting program based on his/her individualized needs.</p> <p>4. The Medical Director met with the Director of Nursing (DON) on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program. Revisions were made to the policy, Accident and Incidents, for physician and responsible party notification to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Revision was made to the policy, Falls Prevention, to check safety devices each shift to ensure they are in place and functioning properly.</p> <p>5. The procedure for conducting neurological checks was reviewed by the DON and the Staff Development Coordinator and all licensed nurses provided education on that process on 01/10/15 through 01/13/15. The DON and the Staff Development Coordinator conducted the inservice training on neurological checks and additional pen lights (used to conduct the neurological checks) were ordered by the DON on 01/12/15.</p> <p>6. The MDS Coordinator, MDS Nurse, DON and Risk Manager are responsible for ensuring care</p>	F 280			



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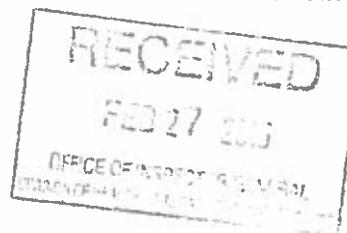
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F 280	<p>Continued From page 53</p> <p>plans are completed/revised in a timely/accurate manner. The care plans of residents who have fallen would be reviewed weekly in a Standards of Care meeting led by the MDS Nurse and the MDS Coordinator. In attendance at that meeting are the Dietary Manager, Risk Manager, Social Services Representative and the Activity Director. A report would be generated in that meeting of all falls, the review/revision of the residents' care plans and any actions taken to address concerns which would include staff education, staff discipline and care plan revisions to the Quality Assessment and Assurance Committee monthly from January 2015 - December 2015.</p> <p>7. The DON and the Staff Development Coordinator were provided training by the Administrator on 01/09/15 on physician and responsible party notification. The DON and the Staff Development Coordinator initiated all licensed nurses' and Certified Nursing Assistants' (CNA) training on 01/10/15 and continued that training through 01/13/15. A total of one hundred nineteen (119) staff had been trained by 9:30 PM on 01/13/15 with one (1) remaining staff notified they must receive training by their supervisor prior to returning to work. The training to all licensed nurses and certified nursing assistants included: work order process, care plans, certified nursing assistant care sheets, proper use and types of alarms, the scheduled toileting program process/form to be used and proper completion of the form. The licensed nurses received training on: falls and proper process for notification of the resident's physician, the responsible party, the neurological check process, the proper completion of the Event Report Form, review/revision of care plans, root cause analysis process, policy and procedure on</p>	F 280			



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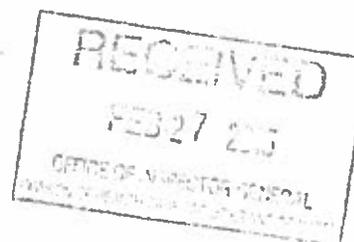
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F 280	<p>Continued From page 54</p> <p>Accidents and Incidents, policy on Falls Prevention, Neurological check protocol form and the form used for the Scheduled Toileting Program.</p> <p>8. The Administrator provided training to the Director of Nursing, the Risk Manager and therapy staff on 01/12/15 and 01/13/15 regarding the IJ, policy and procedure revisions, processes of Falls Committee Meeting, quality assessment and assurance committee role to ensure compliance and develop further actions to be taken.</p> <p>9. Three (3) notifications of residents' who fell prior to 01/12/15 was made to the attending physicians and responsible party on 01/12/15 with one (1) physician and the responsible party notification of a fall which occurred on 01/13/15.</p> <p>10. A Falls Committee was initiated 01/12/15 to review fall interventions, to review reviewed/revised care plans and to complete root cause analysis for falls during the meeting. The Falls Committee is comprised of the Administrator, the DON, a MDS Nurse, Social Worker, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services Manager and meets Monday-Friday.</p> <p>11. The DON provided training to the Restorative/Wound Care Nurse on 01/08/15, 01/10/15 and 01/12/15 addressing the facility's scheduled toileting program, the toileting program as it relates to falls, review of the four day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program form and</p>	F 280		



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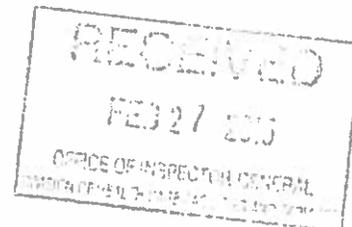
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F 280	<p>Continued From page 55</p> <p>the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of the toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee.</p> <p>12. The Restorative/Wound Care Nurse would audit the toileting program using the Scheduled Toileting Audit tool. The toileting program documentation was to ensure accuracy and completeness of scheduled toileting programs. The audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. On 01/12/15 the Restorative/Wound Care Nurse audited twenty-nine (29) clinical records finding one (1) area of concern and on 01/13/15 she audited twenty-eight (28) clinical records finding one (1) area of concern. The Restorative/Wound Care Nurse is to report identified concerns with the toileting program to the DON and the Quality Assessment and Assurance Committee will review and monitor those findings.</p> <p>13. The facility will utilize the Quality Assessment and Assurance Committee to review, evaluate and monitor for compliance with the notification of physician/responsible party, revision of resident care plans, toileting program and accidents and supervision with the following documents to be utilized: audits for falls, audits of notification of resident's attending physician/responsible party, audits of care plans addressing falls and audits of toileting program. The monthly meeting of the Quality Assessment and Assurance Committee to be held in February 2015 will be the initial meeting to review all of the</p>	F 280			



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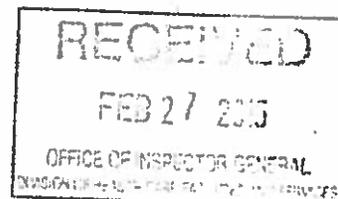
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F 280	<p>Continued From page 56</p> <p>audit information. These meetings will continue monthly for the next calendar year and will review the audit findings, assess the effectiveness of actions taken, revise action plans if necessary and continue to monitor the specifics of all falls within the facility.</p> <p>On 01/23/15, the State Survey Agency (SSA) validated the facility's AOC prior to exit through observation, interview and record review as follows:</p> <ol style="list-style-type: none"> <li>1. Telephone interview with the Medical Director, on 01/28/15 at 2:30 PM, post survey due to lecture schedule and unavailability, revealed he was contacted by the Director of Nursing (DON) on 01/08/15 regarding the Immediate Jeopardy. The Medical Director revealed he and the DON discussed several issues in regard to the Immediate Jeopardy i.e. the cause of resident falls, toileting issues/toileting schedules, CNA education, review of residents' medications, use of non-skid socks/shoes (should always be available) and lighting. He also revealed he and the DON discussed revision of the residents' care plans as necessary and the revisions needed for facility policies; specifically Accidents/Incidents, Fall Prevention and the Toileting Program. The Medical Director indicated he told the DON the question should always be asked after a resident's fall where the facility failed and what should be done to prevent resident falls/accidents.</li> <li>2. Review of the Administrator's notes from telephone conversation with a Governing Body representative revealed the representative retrained the Administrator on the need to ensure policies and procedures were in place (process of</li> </ol>	F 280		



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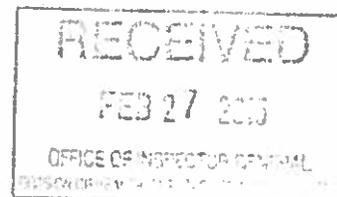
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F 280	<p>Continued From page 57</p> <p>physician/family notification, supervision and falls, care plan revisions and scheduled toileting programs). Further review of the Administrator's notes from telephone conversation with a Governing Body representative on 01/09/15 revealed the representative addressed the process of root cause analysis which required intense and in-depth questioning, record review, and resident, staff and witness interviews. Also discussed during the 01/09/15 training of the Administrator by the Governing Body representative was tracking and trending of all falls and assurance audits are in place to ensure processes are being followed with concerns identified to be addressed in staff training.</p> <p>Interview with the Administrator, on 01/23/15 at 10:50 AM, revealed he had a telephone conversation with a Governing Body representative on 01/08/15 and 01/09/15 to include how to complete the process of physician/family notification when a resident had a fall, how to follow the facility policy regarding falls, care plan revisions, the scheduled toileting programs, and the process in-depth root cause analysis.</p> <p>3. Review of the Resident Audit for Immediate Jeopardy January 2015 document revealed one hundred-eleven (111) residents (census of 01/10/15) were reviewed for falls in the past three (3) months-date/time/root cause; Interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit with signatures of nurses completing the audits. In addition, record review of Unsampled Resident C's individualized toileting program revealed it had been revised as a result of the</p>	F 280			



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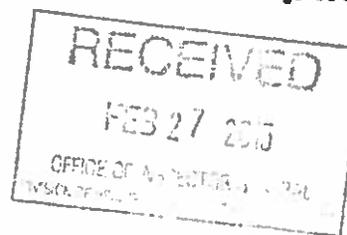
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F 280	<p>Continued From page 58</p> <p>audit on 01/10/15 with changes to reflect a time frame for toileting of 3:00 AM - 5:00 AM as the resident had fallen during those hours when attempting to self toilet.</p> <p>Interview with the DON on 01/23/15 at 10:00 AM revealed he was involved in the audit of all residents' charts who were in the facility on 01/10/15 to review all falls within the past three (3) months in regard-date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit.</p> <p>Interview with the Risk Manager, on 1/23/15 at 4:32 PM, revealed she was involved in the review of residents' falls for the past three (3) months that included the current census of one hundred and eleven (111) residents on 01/10/15 and the review covered the date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit.</p> <p>Interview with the Minimum Data Set nurse, on 01/23/15 at 3:44 PM, the Restorative/Wound Care Nurse, on 01/23/15 at 3:55 PM, two (2) Unit Managers on 01/23/15 at 4:45 PM, a Staff Nurse, on 01/23/15 at 5:05 PM, and the Staff Development Coordinator, on 01/23/15 at 5:30 PM, revealed they had all been involved in the audit of the facility residents on 01/10/15 to review all falls within the past three (3) months in regard-date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit.</p>	F 280	



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F 280	<p>Continued From page 59</p> <p>Record review of one resident's individualized toileting program revealed it had been revised as a result of the audit on 01/10/15 with changes to reflect a time frame for toileting of 3:00 AM - 5:00 AM as the resident has fallen during those hours when attempting to self toilet.</p> <p>4. Review of the policy, Accident and Incidents, on 01/23/15 at 9:00 AM revealed it had been revised to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Review of the policy, Falls Prevention, on 01/23/15 at 9:10 AM, revealed it had been revised to include the check of safety devices each shift to ensure they are in place and functioning properly.</p> <p>Interview with the Administrator and the DON, on 01/23/15 at 10:05 AM, revealed they had met with the Medical Director on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program and they made revisions to the Falls Prevention and the Accident and Incidents policies.</p> <p>Observation, on 01/22/15 at 10:40 AM, revealed Resident #25 had an alarm on the wheelchair as care planned and on 01/22/15 at 1:00 PM, Resident #25 was seated in the wheelchair with an alarm on the wheelchair. Observation of Resident #27, on 01/23/15 at 8:15 AM and 1:25 PM, revealed an alarm on the resident's wheelchair.</p> <p>Review of the record for Resident #25 revealed the resident's alarm had been checked on day shift per facility policy and was functioning and</p>	F 280			

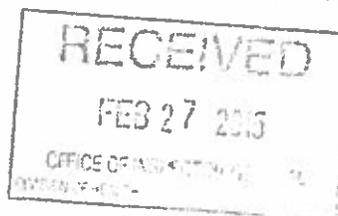


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F 280	<p>Continued From page 60</p> <p>review of Resident #27's record revealed the resident's alarm had been checked on the day shift per facility policy and was functioning.</p> <p>5. Review, on 01/23/15 at 10:13 AM, of the content for an inservice to licensed nursing staff on 01/10/15 revealed the procedure for conducting neurological checks was reviewed by the Director of Nurses and Staff Development with the nurses and they were informed of additional pen lights (used during the neurological checks) being available in the facility on all of the crash carts. Review of two (2) medical supply company invoices on 01/23/15 revealed additional pen lights had been ordered by the Administrator for nurses to use during neurological checks.</p> <p>Observation of a neurological check performed by Licensed Practical Nurse (LPN) #4 on Resident #26, on 01/22/15 at 12:30 PM, revealed proper technique per standards of nursing practice and followed the facility's retraining for nurses on neurological checks.</p> <p>Interview with LPN #4, on 01/23/15 at 10:20 AM, revealed she had been retrained on neurological checks for residents with possible head injury during a training provided to all licensed nurses on 01/10/15 by the Staff Development Coordinator and she knew pen lights were available in the facility on the crash carts.</p> <p>6. Interview with the Activity Director, on 01/23/15 at 3:50 PM, revealed she had been present on 01/21/15 in a Standards of Care meeting and had been involved in the review and revision of care plans for residents who had fallen.</p>	F 280		



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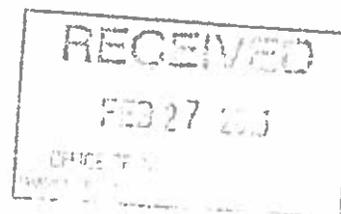
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F 280	<p>Continued From page 61</p> <p>Interview with the MDS Coordinator, on 01/23/15 at 3:44 PM, revealed she was involved in the Standards of Care meetings weekly, on 01/21/15 and in the review or revision of care plans for residents who had fallen.</p> <p>7. Interview and record review with the DON, on 01/23/15 at 2:19 PM, revealed he was provided training by the Administrator on 01/09/15 on physician/responsible party notification after a resident's fall. He revealed he and the Staff Development Coordinator began on 01/10/15 an all nursing staff training regarding the physician/responsible party notification after a resident's fall, and continued through 01/13/15. A review of in-service training records on 01/23/15 revealed one hundred nineteen (119) staff had been trained by 9:30 PM on 01/13/15 as cross-referenced with the facility human resource department staff roster. The training also included: work order process; care plans; certified nursing assistant care sheets; proper use and types of alarms; the scheduled toileting program process/form to be used and proper completion of the form. The licensed nurses received training on: falls and proper process for notification of the resident's physician; the responsible party; the neurological check process; the proper completion of the Event Report Form; review/revision of care plans; root cause analysis process; policy and procedure on Accidents and Incidents; policy on Falls Prevention; Neurological check protocol form and the form used for the Scheduled Toileting Program.</p> <p>Interview with LPN #1, on 01/23/15 at 1:40 PM and the Restorative Nurse, on 01/23/15 at 3:55 PM, revealed she had been trained on physician/responsible party notification regarding</p>	F 280			



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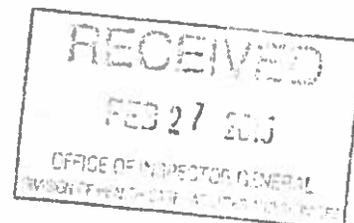
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F 280	<p>Continued From page 62</p> <p>a resident fall, care planning, event reports, scheduled toileting program/four (4) day bowel/bladder trending/proper documentation on 01/10/15 at 9:00 AM.</p> <p>Interview with CNA #11, on 01/23/15 at 1:50 PM, revealed she had been trained on maintenance requests, CNA resident information sheets, resident alarms and the scheduled toileting programs for residents on 01/12/15 at 10:45 PM.</p> <p>Interview with CNA #12, on 01/23/15 at 1:50 PM, revealed she had been trained on how to fill out the toileting program documentation, how to report any maintenance issues, the necessity to check alarms on any residents, to answer call lights timely and to report any concerns immediately.</p> <p>8. Review, on 01/23/15, of a therapy education attendance form and an administrative staff in-service training record each dated 01/13/15 revealed therapy staff and administrative staff had been trained by the Administrator on appropriate protocol to alert the maintenance department of safety issues and maintenance requests and a summary of the IJ received on 01/08/15.</p> <p>Interview with the Business Office Manager, on 01/23/15 at 5:10 PM, revealed she received an in-service regarding the Immediate Jeopardy notification and the ramifications of same. She stated the in-service included reporting maintenance concerns and how the facility was doing root cause analysis during the morning meeting.</p> <p>Interview with a Certified Occupational Therapy</p>	F 280			



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F 280	<p>Continued From page 63</p> <p>Aide, on 01/23/15 at 4:50 PM, revealed he received an inservice about the Immediate Jeopardy, the Falls Prevention policy and root cause analysis among other resident falls concerns like the toileting program and all was presented by the Administrator.</p> <p>9. Review of the nursing notes for Resident #23 and Unsampled Residents B, and C revealed the attending physician and responsible party were notified on 01/12/15 of falls prior to that date and for Unsampled Resident D the attending physician and responsible party was notified on 01/13/15 of a fall which occurred on 01/13/15.</p> <p>Interview with the DON, on 01/23/15 at 2:19 PM, revealed three (3) residents were discovered on 01/12/15 to need physician/family notifications of falls which occurred prior to 01/12/15 and a physician/family notification was made on 01/13/15 regarding a fall on that date all due to implementation of a revised notification system.</p> <p>10. A Falls Committee meeting attendees sign-in sheet was reviewed on 01/23/15 which indicated the Administrator, the DON, the MDS Coordinator, Social Services #2, the Risk Care Manager and the Restorative/Wound Care Nurse were present at a meeting on 01/12/15 to review residents who had falls.</p> <p>Interview with the DON on 01/23/15 at 2:19 PM indicated the residents who were reviewed for falls at the 01/12/15 Falls Committee meeting were Resident #23 and Unsampled Residents B and C.</p> <p>11. Interview with the Restorative Nurse, on 01/23/15 at 3:55 PM, revealed she was trained by</p>	F 280			

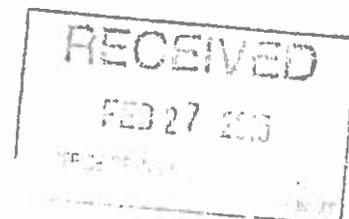


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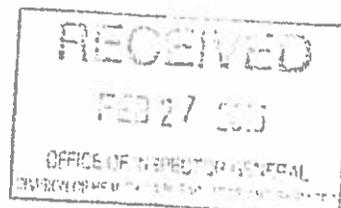
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F 280	<p>Continued From page 64</p> <p>the DON, on 01/10/15 at 9:00 AM, on physician/responsible party notification regarding a resident fall, care planning, event reports, and scheduled toileting program/four (4) day bowel/bladder trending/proper documentation. She stated she had been made aware of the Immediate Jeopardy and the implications of the Immediate Jeopardy on 01/08/15, but she didn't remember if she signed an attendance sheet for that date on 01/12/15.</p> <p>Review of in-service training records revealed the Restorative Nurse signed a training record on 01/09/15 (no time), on 01/10/15 at 9:00 AM and on 01/12/15 (no time).</p> <p>12. Interview with the Restorative Nurse, on 01/23/15 at 3:55 PM, revealed she would use the Scheduled Toileting Audit tool to ensure accuracy and completeness of scheduled toileting programs Monday-Friday. She stated the audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. She indicated she had completed an audit of twenty-nine (29) clinical records on 01/12/15 finding one (1) area of concern and she audited twenty-eight (28) clinical records on 01/13/15 finding one (1) area of concern. The Restorative Nurse revealed she would report to the DON each morning Monday-Friday any concerns she had identified from the audits and he would follow-up on them. She stated she would also report her findings to the Quality Assessment and Assurance Committee monthly and the committee would review and monitor those findings.</p> <p>Review of the scheduled toileting audit for</p>	F 280		



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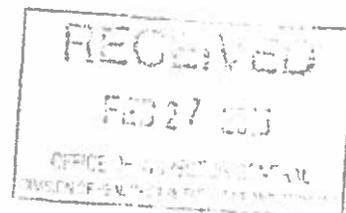
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F 280	Continued From page 65 January 2015 revealed the audit was started on 01/12/15 and was completed to 01/23/15.  13. Interview with the Administrator on 01/23/15 at 5:23 PM revealed the facility utilized the Quality Assessment and Assurance Committee to review, evaluate and monitor for compliance with the notification of physician/responsible party, revision of resident care plans, toileting program and accidents and supervision with the following documents to be utilized: audits for falls, audits of notification of resident's attending physician/responsible party, audits of care plans addressing falls and audits of toileting program. The monthly meeting of the Quality Assessment and Assurance Committee to be held in February 2015 will be the initial meeting to review all of the audit information. These meetings will continue monthly for the next calendar year and will review the audit findings, assess the effectiveness of actions taken, revise action plans if necessary and continue to monitor the specifics of all falls within the facility.  Interview with the Director of Nursing, on 01/23/15 at 3:25 PM, revealed the Quality Assurance Committee met and discussed resident charts, care plans, falls, and risk factors. As an example, Resident #13 was reviewed, with changes made to the care plan for a Gerichair for comfort and safety, and an OT evaluation for falls.	F 280			
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?  Unit Manager responded to Resident #3's needs on 01/07/15. LPN #5 was provided	02/25/15	



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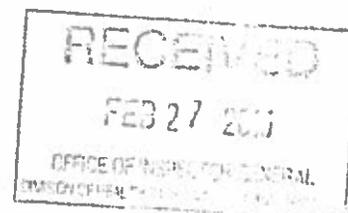
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F 282	Continued From page 66 care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and policy review, it was determined the facility failed to have an effective system in place to ensure the comprehensive plan 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.	F 282	Continued from page 66 education on the need to respond to resident care needs in a dignified and prompt manner and address their needs or delegate another staff member to address the resident's needs. Education was provided to LPN #5 by the Unit Manager on 01/07/15. LPN #5 was instructed to familiarize self with the residents' care plans and given direction on how and when to review and revise care plans as needed. Education was provided by the Restorative/Wound Care Nurse to CNA #5 on the process to ensure alarms have batteries and are functioning. All Nursing staff were provided training on the proper use and verification of proper function of alarms initiated on 01/10/14 and ended on 01/13/14 by the DON and Staff Development Coordinator (SDC). Licensed nurses were provided education on the proper action and documentation to be taken and made when an alarm is to be used to include who, how, and when the alarms are to be checked for functioning by the DON and SDC initiated on 01/10/14 and ended on 01/13/14. CNAs were provided training on their responsibility in the application and checking for functioning of alarms that are care planned for use on 01/10-13/15 by the DON and SDC.  2. How the facility will identify other residents having the potential to be affected by the same deficient practice?		



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



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F 282	<p>Continued From page 68</p> <p>medication cart down the hall and prepared medications to be administered. Resident #3 continued to yell, "Please will you do it, I don't want to, please help me, someone turn me over please."</p> <p>Observation, on 01/07/15 at 8:00 AM, revealed LPN #5 was at the end of the hall and Resident #3 yelled louder, "Please, please, I want to turn over, come on, please! Come on now. Please, not kidding when I say I want to turn over, please come on." LPN #5 continued with the medication pass. Resident #3 continued to yell, "Where you at? Hey, I'm not going to wait to turn over, please, please somebody." The resident could not turn them self or reposition.</p> <p>Observation, on 01/07/15 at 8:05 AM, revealed LPN #5 was beside Resident #3's room with the medication cart. Resident #3 yelled, "Please, please, I want to turn over please." LPN #5 continued to prepare medication for administration. At 8:10 AM, LPN #5 was observed in the room next to Resident #3. Resident #3 yelled, "Please turn me over, please come on now. Come on, I don't care. Please turn me over, I hurt. Please turn me over. Turn me over." Observation at 8:13 AM, revealed LPN #5 was outside of Resident #3's room and standing at the medication cart when the Unit Manager (UM) walked up to her. The UM was observed answering Resident #3 from the hallway and walked into the resident's room. LPN #5 continued past Resident #3's room without entering.</p> <p>Interview with Resident #3, on 01/07/14 at 8:15 AM, revealed the resident felt much better since he/she had been repositioned and was now on</p>	F 282	<p>Continued from page 68</p> <p>observed and document such education. A total of twenty-five (25) observations per month per shift will be completed.</p> <p>Each resident who has an alarm being used will have their CNA care sheet documented to reflect the CNA is to check the alarm for proper functioning each shift. A listing of residents with alarms will be created and maintained by the Risk Manager. This listing of residents with alarms is used to determine audits and review during Standards of Care meeting. Administrator will assign Department Heads and Administrative Staff the responsibility of observing the provision of care, record review and staff and resident interviews based on specific problems/needs, goals and targets and approaches from residents' plan of care seven (7) days a week. Five (5) assignments will be made each day. Staff assigned will document their findings and present to the Administrator during the Daily QAPI/IDT meeting the following day during the week and the next business day after a weekend. These observations will be ongoing. Identified concerns will be reviewed by the members of the QAPI/IDT team and action plans created and assignments of staff made to ensure actions are taken. Progress of actions plans will be reported to and reviewed by the QAPI/IDT team.</p>	
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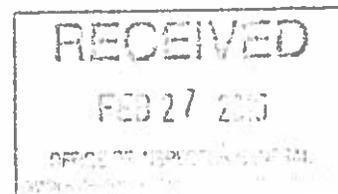
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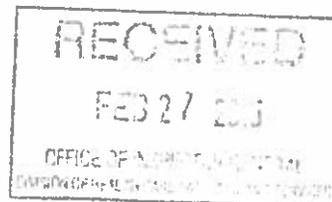
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F 282	<p>Continued From page 69 his/her back.</p> <p>Interview, on 01/07/15 at 11:00 AM, with LPN #5 revealed when she got near Resident #3's room to administer medication, she heard the resident call out, but she did not go into the room because the UM went into Resident #3's room to assist. Further interview with LPN #5 revealed she was not familiar with Resident #3's care plan. LPN #5 stated residents should be turned at least every two (2) hours by the Certified Nurse Aides (CNAs). LPN #5 stated she monitored the CNAs' turning of residents by comparing the residents' positions to how they were positioned the last time she observed them.</p> <p>Interview, on 01/07/15 at 11:55 AM, with the Orchard Unit Manager (UM), revealed she went to speak to LPN #5 regarding another resident and she heard Resident #3 call out for assistance. The UM stated when she went into Resident #3's room; the resident was laying on his/her side facing the door and the resident asked to be turned. She assisted by repositioning Resident #3 onto his/her back. The UM stated crying in pain and begging to be turned was not the usual behavior for the resident. The UM stated all staff was responsible for seeing to the needs of the residents. The UM further stated she attended all residents' care plan meetings with their families, but she did not know Resident #3's care plan off the top of her head.</p> <p>Interview, on 01/08/15 at 10:15 AM, with the Director of Nursing (DON), revealed he expected staff to answer resident's call lights within five (5) minutes, emergency lights within three (3)</p>	F 282	<p>Continued from page 69</p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained?</p> <p>The Risk Care Manager will submit a report to the Quality Assessment and Assurance Committee reflecting the residents who have alarms, that they are care planned and placed on the C.N.A. care sheets and that five (5) audits of the alarms for proper functioning have been completed on a weekly basis with any necessary education and action having been taken. This report by the Risk Care Manager will be provided on a monthly basis for the remainder of the 2015 calendar year. Quality Assessment and Assurance Committee will monitor this report provided by the Risk Care Manager on a monthly basis for calendar year 2015.</p>		



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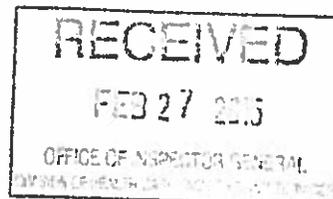
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F 282	<p>Continued From page 70</p> <p>minutes and a resident's call for help, immediately. The DON further stated twenty-three (23) minutes was too long for a resident's cry for assistance to go unanswered. The DON stated call light audits were completed monthly and if issues were noted, they were discussed with staff during in-services.</p> <p>2. Review of Resident #16's clinical record revealed the facility originally admitted the resident on 08/05/10, and readmitted the resident on 01/20/11 with diagnoses of Atrial Flutter, Hypertension, Hyperlipidemia, a history of Urinary Tract Infections (UTIs), Cardiomegaly, and Dementia with Behavior Disturbance.</p> <p>Continued review of Resident #16's clinical record revealed he/she received routine anticoagulation therapy (Coumadin) along with Digoxin and Aspirin for a diagnosis of Atrial Fibrillation. Resident #16's Minimum Data Set (MDS) assessment, dated 12/10/14, revealed falls was a triggered care area. Review of the Comprehensive Care Plan, dated 02/20/14, revealed a care plan for falls with multiple interventions, which included a sensor pad/alarm to the resident's bed; however, it did not give direction as to who, how, or when the alarm was to be checked for function or to check the batteries.</p> <p>Review of the Nurses' Notes revealed it was documented that Resident #16 was found, on 12/30/14 at 2:45 AM, with his/her body half on the bed, and half on the floor. The Nurse's Note stated the resident had no apparent injuries, but neurological (neuro) checks were initiated by the facility's protocol. The Physician was notified later</p>	F 282			



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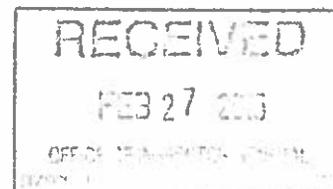
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F 282	<p>Continued From page 71 that morning at 10:40 AM and returned the call at 12:05 PM.</p> <p>Review of the facility's investigation, revealed it was documented that three (3) hours prior to the incident, Resident #16 was awake, talking and reclining on his/her bed. But, at 2:45 AM Certified Nursing Assistant (CNA) #5 observed Resident #16 sitting on the floor on the fall mat beside his/her bed. When the unit's licensed nurse inspected the sensor pad on the bed, the batteries that powered the device were missing.</p> <p>Interview, on 01/09/15 at 9:35 AM, with CNA #5 revealed she was assigned to provide care to Resident #16 on the second shift on 12/29/14 and on the third shift on 12/30/14. CNA #5 stated she prepared the resident for bed by performing perineal care, putting the bed in lowest position, and placing the floor mat beside the bed. However, CNA #5 stated she forgot to check the sensor alarm for function before leaving Resident #16's room. CNA #5 stated that during the early morning hours of 12/30/14 at 2:45 AM, she entered Resident #16's room, turned on the light and saw the resident seated by the bed and on the floor mat. CNA #5 stated Resident #16 was confused. Continued interview with CNA #5 revealed the facility's Staff Development Nurse provided a written in-service on tab and bed alarms. The facility's in-service instructed staff that it was the CNA's responsibility to be sure the alarms had batteries and were functioning. CNA #5 stated that she could not remember exactly when that in-service occurred. CNA #5 stated Resident #16 was supposed to have a long sensor pad on his/her bed, and the alarm on the pad should sound if the resident tried to get up from bed. CNA #5 stated the staff person</p>	F 282			



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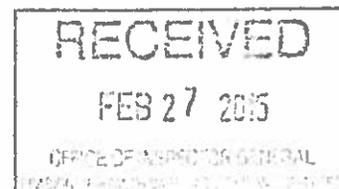
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F 282	Continued From page 72 responsible for caring for the resident was supposed to test the residents' alarms during his/her rounds at the beginning of the shift. CNA #5 stated she failed to check Resident #16's alarm for functioning.  Interview, 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 282			
F 315 SS=J	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive	F 315	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	02/25/15	



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F 315	Continued From page 73 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: 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 two falls with injury related to incontinence and trying to change soiled clothes. On 12/10/14 the resident was ambulating from the toilet to the wheelchair when they fell hit his/her head. On 12/14/14 the resident was found in the closet trying to change his/her clothing, the brief was around the ankles wet with urine and feces was found on the resident's buttocks. The resident fell and hit their head on the room mates foot board and sustained a hematoma. The resident was	F 315	Continued from page 73 The Medical Director was notified of Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday 01/08/15. A representative of the Governing Body provided the Administrator guidance and education on physician and family notification, supervision and investigation of falls, care plan revisions and scheduled toileting programs on 01/08/15 and 01/09/15. Licensed nurses (DON, Staff Development Coordinator, Risk Care Manager, Restorative/Wound Care Nurse, Minimum Data Set Nurse, House Supervisor, two (2) Unit Managers and a Staff Nurse) completed an audit on 01/10/15 for the one hundred eleven (111) residents currently in the facility. This included thirty (30) residents who had a fall in the past three (3) months, and eighty-one (81) residents who had no fall within the past three (3) months. The audit included a review of the fall event document for those who had fallen for root cause of the fall, interventions added to the care plans at the time of the fall, times of scheduled toileting program (if any), alarms utilized, care plans, notifications made to the attending physician and resident's responsible party and interventions added after the audit was completed. An action taken as a result of the audit included update/revision to care plans for eleven (11)	



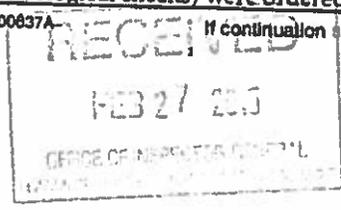
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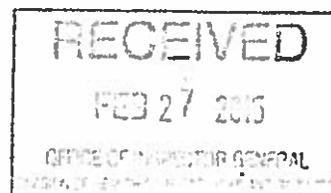
F 315	<p>Continued From page 74 transferred to the hospital for evaluation and expired on 12/16/14.</p> <p>Review of Resident #15's toileting program revealed inconsistent documentation of the program and the resident sustained three (3) falls with injury related to incontinence and attempting to take self to the toilet. On 11/17/14 the resident was taking self to the bathroom and fell receiving a laceration to left eyebrow. On 12/15/14 the resident was Incontinent and fell with pain in the right shoulder. On 12/17/14 the resident was taking self to the bathroom and fell sustaining an abrasion to the back and a skin tear to the elbow.</p> <p>The facility's failure to have an effective system in place for implementing, monitoring and revising the toileting programs for residents has caused or is likely to cause serious injury, harm, impairment or death to resident. The Immediate Jeopardy was identified on 01/08/15 and determined to exist on 12/10/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 01/20/15 alleging the Immediate Jeopardy was removed on 01/14/15. The State Survey Agency validated the Immediate Jeopardy was removed on 01/14/15 as alleged, prior to exit on 01/23/15. The scope and severity was lowered to a "D" while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the a policy titles Bowel and Bladder and provided by the facility as the toileting program policy, dated September 2010, revealed</p>	F 315	<p>Continued from page 74 residents that included reachers; toileting in early morning hours, sensor pads; mattresses; and non-skid strips to the floor. In addition, one resident's toileting program was addressed as a result of the 01/10/15 audit with changes to the timing of the toileting program based on his/her individualized needs. The Medical Director met with the Director of Nursing (DON) on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program. Revisions were made to the policy, Accident and Incidents, for physician and responsible party notification to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Revision was made to the policy, Falls Prevention, to check safety devices each shift to ensure they are in place and functioning properly. The procedure for conducting neurological checks was reviewed by the DON and Staff Development Coordinator and all licensed nurses provided education on that process on 01/10/15 through 01/13/15. The DON and the Staff Development Coordinator conducted the inservice training on neurological checks and additional pen lights (used to conduct the neurological checks) were ordered by</p>	
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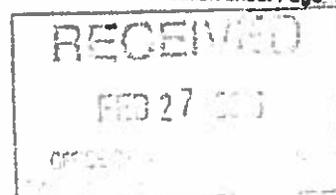
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F 315	<p>Continued From page 75</p> <p>every resident would be assessed and maintained at their highest level of continence. The toileting program would be individualized specific to a resident's incontinent pattern. The program would be implemented and noted on the plan of care.</p> <p>1. Review of the closed clinical record for Resident #20 revealed the facility admitted the resident on 05/21/14 with diagnoses of Deep Vein Thrombosis, Alzheimer's, and Gait Ataxia. Resident #20 also had a history of falls.</p> <p>Review of Resident #20's Quarterly Minimum Data Set (MDS) assessment, completed on 11/07/14, revealed the facility assessed the resident as not steady on his/her feet and requiring extensive assistance from staff to toilet, walk, and bathe. The MDS assessed Resident #20 as frequently incontinent of urine and was currently on a urinary toileting program. The facility conducted a Brief interview for Mental Status (BIMS) during the assessment and the resident scored an eight (8) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Review of Resident #20's Initial Plan of Care for Scheduled Toileting, dated 05/21/14 and the comprehensive care plan dated 05/29/14, revealed the goal was for the resident to have decreased episodes of incontinence. Interventions listed included; encourage resident to use the toilet in accordance with the program; evaluate the program quarterly and as needed; and, encourage the resident to request staff assistance with toileting at times other than scheduled toileting times.</p> <p>Review of the Behavioral Program form, dated</p>	F 315	<p>Continued from page 75</p> <p>the DON on 01/12/15. The MDS Coordinator, MDS Nurse, DON and Risk Manager are responsible for ensuring care plans are completed/ revised in a timely/ accurate manner. A Falls Committee was initiated 01/12/15 to review fall interventions, to review reviewed/ revised care plans and to complete root cause analysis for falls during the meeting. The Falls Committee is comprised of the Administrator, the DON, a MDS Nurse, Social Services Representative, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services Manager or therapy representative and meets Mondy through Friday. The MDS Coordinator, MDS Nurse, DON and Risk Care Manager are responsible for ensuring care plans are completed/ revised in a timely/accurate manner. A Standards of Care meeting is led by the MDS Nurse and the MDS Coordinator. In attendance at that meeting are the Dietary, Risk Manager, Social Service Representative and the Activity Director. A report would be generated in that meeting of all falls, the review/revision of the residents' care plans and any actions taken to address concerns which would include staff education, staff discipline and care plan revisions to the Quality Assessment and Assurance Committee monthly from January 2015 - December 2015. The DON and the Staff Development</p>		



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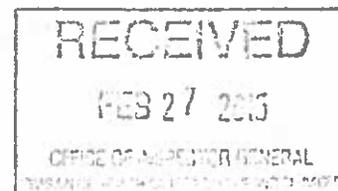
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F 315	<p>Continued From page 76</p> <p>05/29/14, revealed Resident #20 was placed on a scheduled toileting program with interventions to toilet at regular intervals that matched elimination patterns identified. However, the Four (4) Day Bowel and Bladder assessment form, used to determine Resident #20's elimination patterns, dated 05/23/14, revealed no documentation the resident was toileted, found wet or dry for an eight (8) hour time-frame, on 05/22/14 from 5:00 AM to 1:00 PM, and for a twenty-two (22) hour time-frame on 05/24/14 from 2:00 AM until 11:00 PM. Again on 05/25/14, there was no documentation for a fourteen (14) hour time-frame from midnight till 2:00 PM.</p> <p>Review of the Scheduled Toileting Program plans, dated June 2014 through December 2014, revealed staff was to document continent episodes on the form under headings labeled: Toilet as needed during the night, with morning care, after breakfast, after lunch; between 3:00 PM and 5:00 PM, after supper, at bedtime; and, between 10:00 PM and 12:00 PM. On the bottom portion of the form the staff was to document incontinent episodes every two hours. Continued review of the Scheduled Toileting program forms revealed numerous blanks, indicating staff did not document continent and incontinent episodes as required each month. Continued review of the documents revealed no revisions were made to Resident #20's scheduled toileting time-frames to indicate the staff was performing toileting at the time the resident would mostly likely need to toilet.</p> <p>Review of the Restorative Monthly Assessment form, dated 11/07/14, revealed staff documented the resident continued to frequently dribble urine and had a decrease in ambulation ability due to</p>	F 315	<p>Continued from page 76</p> <p>Coordinator were provided training by the Administrator on 01/09/15 on physician and responsible party notification. The DON and the Staff Development Coordinator initiated all licensed nurses' and Certified Nursing Assistants' (CNA) training on 01/10/15 and continued that training through 01/13/15. All staff have been trained. The training to all licensed nurses and certified nursing assistants included: work order process, care plans, certified nursing assistant care sheets, proper use and types of alarms, the scheduled toileting program process/form to be used and proper completion of the form. The licensed nurses received training on: falls and proper process for notification of the resident's physician, the responsible party, the neurological check process, the proper completion of the Event Report Form, review/revision of care plans, root cause analysis process, policy and procedure on Accidents and Incidents, policy on Falls Prevention, Neurological check protocol form and the form used for the Sheduled Toileting Program. The Administrator provided training to the Director of Nursing, the Risk Manager and the therapy staff on 01/12/15 and 01/13/15 regarding the IJ, policy and procedure revisions, processes of Falls Committee Meeting, quality assessment and assurance committee role to ensure compliance and</p>	



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F 315	<p>Continued From page 77</p> <p>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.</p> <p>Review of the Restorative Monthly Assessment form, dated 12/03/14, revealed staff documented Resident #20 had a significant decline in ambulation with complaints of bilateral leg pain and the resident remained on the scheduled toileting to decrease wetness along with unsafe transfers. However, there was no documented assessment to determine if the program was meeting the needs of the resident or the goal to decrease the number of incontinent episodes. The assessment forms further did not address the resident's falls sustained on 06/10/14, 06/11/14, 08/09/14, 09/08/14 and 10/20/14. On 12/10/14 and 12/14/14 that found the resident incontinent with each of these falls and received a head injury that required hospitalization and subsequent death.</p> <p>Interview with CNA #5, on 01/08/15 at 11:25 AM, revealed Resident #20 was only toileted every two (2) hours, the same as the other residents.</p> <p>Interview with CNA #7, on 01/08/15 at 10:55 AM, revealed she toileted the resident every two (2) hours and as needed. Resident #20 wanted to do it by him/herself and did not want to ask for help.</p> <p>2. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 08/19/13 with diagnoses of Dementia, Anemia, Osteoarthritis, and Bladder Disorder. Further review revealed Resident #15 had a history of</p>	F 315	<p>Continued from page 77</p> <p>develop further actions to be taken. Three (3) notifications of residents' who fell prior to 01/12/15 was made to the attending physicians and responsible party on 01/12/15 with one (1) physician and the responsible party notification of a fall which occurred on 01/13/15. The DON provided training to the Restorative/Wound Care Nurse on 01/08/15, 01/10/15 and 01/12/15 addressing the facility's scheduled toileting program, the toileting program as it relates to falls, review of the four-day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program form and the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of the toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee. The Restorative/Wound Care Nurse would audit the toileting program using the Scheduled Toileting Audit tool. The toileting program documentation was to ensure accuracy and completeness of scheduled toileting programs. The audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the</p>	

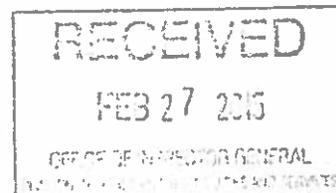


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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/23/2015
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS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

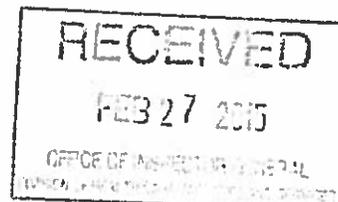
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F 315	<p>Continued From page 78</p> <p>falls and was receiving anti-depressant and anti-anxiety medications to treat symptoms of Depression and Anxiety.</p> <p>Review of Resident #15's quarterly Minimum Data Set (MDS) assessment, completed on 12/02/14, revealed the facility assessed the resident not steady on his/her feet and needed extensive assistance from staff to toilet, walk, transfer and bathe. The MDS further revealed staff could not conduct a Brief Interview for Mental Status (BIMS) due to the resident having short-term and long-term memory problems which affected his/her ability to make decisions and follow cues. The facility determined on the MDS the resident required supervision in daily decision making. The assessment further determined the resident was a candidate for a urinary toileting program.</p> <p>Review of the comprehensive care plan, dated 07/08/14, revealed the resident was on a Restorative Nursing Program scheduled toileting. Resident required restorative nursing scheduled toileting program related to decrease episodes of urinary incontinence and unsafe self transfers related to toileting needs. The undated interventions stated to observe skin for breakdown while toileting per individual schedule; encourage resident to use toilet in accordance with the program and as needed; evaluate restorative program quarterly and as needed; encourage resident to request staff assist to bathroom as needed at times other than scheduled toileting times. However, the comprehensive care plan did not provide direction to staff as to when to take the resident to the bathroom.</p>	F 315	<p>Continue from page 78</p> <p>toileting program and her initials. On 01/12/15 the Restorative/Wound Care Nurse audited twenty-nine (29) clinical records finding one (1) area of concern and on 01/13/15 she audited twenty-eight (28) clinical records finding one (1) area of concern. The Restorative/Wound Care Nurse is to report identified concerns with the toileting program to the DON and the Quality Assessment and Assurance Committee will review and monitor those findings. The facility will utilize the Quality Assessment and Assurance Committee to review, evaluate and monitor for compliance with the notification of physician/responsible party, revision of resident care plans, toileting program and accidents and supervision with the following documents to be utilized: audits for falls, audits of notification of resident's attending physician/responsible party, audits of care plans addressing falls and audits of toileting program. The monthly meeting of the Quality Assessment and Assurance Committee to be held in February 2015 will be the initial meeting to review all of the audit information. These meetings will continue monthly for the next calendar year and will review the audit findings, assess the effectiveness of actions taken, revise action plans if necessary and continue to monitor the specifics of all</p>	



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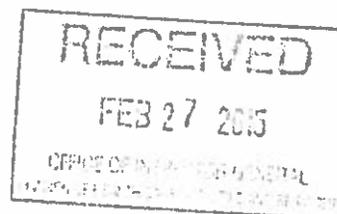
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F 315	<p>Continued From page 79</p> <p>Review of the Scheduled Toileting Program Plan revealed a flow sheet with a documentation key D-decline, V-toileted/voided, O-toileted-did not void, V/BM-toiled, voided and bowel movement. It further was divided into two sections one titled Continent Episodes only and Incontinent Episodes. The form contain a daily grid for each day and time noted as toilet prn during night; with AM care; after breakfast; after lunch; between 3P-5P, after supper; between 10P and 12A. The form further revealed it was not individualized, but toileting took place every two hours.</p> <p>Review of the Scheduled Toileting Program Plan, for Resident #15, dated June 2014, revealed nine (9) toileting times per day the resident was scheduled to be toileted. There were no entries made for one hundred and two (102) of the two hundred and seventy (270) toileting opportunities.</p> <p>Review of the Scheduled Toileting Program Plan, dated July 2014, revealed nine (9) toileting times per day the resident was scheduled. However, there was no entry made for fifty-five (55) of the two hundred seventy-nine (279) toileting opportunities.</p> <p>Review of the Scheduled Toileting Program Plan, dated August 2014, revealed nine (9) toileting times per day the resident was scheduled to be toileted. However, there were no entries made for sixty-eight (68) of the two hundred seventy-nine (279) toileting opportunities.</p> <p>Review of the Scheduled Toileting Program Plan, dated September 2014, revealed nine (9) toileting times per day the resident was scheduled to be toileted. However, there were no entries made for eighty-nine (89) of the one hundred sixty-two</p>	F 315	<p>Continued from page 79 falls within the facility.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same practice?</p> <p>All residents of the facility have the potential to be affected should the facility's system to ensure a toileting program is implemented, monitored and revised to meet the residents' individual incontinent needs not be effective.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Licensed nurses and CNAs were provided training on the Scheduled Toileting Program by the Restorative/Wound Care Nurse, DON and SDC on 01/10-13/14 addressing the toileting program components including the four-day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program forms and the toileting program as it relates to the prevention of falls. The Restorative/Wound Care Nurse developed an audit tool to audit the clinical documentation relative to the toileting program. The Restorative/Wound Care Nurse is auditing the toileting program on Monday through Friday. The Scheduled</p>	



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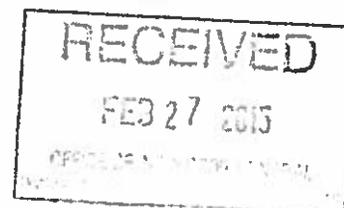
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F 315	<p>Continued From page 80 (162) toileting opportunities between 09/01/14 and 09/18/14. No toileting documentation was completed on this sheet between 09/18/14 and 09/30/14.</p> <p>Review of the Scheduled Toileting Program Plan, dated October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



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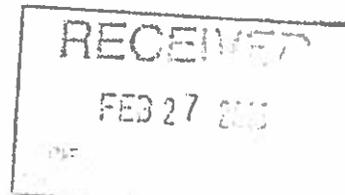
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F 315	<p>Continued From page 81</p> <p>Interview with Certified Nursing Assistant (CNA) #9, on 01/09/15 at 12:00 PM, revealed she would toilet residents on the toileting program every two hours. She stated if a resident did not void she left the box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



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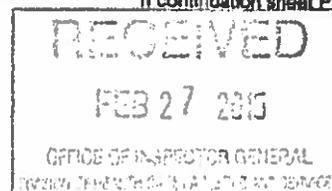
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F 315	<p>Continued From page 82</p> <p>the residents continued to qualify for the program. She stated she did not track or trend the information gathered regarding the residents toileting habits to determine if changes needed to be made to a resident's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



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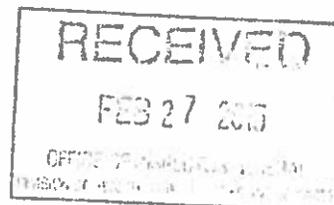
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F 315	<p>Continued From page 83</p> <p>Immediate Jeopardy and incidents causing the Immediate Jeopardy on Thursday 01/08/15.</p> <p>2. A representative of the Governing Body provided the Administrator guidance and education on physician and family notification, supervision and investigation of falls, care plan revisions and scheduled toileting programs on 01/08/15 and 01/09/15.</p> <p>3. Licensed nurses (DON, Staff Development Coordinator, Risk Care Manager, Restorative/Wound Care Nurse, Minimum Data Set Nurse, House Supervisor, two (2) Unit Managers and a Staff Nurse) completed an audit on 01/10/15 for the one hundred eleven (111) residents currently in the facility. This included thirty (30) residents who had a fall in the past three (3) months, and eighty-one (81) residents who had no fall within the past three (3) months. The audit included a review of the fall event document for those who had fallen for root cause of the fall, interventions added to the care plans at the time of the fall, times of scheduled toileting program (if any), alarms utilized, care plans, notifications made to the attending physician and resident's responsible party and interventions added after the audit was completed. An action taken as a result of the audit included update/revision to care plans for eleven (11) residents that included reachers; toileting in early morning hours; sensor pads; mattresses; and, non-skid strips to the floor. In addition, one resident's toileting program was addressed as a result of the 01/10/15 audit with changes to the timing of the toileting program based on his/her individualized needs.</p> <p>4. The Medical Director met with the Director of</p>	F 315			



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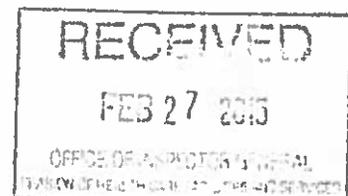
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F 315	<p>Continued From page 84</p> <p>Nursing (DON) on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program. Revisions were made to the policy, Accident and Incidents, for physician and responsible party notification to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Revision was made to the policy, Falls Prevention, to check safety devices each shift to ensure they are in place and functioning properly.</p> <p>5. The procedure for conducting neurological checks was reviewed by the DON and the Staff Development Coordinator and all licensed nurses provided education on that process on 01/10/15 through 01/13/15. The DON and the Staff Development Coordinator conducted the inservice training on neurological checks and additional pen lights (used to conduct the neurological checks) were ordered by the DON on 01/12/15.</p> <p>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</p>	F 315			



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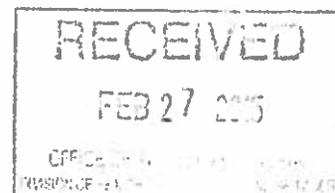
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F 315	Continued From page 85 Assessment and Assurance Committee monthly from January 2015 - December 2015.  7. The DON and the Staff Development Coordinator were provided training by the Administrator on 01/09/15 on physician and responsible party notification. The DON and the Staff Development Coordinator initiated all licensed nurses' and Certified Nursing Assistants' (CNA) training on 01/10/15 and continued that training through 01/13/15. A total of one hundred nineteen (119) staff had been trained by 9:30 PM on 01/13/15 with one (1) remaining staff notified they must receive training by their supervisor prior to returning to work. The training to all licensed nurses and certified nursing assistants included: work order process, care plans, certified nursing assistant care sheets, proper use and types of alarms, the scheduled toileting program process/form to be used and proper completion of the form. The licensed nurses received training on: falls and proper process for notification of the resident's physician, the responsible party, the neurological check process, the proper completion of the Event Report Form, review/revision of care plans, root cause analysis process, policy and procedure on Accidents and Incidents, policy on Falls Prevention, Neurological check protocol form and the form used for the Scheduled Toileting Program.  8. The Administrator provided training to the Director of Nursing, the Risk Manager and therapy staff on 01/12/15 and 01/13/15 regarding the IJ, policy and procedure revisions, processes of Falls Committee Meeting, quality assessment and assurance committee role to ensure compliance and develop further actions to be	F 315			



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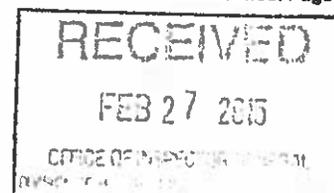
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 315	<p>Continued From page 86 taken.</p> <p>9. Three (3) notifications of residents' who fell prior to 01/12/15 was made to the attending physicians and responsible party on 01/12/15 with one (1) physician and the responsible party notification of a fall which occurred on 01/13/15.</p> <p>10. A Falls Committee was initiated 01/12/15 to review fall interventions, to review reviewed/revised care plans and to complete root cause analysis for falls during the meeting. The Falls Committee is comprised of the Administrator, the DON, a MDS Nurse, Social Worker, Risk Care Manager, Restorative/Wound Care Nurse and the Rehabilitation Services Manager and meets Monday-Friday.</p> <p>11. The DON provided training to the Restorative/Wound Care Nurse on 01/08/15, 01/10/15 and 01/12/15 addressing the facility's scheduled toileting program, the toileting program as it relates to falls, review of the four day bowel and bladder assessment process to note patterns and trends to develop an individualized scheduled toileting program for the resident, the process of documentation on the toileting program form and the creation of an audit tool to audit the clinical documentation relative to the toileting program, monitor for patterns and trends of the toileting program and a system to report findings of the audits to the Quality Assessment and Assurance Committee.</p> <p>12. The Restorative/Wound Care Nurse would audit the toileting program using the Scheduled Toileting Audit tool. The toileting program documentation was to ensure accuracy and completeness of scheduled toileting programs.</p>	F 315		



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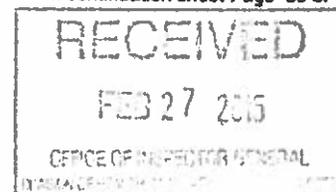
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F 315	<p>Continued From page 87</p> <p>The audit would include completion of all fields on the toileting program document, issues noted, trends noted, updates to the toileting program and her initials. On 01/12/15 the Restorative/Wound Care Nurse audited twenty-nine (29) clinical records finding one (1) area of concern and on 01/13/15 she audited twenty-eight (28) clinical records finding one (1) area of concern. The Restorative/Wound Care Nurse is to report identified concerns with the toileting program to the DON and the Quality Assessment and Assurance Committee will review and monitor those findings.</p> <p>13. The facility will utilize the Quality Assessment and Assurance Committee to review, evaluate and monitor for compliance with the notification of physician/responsible party, revision of resident care plans, toileting program and accidents and supervision with the following documents to be utilized: audits for falls, audits of notification of resident's attending physician/responsible party, audits of care plans addressing falls and audits of toileting program. The monthly meeting of the Quality Assessment and Assurance Committee to be held in February 2015 will be the initial meeting to review all of the audit information. These meetings will continue monthly for the next calendar year and will review the audit findings, assess the effectiveness of actions taken, revise action plans if necessary and continue to monitor the specifics of all falls within the facility.</p> <p>On 01/23/15, the State Survey Agency (SSA) validated the facility's AOC prior to exit through observation, interview and record review as follows:</p>	F 315			



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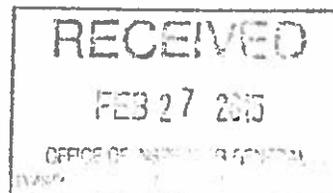
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN MEADOWS HEALTH CARE CENTER 1</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047</b>		
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F 315	<p>Continued From page 88</p> <p>1. Telephone interview with the Medical Director, on 01/26/15 at 2:30 PM, post survey due to lecture schedule and unavailability, revealed he was contacted by the Director of Nursing (DON) on 01/08/15 regarding the Immediate Jeopardy. The Medical Director revealed he and the DON discussed several issues in regard to the Immediate Jeopardy i.e. the cause of resident falls, toileting issues/toileting schedules, CNA education, review of residents' medications, use of non-skid socks/shoes (should always be available) and lighting. He also revealed he and the DON discussed revision of the residents' care plans as necessary and the revisions needed for facility policies; specifically Accidents/Incidents, Fall Prevention and the Toileting Program. The Medical Director indicated he told the DON the question should always be asked after a resident's fall where the facility failed and what should be done to prevent resident falls/accidents.</p> <p>2. Review of the Administrator's notes from telephone conversation with a Governing Body representative revealed the representative retrained the Administrator on the need to ensure policies and procedures were in place (process of physician/family notification, supervision and falls, care plan revisions and scheduled toileting programs). Further review of the Administrator's notes from telephone conversation with a Governing Body representative on 01/09/15 revealed the representative addressed the process of root cause analysis which required intense and in-depth questioning, record review, and resident, staff and witness interviews. Also discussed during the 01/09/15 training of the Administrator by the Governing Body representative was tracking and trending of all</p>	F 315			



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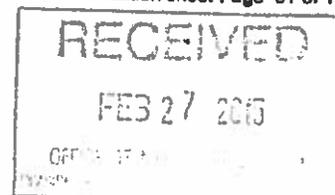
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F 315	<p>Continued From page 89</p> <p>falls and assurance audits are in place to ensure processes are being followed with concerns identified to be addressed in staff training.</p> <p>Interview with the Administrator, on 01/23/15 at 10:50 AM, revealed he had a telephone conversation with a Governing Body representative on 01/08/15 and 01/09/15 to include how to complete the process of physician/family notification when a resident had a fall, how to follow the facility policy regarding falls, care plan revisions, the scheduled toileting programs, and the process in-depth root cause analysis.</p> <p>3. Review of the Resident Audit for Immediate Jeopardy January 2015 document revealed one hundred-eleven (111) residents (census of 01/10/15) were reviewed for falls in the past three (3) months-date/time/root cause; interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit with signatures of nurses completing the audits. In addition, record review of Unsampled Resident C's individualized toileting program revealed it had been revised as a result of the audit on 01/10/15 with changes to reflect a time frame for toileting of 3:00 AM - 5:00 AM as the resident had fallen during those hours when attempting to self toilet.</p> <p>Interview with the DON on 01/23/15 at 10:00 AM revealed he was involved in the audit of all residents' charts who were in the facility on 01/10/15 to review all falls within the past three (3) months in regard-date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care</p>	F 315			



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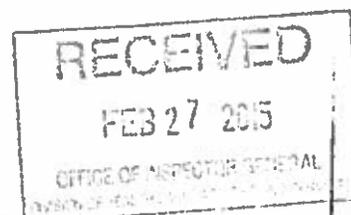
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NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
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F 315	<p>Continued From page 90 plan updated at time of fall and any interventions added at time of audit.</p> <p>Interview with the Risk Manager, on 1/23/15 at 4:32 PM, revealed she was involved in the review of residents' falls for the past three (3) months that included the current census of one hundred and eleven (111) residents on 01/10/15 and the review covered the date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit.</p> <p>Interview with the Minimum Data Set nurse, on 01/23/15 at 3:44 PM, the Restorative/Wound Care Nurse, on 01/23/15 at 3:55 PM, two (2) Unit Managers on 01/23/15 at 4:45 PM, a Staff Nurse, on 01/23/15 at 5:05 PM, and the Staff Development Coordinator, on 01/23/15 at 5:30 PM, revealed they had all been involved in the audit of the facility residents on 01/10/15 to review all falls within the past three (3) months in regard-date/time/root cause, interventions added at time of fall, scheduled toileting and times, alarms type/location/ care plan updated at time of fall and any interventions added at time of audit. Record review of one resident's individualized toileting program revealed it had been revised as a result of the audit on 01/10/15 with changes to reflect a time frame for toileting of 3:00 AM - 5:00 AM as the resident has fallen during those hours when attempting to self toilet.</p> <p>4. Review of the policy, Accident and Incidents, on 01/23/15 at 9:00 AM revealed it had been revised to include notification to the physician within thirty (30) minutes of a fall involving head injury or a fall which was not witnessed. Review</p>	F 315		



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F 315	<p>Continued From page 91</p> <p>of the policy, Falls Prevention, on 01/23/15 at 9:10 AM, revealed it had been revised to include the check of safety devices each shift to ensure they are in place and functioning properly.</p> <p>Interview with the Administrator and the DON, on 01/23/15 at 10:05 AM, revealed they had met with the Medical Director on 01/08/15 to review policies, procedures and practices for physician notification, root cause analysis of accidents, incidents and falls prevention, revision of care plans and the scheduled toileting program and they made revisions to the Falls Prevention and the Accident and Incidents policies.</p> <p>Observation, on 01/22/15 at 10:40 AM, revealed Resident #25 had an alarm on the wheelchair as care planned and on 01/22/15 at 1:00 PM, Resident #25 was seated in the wheelchair with an alarm on the wheelchair. Observation of Resident #27, on 01/23/15 at 8:15 AM and 1:25 PM, revealed an alarm on the resident's wheelchair.</p> <p>Review of the record for Resident #25 revealed the resident's alarm had been checked on day shift per facility policy and was functioning and review of Resident #27's record revealed the resident's alarm had been checked on the day shift per facility policy and was functioning.</p> <p>5. Review, on 01/23/15 at 10:13 AM, of the content for an inservice to licensed nursing staff on 01/10/15 revealed the procedure for conducting neurological checks was reviewed by the Director of Nurses and Staff Development with the nurses and they were informed of additional pen lights (used during the neurological checks) being available in the facility on all of the</p>	F 315		



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F 315	<p>Continued From page 92</p> <p>crash carts. Review of two (2) medical supply company invoices on 01/23/15 revealed additional pen lights had been ordered by the Administrator for nurses to use during neurological checks.</p> <p>Observation of a neurological check performed by Licensed Practical Nurse (LPN) #4 on Resident #26, on 01/22/15 at 12:30 PM, revealed proper technique per standards of nursing practice and followed the facility's retraining for nurses on neurological checks.</p> <p>Interview with LPN #4, on 01/23/15 at 10:20 AM, revealed she had been retrained on neurological checks for residents with possible head injury during a training provided to all licensed nurses on 01/10/15 by the Staff Development Coordinator and she knew pen lights were available in the facility on the crash carts.</p> <p>6. Interview with the Activity Director, on 01/23/15 at 3:50 PM, revealed she had been present on 01/21/15 in a Standards of Care meeting and had been involved in the review and revision of care plans for residents who had fallen.</p> <p>Interview with the MDS Coordinator, on 01/23/15 at 3:44 PM, revealed she was involved in the Standards of Care meetings weekly, on 01/21/15 and in the review or revision of care plans for residents who had fallen.</p> <p>7. Interview and record review with the DON, on 01/23/15 at 2:19 PM, revealed he was provided training by the Administrator on 01/09/15 on physician/responsible party notification after a resident's fall. He revealed he and the Staff Development Coordinator began on 01/10/15 an</p>	F 315			

