| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185164 | A. Building<br>B. Wing | 09/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Barbourville Health and Rehabilitation Center | 65 Minton Hickory Farm Road<br>Barbourville, KY 40906 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>51156<br><br>Based on observation, interview, record review, and review of the facility's policy, the facility failed to protect and promote the rights of 1 of 63 sampled residents (Resident (R) 95).<br><br>R95 refused an injection on 08/25/2024; however, nurses administered the injection after the resident's refusal.<br><br>The findings include:<br><br>Review of the facility's policy titled, Policy and Procedure: Resident Rights, revised 12/2022, revealed its purpose was to protect and promote the rights of each resident. Continued review of the policy revealed each resident had a right to refuse treatment and to be given the opportunity to participate in care and treatment.<br><br>Review of R95's Admission Record revealed the facility admitted the resident on 12/30/2022, with diagnoses that included neuromuscular dysfunction of the bladder, type 2 diabetes mellitius without complications, urinary tract infections (UTIs), and Gullain-Barre syndrome.<br><br>Review of R95's Quarterly Minimum Data Set (MDS) Assessment, dated 07/23/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated intact cognition.<br><br>Review of R95's comprehensive care plan, undated, revealed a focus problem of potential for infection with a goal for R95 to be free of infection through the next review. Continued review revealed interventions that included: administer medications as ordered, observe for any signs of infections and notify the Physician, as needed.<br><br>Review of R95's Medication Administration Record (MAR) dated August 2024, revealed the resident received a Rocephin injection (antibotic ordered for a Urinary Tract Infection) intramuscularly on 08/25/2024 at 11:18 PM.<br><br>(continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/30/2024 |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with R95, and observation at the time of the interview, on 08/26/2024 at 10:48 AM, revealed he was upset when talking about the antibiotic injection he received on the night of 08/25/2024. R95 screamed he was sick to his stomach because he was given a shot he did not want last night. The resident stated he had taken the Rocephin shot on Thursday and Friday nights (08/22/2024 and 08/23/2024) before he realized it was making him sick. He stated he was sick all day Saturday (08/24/2024) and unable to eat.<br><br>Review of the meal intake record revealed R95 refused all meals on 08/24/2024. R95 refused the Rocephin injection on 08/24/2024 due to nausea.<br><br>During continued interview with R95 on 08/26/2024 at 10:48 AM, he stated that was why he refused to take the shot on 08/25/2024. The resident stated a nurse later came in at 1:30 AM and woke him up to take his (Rocephin) shot. R95 stated he told the nurse the shot made him sick to his stomach and he was unable to eat. He stated he told the nurse not being able to eat scared him because he was a diabetic and needed to eat so he would not die. Per R95, the nurse told him he had to take it, that the doctor ordered it, and the nurse then proceeded to give the shot in his hip. R95 stated, I screamed for the nurse to not give me the shot, but I [couldn't] fight them off because I don't have enough strength. R95 stated two nurses were present in his room when the shot was given, but he could not remember their names. He stated Certified Nursing Assistant 10 (CNA10) was also in the room.<br><br>In interview on 08/26/2024 at 3:05 PM, Registered Nurse 1 (RN1) stated R95 refused his (antibiotic) shot on Sunday night (08/25/2024) because he said it made him sick. RN1 stated he educated R95 on refusing the medication, and later on, he had another nurse try to give the resident his shot. He stated that the nurse talked R95 into taking the shot so he (RN1) gave it to the resident. The RN further stated he had been trained on residents' rights and knew a resident could refuse to take a medication.<br><br>In interview on 08/26/2024 at 3:40 PM, CNA10 stated, one night R95 took his shot with no issues; however, last night (08/25/2024) he was feeling sick and refused the shot. CNA10 stated, I believe it was around 2:30 AM, last night, R95 did not want the shot, but then LPN 3 talked him into it and gave the resident the shot.<br><br>Review of the nurse practitioner's (NP) note dated 08/26/2024, revealed a new order to stop the Rocephin injections due to adverse effects, and give Zofran 4 mgs (milligrams) by mouth every six hours as needed.<br><br>Review of R95's Progress Note, dated 08/26/2024 at 2:25 PM revealed the NP was notified related to the resident's complaints of nausea due to the intramuscular antibiotic injection. A new order was received for ondanstron HCL (Zofran) 4 mg by mouth every 6 hours as needed for nausea.<br><br>During interview on 08/27/2024 at 1:38 PM, R95 stated he was feeling better but still felt sick to his stomach. He stated, I'm mad as hell with them for giving me that shot because I have the right to refuse it. I told her no.<br><br>During interview on 08/28/2024 at 9:30 AM, R95 stated he was scared this would happen again if he had one of the ''hardheaded'' nurses who just do it (in reference to giving injections). R95 stated he knew he could refuse medications, but the hardheaded nurses would bring in other staff like they had done the other night and make him . take it again.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview on 08/27/2024 at 4:38 PM, Licensed Practical Nurse 3 (LPN3) stated it usually took two people to give the resident his medications because of his refusals. LPN3 stated she explained things to the resident in a way he could understand, and had done that with him when he refused his shot on 08/25/2024. She stated she told the resident the doctor ordered the shot and he really needed to take it. The LPN stated R95 was lying on his side, and she and RN1 were standing together, when the RN gave the resident's injection (on 08/25/2024). LPN3 stated CNA10 was also in the room when the injection was given. She stated she knew residents could refuse medications and if that happened she waited a bit and then revisited the resident. The LPN stated if residents continued to refuse a medication she would call the doctor; however, she did not call the doctor about R95 refusing his medication.<br><br>In interview on 08/27/2024 at 1:18 PM, the Administrator stated R95 had a history of refusing things. She stated she had to have conversations with R95 in the past related to refusing medications and his showers. The Administrator stated however, a resident had the right to refuse a medication and the Physician should be notified of the refusal. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46651<br><br>Based on observation, interview, record review, and review of the facility's policy, the facility failed to immediately consult with the resident's Physician and notify the resident's representative(s) when there was an accident or need to alter treatment for 3 of 63 sampled residents, (Resident (R)15, R95 and R274).<br><br>1. R15 sustained a fall on 04/29/2024; however, the facility failed to notify the resident's State Guardian and Physician until 04/30/2024. On 04/30/2024, the facility transferred R15 to the Emergency Department (ED) for evaluation. R15 was diagnosed with a spiral humeral fracture (a type of bone break occurring from a twisting motion in the upper arm) which was comminuted (when a bone breaks into multiple pieces) and displaced.<br><br>2. R274 sustained an injury on 07/06/2022; however, the facility failed to notify the resident's Responsible Party and Physician until 07/08/2022. On 07/09/2022, the facility transferred R15 to the Emergency Department (ED) for evaluation. R274 was diagnosed with an angulated spiral fracture (a fracture with the appearance of a corkscrew) of the midshaft of the humerus with mild impaction.<br><br>3. R95 had an order for rocephin 1 GM (gram) intramuscular injection at bedtime on 08/22/2024 for five days. He refused the injection on 08/24/2024 and 08/25/2024 because it made him sick. However, the facility failed to notify the Physician or the Nurse Practitioner (NP) of R95's refusal. When the Nurse Practitioner (NP) visited R95 on 08/26/2024, the resident reported feeling sick from the antibiotic medication injections. The NP discontinued the injections.<br><br>The findings include:<br><br>Review of the facility's policy titled, Notification of Change in Resident's Status, undated, revealed the attending physician or their alternate, along with the resident's representative were to be notified of any changes in a resident's condition. Further review revealed the changes in a resident's condition could include an accident or incident which resulted in injury or a need to alter treatment.<br><br>Review of the facility's policy titled, Falls Management/Prevention, revised 07/2024, under the Managing the Resident Who Experiences a Fall section, revealed the facility was to notify the Physician and the resident's representative of the fall.<br><br>1. Review of R15's Face Sheet revealed the facility admitted R15 on 09/16/2019 with diagnoses of dementia, Alzheimer's, paranoid schizophrenia, history of falls, and lack of coordination.<br><br>Review of R15's Minimum Data Set (MDS) Assessment, dated 04/12/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was unable to complete the interview.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R15's Comprehensive Care Plan (CCP) revealed the facility developed a focus problem for falls, dated 01/16/2024. Per review, R15 was at high risk for falls due to diagnoses of osteoarthritis, osteopenia, impaired cognition and history of falls. Continued review revealed R15's risk for falls also included a history of left hip fracture and required total staff assistance to complete activities of daily living (ADL's). Review of the goal dated 05/09/2024, noted R15 was to be protected from falls through the next review period with a target date of 11/19/2024. Further review revealed an intervention dated 01/23/2024, for notifying the Medical Doctor and Responsible Party (RP) as needed.<br><br>Review of R15's Health Status Note with an effective date of 04/29/2024 at 10:00 PM, (created on 04/30/2024 at 9:50 PM, as a late entry note), documented by Registered Nurse 1 (RN 1) revealed on 04/29/2024 at 10:00 PM, he had been approached by a Certified Nursing Assistant (CNA) and was told R15 was lying on the floor. Per review, LPN 2 went to R15's room where she found the resident lying on her back on the floor next to the bed on the fall mat. Continued review revealed the facility assessed R15 head-to-toe for any injury, with none found. Staff assisted R15 back to bed. Further review revealed R15 had no complaints of pain or discomfort, and the bed was placed in the lowest position. However, record review revealed no documented evidence the Physician/NP or State Guardian were notified of R15's fall on 04/29/2024.<br><br>Review of R15's Health Status Note, dated 04/30/2024 at 12:30 PM (created on 04/30/2024 at 4:14 PM as a late entry), documented by Clinical Coordinator #2 (CC 2) revealed CNA 8 came to her and told her R15 had a swollen arm. Per review, CC 2 went to R15's room and observed the resident's left shoulder had a large swollen red and purple area on it. Continued review revealed CC 2 notified Registered Nurse 6 (RN 6), who was caring for R15 that day, and the Nurse Practitioner (NP) of the condition of R15's left shoulder.<br><br>Review of R15's Health Status Note, dated 04/30/2024 at 1:09 PM, documented by RN 6, revealed a Physician's order to transfer R15 to the ED for evaluation of her left shoulder and arm which were red and swollen.<br><br>Review of the facility's Incident Note for R15 dated 04/30/2024 at 7:08 PM, documented by RN 6 revealed when she lifted R15's shirt sleeve to assess the area on her left arm, the resident grimaced, moaned and verbalized profanity when her arm was touched. Continued review revealed RN 6 observed redness and swelling at R15's shoulder area, which was also warm to touch. Further review revealed the NP was immediately notified and an order was obtained to transfer R15 to the local ED for further evaluation, and the responsible party was notified.<br><br>Review of the hospital nursing assessment dated [DATE], revealed R15's left upper extremity was assessed and observed as bruised and swollen. Per review, Fentanyl (a powerful synthetic opioid used to treat pain) 50 micrograms (mcg) was given intramuscularly (IM) for R15's pain. Further review revealed hospital staff diagnosed R15 with a spiral humeral fracture (a type of bone break occurring from a twisting motion in the upper arm) which was comminuted (a type of bone break when the bone breaks into multiple pieces) and displaced.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 08/26/2024 at 3:06 PM, RN 1 stated the night R15 fell (04/29/2024) he had been the nurse assigned to the resident's care. The RN stated that night a CNA (he could not recall which CNA) came to him and LPN 2 and told them the resident had fallen. He stated LPN 2 went to assess R15, as all the nurses worked as a team and sometimes cared for each other's assigned residents if needed. Per RN 1, he was told by LPN 2 the resident had no injuries and no pain noted and seemed alright. RN 1 stated when he passed R15's 6:00 AM medications on 04/30/2024, he had not noticed anything out of the ordinary with the resident. He stated he did not call R15's medical provider or the responsible party (RP) and did not fill out the incident report or document the fall in the progress notes. RN 1 stated he trusted LPN 2 and thought she had completed the necessary documentation and had not thought to check to make sure everything had been completed. The RN stated there had been a miscommunication between him and LPN 2. He stated he thought since LPN 2 assessed R15, she also called the provider and RP, and filled out the incident report. RN 1 stated he was not aware of any injury to R15 until the next day when he returned to work and was questioned about the resident's injuries by leadership.<br><br>Telephonic (phone) attempts to reach LPN 2 made on 08/26/2024 at 3:35 PM; 08/27/2024 at 7:07 PM; and, on 08/29/2024 at 3:00 PM, were all unsuccessful.<br><br>During interview with the Quality Nurse/Staff Development Coordinator/Infection Prevention Nurse (QN/SDC/IP), on 08/29/2024 at 1:00 PM, she stated it was the facility's expectation that all falls were reported to the on call supervisor, the NP, and the resident's representative.<br><br>During interview on 08/30/2024 at 8:49 AM, the Director of Nursing (DON) stated during lunch tray pass on 04/30/2024, a CNA noticed bruising and swelling to R15's left upper extremity when she was repositioning the resident for the meal. She stated she spoke to RN 6, the nurse in charge of R15's care during the day on 04/30/2024. The DON stated the RN reported to her not having identified any bruising on R15 during her skin assessment that morning. She stated R15 was immediately sent to the ED for evaluation and the facility began an investigation. The DON stated during the investigation, on 04/30/2024, the CCN was interviewed and told her R15 had fallen the night before (04/29/2024). She stated the CCN told her LPN 2 had assessed R15 with no injury after the fall, so they assisted the resident back to bed. The DON stated RN 1 was the nurse responsible for R15's care the night of her fall. However, LPN 2 had assessed the resident after the fall. She stated the nursing staff worked as a team and helped one another. The DON stated RN 1 and LPN 2 should have clarified who was completing the fall investigation and the notification to the provider and the resident's responsible party. She stated the two nurses got their wires crossed and each thought the other had reported the fall to the (medical) provider and the resident's representative. The DON stated it was the facility's policy and expectation for all residents' falls to be reported to the NP, resident's representative, and the supervisor, and an incident report completed. She stated LPN 2 and RN 1 were re-educated on the notifying the provider and the resident's responsible party, as well as completing the necessary documentation.<br><br>During interview on 08/30/2024 at 10:00 AM, the Administrator stated the tracking and trending of residents' falls was her responsibility. She stated the necessary notifications and fall investigation should have been completed as required. The Administrator also stated the facility's policy and expectation was for all falls to be reported to the NP, resident's representative, and the supervisor, and for an incident report to be completed.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 08/30/2024 at 11:18 AM with the NP she stated she was in the facility five days a week to assess residents for acute issues, post falls, or residents' complaints. The NP stated she was notified of R15's fall on 04/30/2024, when she arrived at the facility. However, she stated when any resident fell , the (medical) provider on call should be notified immediately.<br><br>During interview on 08/30/2024 at 3:23 PM, the Medical Director stated the reporting of falls to the provider on call and facility leadership and completion of documentation was his expectation.<br><br>51156<br><br>2. Review of R274's, Admission Record revealed the facility admitted the resident on 01/11/2013, with diagnoses of Alzheimer's disease, dementia, aphasia, visual loss; and contractures of the right shoulder, right elbow, right hand, right knee, left shoulder, left elbow, left hand, and left knee.<br><br>Review of the Nurse's Note dated 07/08/2022 12:30 AM, documented by Registered Nurse #9 (RN 9) revealed the RN was alerted to R274's room by a CNA. Per review, R274 was noted to have swelling, bruising/discoloration to the left upper extremity. Further review revealed the resident was non-verbal and was unable to give any information.<br><br>Review of the Nurse's Note dated 07/08/2022 revealed no documented evidence the necessary State Agencies, including law enforcement, were notified.<br><br>Review of R274's ED (Emergency Department) Hospital Record dated 07/09/2022 revealed the facility transferred R274 to the ER and was diagnosed with a fracture of the left humerus. Review of the 07/09/2022, ED Hospital Record documentation revealed R274 was noted to have pain and swelling of the left arm with yellow discoloration consistent with old bleeding and moderate aching/cramping pain to the left shoulder that was constant. Continued review revealed R274's left upper arm was splinted, and x-rays revealed an angulated spiral fracture (a fracture with the appearance of a corkscrew) of the midshaft of the humerus with mild impaction. Further review revealed the hospital personnel notified Adult Protective Services (APS) of R274's injury of unknown origin.<br><br>Review of the State Survey Agency's, Intake Information document dated 07/13/2022 at 4:00 PM, revealed the Department of Community Based Services (DCBS) reported R274 had been transferred to the hospital Emergency Department (ED). Further review revealed the facility transferred R274 to the ED due to swelling and bruising of the upper left arm, which x-rays showed a fracture of the humerus, that the facility could not explain.<br><br>In interview on 09/30/2024 at 4:51 PM, the Administrator stated CNA 20 was a contract agency employee, and they did not have contact information for that individual.<br><br>Continued review of the facility's investigation documentation revealed CNA 18's statement dated 07/09/2022 which noted she and CNA 19 had been bathing R274 on 07/06/2022, when CNA 19 raised the resident's left arm and heard two pops. Further review of CNA 18's written statement revealed CNA 18 notified Licensed Practical Nurse (LPN) 5 after they completed R274's bath.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of the facility's investigation documentation revealed LPN 5's undated statement, which revealed LPN 5 assessed R274 throughout his shift (on 07/09/2022) and noticed no bruising, swelling, or change in condition. In addition, review of the investigation documentation revealed RN 9's undated statement that noted CNA 20 asked RN 9 to assess R274's left arm due to it being swollen and discolored with bruising, and the RN notified the doctor.<br><br>In interview conducted on 09/30/2024 at 4:51 PM, the Administrator said the incident investigation involving R274's injury of unknown source was the first investigation she and the DON performed since being in their current positions. She stated she had not been sure of the investigation process. The Administrator stated no one had been in leadership (the Regional Consultant) to help her and direct the investigation because of an incident at a sister facility. In further interview, the Administrator stated she had known the injury R274 sustained had been a reportable event; however, she and the DON failed to do everything needed for the investigation.<br><br>In interview conducted on 09/30/2024 at 5:00 PM, the DON stated she and the Administrator had still been learning at the time of R274's investigation and they failed to do everything required for the investigation.<br><br>3. Review of R95's Face Sheet revealed the facility admitted the resident on 12/30/2022, with diagnoses to include Gullain-Barre Syndrome, acute infarction of spinal cord, neuromuscular dysfunction of the bladder, type 2 diabetes mellitus, and urinary tract infection.<br><br>Review of the Quarterly MDS Assessment, dated 07/23/2024, revealed the facility assessed R95 to have a BIMS' score of 13 out of 15, which indicated the resident was cognitively intact.<br><br>Review of R95's comprehensive care plan, undated, revealed the facility developed a care plan focus for potential for infection. Continued review revealed the facility developed interventions that included: administering medications as ordered, and observing for any signs of infections and notifying the Physician as needed.<br><br>Review of the urinalysis laboratory (lab) report for urine collected on 08/20/2024 at 4:00 PM, revealed R95 had a urinary tract infection (UTI).<br><br>Review of NP 1's Note dated 08/22/2024, revealed the NP ordered rocephin (antibiotic) 1 gram (GM) intramuscularly (injection into a muscle) daily for five days and levaquin (antibiotic) 500 milligram (mg) by mouth daily for seven days.<br><br>Review of R95's MAR revealed on 08/24/2024, the resident refused the antibiotic injections, and refused it again on 08/25/2024 at 11:18 PM. However, continued review of R95's medical record revealed no documented evidence the facility notified the Physician or NP of R95's refusal of the antibiotic injections.<br><br>In interview on 08/26/2024 at 10:48 AM, R95 stated he had been sick to his stomach because of the rocephin injection. The resident stated he had taken the injection on Thursday and Friday nights (08/22/2024 and 08/23/2024) before he realized it was making him sick. He stated he had been sick all day Saturday (08/24/2024) and unable eat. R95 stated he refused the rocephin injection on 08/24/2024 due to the nausea.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Nurse's Progress Notes revealed no documented evidence the facility notified the Physician or NP of R95's complaints of being sick to his stomach or his refusal of the rocephin injection.<br><br>During interview with RN 1 on 08/26/2024 at 3:05 PM, he stated on Sunday night (08/25/2024) the resident refused the shot (injection) because he said it made him sick. RN 1 stated he had not notified the Physician or NP of R95's refusal of the antibiotic injections, nor of the nausea the resident had experienced related to the injections.<br><br>During interview with LPN 3 on 08/27/2024 at 4:38 PM, she stated she was with RN 1 when he gave the rocephin injection to R95. LPN 3 stated she did not notify the doctor or NP of R95's refusal of the antibiotic injections, or of the resident's complaints that the rocephin was making him sick to his stomach.<br><br>During interview on 08/30/2024 at 11:18 AM, the NP stated she was called on 08/22/2024 by the nurse on duty to report R95's urinalysis culture results. She stated she ordered rocephin 1 GM IM daily for five days, and levaquin 500 mg by mouth every day for seven days to treat R95's UTI. The NP stated she had been the provider on call from 08/23/2024 through 08/26/2024, and had not been contacted by anyone from the facility. She stated on Monday, 08/26/2024 she visited R95 and the resident told her the (antibiotic) shot was making him sick. The NP stated staff had not contacted her that R95 had been refusing the antibiotic shot because it was making him sick. She further stated she discontinued the rocephin injection due to the adverse side effects.<br><br>In interview 08/27/2024 at 1:18 PM, the DON stated staff had not reported any issues to her regarding R95 having refused his medications or that the rocephin had made him sick to his stomach.<br><br>In interview 08/27/2024 at 1:18 PM, the Administrator stated R95 had a history of refusing things. She stated the Physician should be notified of a resident's refusal of medication, so an alternate medication could be ordered if needed. |

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| NAME OF PROVIDER OR SUPPLIER Barbourville Health and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 65 Minton Hickory Farm Road Barbourville, KY 40906 | |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49360<br><br>Surveyor [NAME]<br><br>Based on interview, record review, and review of the facility's policy, it was determined the facility failed to report an injury of unknown origin immediately, but not later than two hours after the allegation was made to the facility's Administrator and other officials, including the State Survey Agency and Adult Protective Services (APS) for 1 of 63<br><br>sampled residents, (Resident (R) 274).<br><br>The findings include:<br><br>Review of the facility's policy titled, Abuse, Neglect, Misappropriation and Exploitation Policy revealed all allegations involving suspected abuse, neglect, misappropriation or exploitation including injuries of unknown source or misappropriation of a resident's property were to be reported immediately, but no later than two hours after the allegation was made to the Director of Nursing (DON) and/or Administrator. Continued review revealed the DON, Administrator or Designee were to report such allegations to the appropriate state and federal agencies, including law enforcement, as required.<br><br>Review of R274's Admission Record, revealed on 01/11/2013, the facility admitted the resident with diagnoses of dementia, aphasic, Alzheimer's disease, visual loss; and contractures of the left and right elbow, hand, shoulder, knee.<br><br>Review of R274's Nurse's Note dated 07/08/2022 at 12:30 AM, documented by Registered Nurse 9 (RN 9) revealed the RN was summoned to the resident's room by a Certified Nursing Assistant (CNA). Review further revealed R274 was non-verbal and unable to give any information. RN 9 noted R274 had bruising/discoloration and swelling to the left upper extremity.<br><br>Review of R274's additional Nurse's Notes dated 07/08/2022, revealed no documented evidence the appropriate State Agencies, including law enforcement, were notified of the resident's injury of unknown source.<br><br>Review of R274's emergency department (ED) documentation dated 07/09/2022, revealed the facility had sent the resident to the hospital ED with pain and swelling of the left arm and a yellow discoloration consistent with old bleeding and constant moderate aching/cramping pain to the left shoulder. Per review, R274 was diagnosed with a fracture of the left humerus, and the resident's left upper arm was splinted. Further review revealed x- rays taken revealed an angulated spiral fracture (fracture resembling a corkscrew) of the midshaft of the humerus with mild impaction. In addition, review revealed the hospital notified Adult Protective Services (APS) of R274's injury of unknown origin.<br><br>Review of the State Survey Agency's (SSA's) intake document dated 07/13/2022 at 4:00 PM, revealed the Department of Community Based Services/Adult Protective Services (DCBS-APS) reported the facility had transferred R274 to the hospital ED related to bruising and swelling of his upper left arm. Further review revealed the ED x-rays showed a fracture which the facility was unable to explain.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's investigation, performed by the Administrator and DON, for the incident involving R274 revealed the injury of unknown source was identified on 07/08/2022. Review of the facility's investigation, revealed a witness statement obtained on 07/09/2022, from Certified Nursing Assistant (CNA) 18. Per CNA 18's witness statement she and CNA 19 had been bathing R274 on 07/06/2022, when CNA 19 raised the resident's left arm and heard two pops. Continued review of CNA 18's written statement revealed she notified Licensed Practical Nurse (LPN) 5 after R274's bath was completed on 07/06/2022. However, further review of the facility's investigation revealed no documented evidence R274's injury of unknown source was reported to the appropriate State Agencies.<br><br>In interview on 09/30/2024 at 4:51 PM, the Administrator stated the investigation of the incident involving R274's injury of unknown source was the first investigation for her and the DON since taking their positions. The Administrator stated she had not been sure of the investigation process and at the time there was no one in leadership (Regional consultants) to help her and direct the investigation. She stated she knew R274's injury had been a reportable event but she and the DON had failed to do everything needed for the investigation.<br><br>In interview on 09/30/2024 at 5:00 PM, the DON stated at the time of the investigation involving R274, she and the Administrator were still learning and they failed to get and do everything needed. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49360<br><br>Surveyor: [NAME]<br><br>Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure a thorough investigation was completed for an injury of unknown origin for 1 of 63 sampled residents (Resident (R) 274).<br><br>The facility admitted R274 with contractures of both upper and lower extremities. On 07/06/2022, two Certified Nursing Assistants were bathing R274, when one CNA lifted the resident's left arm and heard two pops. On 07/08/2022, an injury of unknown source was identified; however, the facility's investigation was not initiated until the day after the injury was discovered. In addition, the facility failed to interview all the staff present when the incident occurred.<br><br>The facility transferred R274 to the hospital emergency department (ED). Hospital staff diagnosed R274 with an angulated spiral (corkscrew like fracture) fracture of the midshaft of the left humerus with mild impaction.<br><br>The findings include:<br><br>Review of the facility's policy titled, Abuse, Neglect, Misappropriation and Exploitation Policy revealed all allegations involving suspected abuse, neglect, misappropriation or exploitation including injuries of unknown source were to be reported to the Director of Nursing (DON) and/or Administrator of the facility. Review of the policy revealed if suspected incidents of resident abuse or neglect were reported, the Administrator or DON, were to appoint a representative to investigate the incident. Review of the policy further revealed the investigation was to be thorough and completed in a Resident Abuse Investigation Report Form and an Investigative Summary Report.<br><br>Review of R274's Admission Record documentation revealed the facility admitted the resident on 01/11/2013, with diagnoses that included: contractures of the bilateral left and right: knees, shoulders, elbows, and hands. Continued review revealed additional diagnoses that included Alzheimer's disease, and dementia.<br><br>Review of the facility's, Nurse's Note dated 07/08/2022 at 12:30 AM for R274, documented by Registered Nurse (RN) 9 revealed the RN was summoned to the resident's room by a Certified Nursing Assistant (CNA). Continued review revealed R274 had swelling and bruising/discoloration to the left upper extremity.<br><br>Review of R274's emergency department (ED) documentation dated 07/09/2022, revealed the resident had been diagnosed with an angulated spiral fracture (fracture resembling a corkscrew) of the midshaft of the humerus with mild impaction. Review further revealed the hospital notified Adult Protective Services (APS) of R274's injury of unknown origin.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's investigation documentation, completed by the Administrator and DON, for R274's injury of unknown source revealed the injury had been identified on 07/08/2024. Review revealed no written statement present in the investigation for CNA 20, even though the CNA reported the injury. Continued review of the investigation revealed all the witness statements were undated. Review of the witness statement for CNA 18 dated 07/09/2022, revealed she and CNA 19 were bathing R274 on 07/06/2022, when CNA 19 raised the resident's left arm and heard two pops. Review of CNA 18's written statement revealed the CNA notified Licensed Practical Nurse (LPN) 5 of the incident after R274's bath was completed.<br><br>Further review of the facility's investigation documentation revealed a witness statement for LPN 5 that noted he assessed R274 throughout his shift. Per continued review of LPN 5's statement, he noticed no swelling, bruising, swelling, or change in the resident's condition during his assessments. Further review of the investigation revealed RN 9's witness statement noting CNA 20 requested the nurse assess R274's left arm due to it being swollen and discolored with bruising. Additionally, RN 9's witness statement documented the RN notified the doctor.<br><br>In interview on 09/30/2024 at 5:00 PM, the DON stated she and the Administrator had still been learning at the time of the investigation into R274's injury, and they failed to do everything required.<br><br>In interview on 09/30/2024 at 4:51 PM, the Administrator stated CNA 20 was an agency employee, and the facility did not have contact information for the CNA. She stated the investigation of R274's injury of unknown source was the first investigation she and the DON had completed since taking their positions. Per the Administrator's interview, she had not been sure of the investigation process and there had been no one in leadership (such as the Regional Consultant) at that time to help her and direct the investigation. In further interview she stated she had known R274's injury was a reportable event but they (she and the DON) failed to do everything needed for the investigation. |

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| F 0657<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974<br><br>Based on observation, interview, record review, and review of the facility's policies, the facility failed to have an effective system to ensure care plans were revised to provide necessary interventions for supervision and monitoring for residents to prevent falls/accidents for 8 of 10 sampled residents, (Resident (R)10, R15, R27, R51, R75, R93, R111, and R274).<br><br>The facility failed to thoroughly investigate and evaluate residents' falls by performing root cause analysis (RCA) to determine the root cause of the numerous residents' falls in order to review/revise the residents' care plans to prevent additional falls and injuries for residents. In addition, the facility failed to ensure residents' comprehensive care plans (CCP) were reviewed/revised for each of the residents' falls, and failed to ensure the date was noted when care plan interventions were initiated.<br><br>The findings include:<br><br>Review of the facility's policy titled, Falls Management/Prevention, revised 07/2024, revealed the purpose of the policy was to establish a program to identify residents with risk factors that might place them at risk for falls. Per review, the purpose also included to manage residents who experienced a fall to minimize the risk of a fall recurring or minimize the risk of injury related to a fall. Continued review revealed the facility was to screen all residents to identify possible risk factors that might place a resident at risk for falls. Policy review revealed the facility would additionally screen residents for possible risk factors to evaluate those risks and implement interventions to reduce the risks and observe the interventions and modify as necessary. Further review revealed the facility was to investigate any resident fall to determine the root cause and appropriate interventions were to be put in place to minimize the risk of recurrence and the risk of injury related to a fall. In addition, policy review further revealed the current care plan interventions were to be reviewed and revised or if no care plan was in place, one was to be developed to minimize the risk of recurrence and the risk of injury related to a fall.<br><br>Review of the facility's policy titled, Care Plan Policy & Protocol dated 09/2017 revealed the care plan was to be updated as indicated with changes in condition, physician orders, fall interventions, etc. The policy stated the Kardex was also to be utilized as a guide for nurse aides in providing care on a daily basis and changes would be made when indicated. According to the policy, the Kardex was to reflect person-centered care preferences.<br><br>Review of the facility's Minimum Data Set (MDS) Coordinator job description dated 09/25/2024, revealed the MDS Coordinator was to achieve the organization's goals for positive outcomes by effective processes, monitoring, and training. Further review revealed the MDS Coordinator was to implement systems that lead to appropriate MDS completion and submission, care planning, and accurate reporting of quality measure data.<br><br>1. Review of the facility's, Admission Record for R10 revealed the facility admitted the resident on 08/18/2022, with diagnoses which included unspecified dementia and anxiety.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of the Quarterly MDS Assessment with an Assessment Reference Date (ARD) of 02/20/2024, revealed the facility assessed R10 to have sustained two (2) or more falls since the previous assessment, two (2) falls with injury. Further review revealed the facility also assessed R10 as dependent and needing staff assistance with ambulation, toileting, transfer, and dressing. Further review revealed a Brief Interview for Mental Status (BIMS) score of 99 indicating R10 was unable to complete the assessment.<br><br>Review of the Fall Risk assessment dated [DATE] for R10, revealed a score of 16 noted, which indicated the resident was at high risk for falls. Further review revealed R10 had experienced three (3) or more falls in the past three (3) months; was chairbound, required assist with elimination, and had a balance problem when standing.<br><br>Review of the facility's, Comprehensive Care Plan (CCP) for R10 revealed the facility developed a falls care plan dated 02/22/2024, which noted the resident was at risk for falls related to a history of a falls which resulted in a right hip fracture; falls at home prior to admission; history of dementia, and cognitive loss; forgetting his physical limitations and attempting to get up without staff assistance. Per review, the goal dated 06/16/2024, stated the resident would be protected from falls through the next review date with a target date of 09/18/2024. Continued review of the CCP, revealed 26 interventions documented which were undated. Further review revealed it could not be determined which interventions were in response to a fall. Additionally, it could not be determined if the interventions were implemented prior to a fall or if the care plan interventions were reviewed/revised after each fall.<br><br>Review of the facility's, Health Status Note, dated 02/23/2024 at 4:35 PM, revealed R10 had been found sitting on the floor in his room in front of the doorway facing out into the hall. Continued review revealed R10 had not been wearing footwear and was unable to explain how he fell . Per review, a head-to-toe assessment was completed with pain noted with movement of R10's left leg/hip, and redness and bruising noted to the resident's right outer ankle with no inward/outward rotation noted to the bilateral lower extremities. Further review revealed the facility transferred R10 to the hospital and the resident's representative was notified.<br><br>Review of the Health Status Note for R10 dated 02/23/2024 at 8:12 PM, revealed the Medical Director was notified the resident had been transferred to a local hospital and diagnosed with a fractured left femur.<br><br>Review of R10's hospital, Discharge Summary, dated 02/28/2024, revealed the resident had undergone surgery on the hip on 02/25/2024 for a left hemiarthroplasty (surgery replacing the hip joint ball portion with an artificial surface, leaving the socket intact). The hospital discharged R10 back to the facility.<br><br>Review of the facility's, Fall Incident Report, (FIR) for R10's fall on 02/23/2024, revealed no documented evidence of a root cause analysis (RCA) for the fall, which resulted in the resident's hip fracture. Per review, there was nothing documented related to a RCA performed to determine if R10's current fall interventions had been implemented prior to the fall or to evaluate whether there was a need to modify interventions to prevent recurrence. The review revealed it could not be determined if new CCP interventions were developed for R10 after the 02/23/2024 fall as the CCP interventions were undated; and there was no documentation noting the resident had sustained the fall with injury.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of the facility's, Fall Risk Assessment, dated 02/28/2024 for R10, revealed the resident had a score of 18 indicating R10 was at high risk for falls. Record review revealed R10 was noted as disoriented to person, place, and time at all times. Continued review revealed R10 had sustained three or more falls in the past three months, was chairbound and required assist with elimination. Further review revealed the resident was noted to have a balance problem when standing and walking, and required the use of an assistive device; however, the type of device was not specified.<br><br>Review of the facility's document titled, Incidents by Incident Type, dated 02/28/2024 through 08/28/2024, revealed R10 experienced nine witnessed falls and 10 unwitnessed falls for a total of 19 falls during the six-month timeframe. Further review of the facility's documentation and record review revealed no documented evidence R10's falls were investigated to determine the root cause of the falls. The review revealed no documented evidence the facility revised the resident's CCP interventions in attempts to prevent additional falls/injuries for R10.<br><br>2. Review of R15's, Admission Record revealed the facility admitted the resident on 09/16/2019, with diagnoses including paranoid schizophrenia, history of falls, history of left hip fracture, dementia, and Alzheimer's.<br><br>Review of R15's Quarterly MDS Assessment with an ARD date of 04/12/2024, revealed the facility assessed the resident to have a BIMS score of 99, which indicated R15 was unable to complete the interview. Further review revealed the facility assessed the resident as dependent and to require substantial maximum assist by staff with dressing, ambulating, toileting and transferring.<br><br>Review of R15's Fall Risk Assessment (FRA) dated 01/12/2024, revealed the facility assessed the resident to have a score of 12, indicating a high risk for falls. Further review revealed R15 was at high risk for falls due to: not being ambulatory; chairbound; intermittently confused; and requiring assist with elimination. Further review of the FRA history revealed no documented evidence of a quarterly FRA for R15 having been completed after the 01/12/2024 assessment to identify risks and hazards related to falls.<br><br>Review of the facility's CCP for R15, revealed a care plan for falls initiated 01/16/2024, which noted the resident was at high risk for falls due to her diagnoses of osteoarthritis and osteopenia; medication use; of history of falls, history of left hip fracture; impaired cognition; and requiring total staff assistance to complete activities of daily living (ADLs). Continued review revealed the goal dated 05/09/2024, revealed R15 was to be protected from falls through the next review period with a target date of 11/19/2024. However, R 15 sustained a fall with injury on 04/29/2024. Review further revealed the facility noted 14 interventions which were not dated to specify when the CCP was update/revised.<br><br>3. Review of R111's, Admission Record revealed the facility admitted the resident on 01/22/2024, with diagnoses including muscle weakness, unspecified fracture of the left acetabulum (hip), lack of coordination, and unspecified dementia.<br><br>Review of the facility's FIRs from 03/11/2024 until 08/17/2024, revealed R111 had sustained 16 falls during that time period. Continued review revealed there was no documented evidence the facility conducted fall investigations to determine the root cause of the falls in order to review/revise individualized resident-centered interventions to prevent further falls.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of R111's FIR dated 06/14/2024, revealed the resident sustained a fall and was screaming and saying her hip was killing her. Further review revealed the facility transferred R111 to the emergency room (ER) for evaluation. R111 sustained a right hip fracture with this fall.<br><br>Review of the facility's documentation and record review revealed after R111 returned to the facility there was no documented evidence the facility reviewed/revised the resident's CCP with additional interventions to prevent additional falls. Review further revealed the resident sustained two additional falls on 07/26/2024 and 08/17/2024.<br><br>4. Review of R27's, Admission Record revealed the facility admitted the resident on 06/21/2016, with diagnoses of generalized muscle weakness, spondylosis without myelopathy of lumbar spinal region, other lack of coordination, osteoarthritis, and difficulty in walking.<br><br>Review of R27's, Quarterly MDS Assessment with an ARD of 06/11/2024, revealed the facility assessed R27 as having a BIMS score of 11 out of 15, which indicated moderate cognitive impairment. Continued review of the MDS revealed the facility assessed the resident to require assist with transfer; supervision or touching assist with chair/bed to chair (wheelchair) transfer and toileting; and partial/moderate assistance with shower/bathing care.<br><br>Review of R27's CCP, last reviewed/revised on 08/13/2024, revealed on 03/13/2024, the facility noted the resident was at high risk for injury related to falls. Per review, R27 was at risk for injury from falls due to decreased mobility skills; frequently incontinent of bladder and bowel; edema to bilateral lower extremities, and history of falls at home prior to admission. Continued review revealed the goal stated the resident was to be protected from falls through the next review with a target date of 09/24/2024.<br><br>Review of the care plan interventions dated 07/06/2016 revealed they included: bed in lowest position; transfer resident safely with assist; keep personal items and call light within reach; encourage use of call light when needing assistance as needed; check every two (2) hours and as needed (PRN) for incontinent episodes;. fall risk assessment quarterly and as needed (PRN); and non-skid footwear (shoes or socks).<br><br>Further review of R27's CCP revealed no documented evidence a RCA was completed after the resident sustained falls on 03/25/2024, 05/25/2024, 06/01/2024, and 06/23/2024, in an attempt to review/revise the CCP with interventions to prevent reoccurrence. Additionally, there was no documented evidence the CCP was revised to include interventions related to supervision and monitoring prior to the resident's fall with significant injury resulting in a right hip fracture on 07/31/2024.<br><br>Review of the facility's,Un-witnessed Fall Incident Report dated 06/23/2024 at 2:25 AM for R27, revealed the resident had been found lying on the floor on her back. Continued review revealed R27 was noted to have a skin tear/abrasion to the right and left upper inner arms. Per review, description of the immediate action taken revealed the facility assessed R27 for injuries; and the skin tears were cleansed with normal saline and an aquacel foam dressing was applied to the right and left upper inner arms.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of the facility's, At Risk for Falls CCP for R27, provided on 08/29/2024, revealed a hand-written care plan dated 06/23/2024, to place a bolster on the right side of the resident's bed. However, further review revealed no documented evidence of interventions revised/updated for supervision and monitoring of R27 after the resident's fall on that date, even though the resident had sustained three (3) falls from 03/25/2024 to 06/23/2024.<br><br>Review of the facility's, Un-witnessed Fall Incident Report, dated 07/31/2024 at 5:53 PM, for R27 revealed the resident had been found lying on the floor in her room beside her bed. Per review, the nurse performed a head-to-toe assessment of R27, who was alert. Further review revealed a small skin tear was noted to R27's fourth (4th) finger on her left hand.<br><br>Review of the facility's Provider Progress Note for R27 dated 08/02/2024 at 9:59 AM, revealed the resident sustained a fall from the bed on 07/31/2024. Continued review revealed R27 had been complaining of right leg/hip pain with movement, with the plan to x-ray right hip and pelvis.<br><br>Review of R27's Health Status Note, dated 08/02/2024 at 1:20 PM, revealed the resident complained of pain in her right hip. Further review revealed the physician was made aware with a new order received for x-ray of R27's right hip and leg.<br><br>Review of the X-ray report, dated 08/02/2024 at 5:28 PM revealed R27 had a suspected slight impacted sub capital femoral neck fracture (a type of hip fracture that occurs at the junction of the femoral head and neck).<br><br>Review of the Emergency to Hospital-Admission Discharge Summary, dated 08/08/2024, revealed R27 initially presented from a skilled nursing facility after a fall with an initial trauma scan revealing right femoral neck fracture. Per review, orthopedic surgery was consulted and after discussion with the family and the surgery team, a decision was made to manage the fracture nonoperatively with weight bearing as tolerated and pain control prn (as needed) given baseline bed bound status.<br><br>Review of the facility's, Risk for Falls CCP with an initiated date of 06/12/2024, revealed a hand-written revised fall intervention dated 07/31/2024, to include placing the bed in the lowest position. Continued review of R27's CCP during the survey from 08/25/2024 through 08/30/2024, revealed no further newly documented fall interventions initiated on the resident's CCP related to the resident's recent fall with hip fracture on 07/31/2024. Per review of R27's CCP Risk for Falls on 09/25/2024, revealed an updated intervention dated 08/13/2024, for the resident's bed to be in lowest position with bilateral floor mats.<br><br>Review of the facility's Kardex for R27 revealed a Care Plan Update dated 09/23/2024, with a Problem related to Resident attempts at times to get out of bed without any assistance, with an intervention to have bilateral floor mats. Additionally, continued review of R27's CCP revealed no updated/revised interventions implemented for the hospital discharge recommendations, dated 08/08/2024, regarding the resident's decline in mental status and Activities of Daily Living (ADL) function and change in assistance requirement such as weight bearing status as tolerated, the need for a therapy screen, pain control as needed, and bed bound status.<br><br>Further record review for R27 revealed no documented evidence an updated fall risk assessment was completed after the resident's fall with fracture, to assess for the need to update/revise the resident's CCP.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Barbourville Health and Rehabilitation Center | 65 Minton Hickory Farm Road<br>Barbourville, KY 40906 |

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F 0657

Level of Harm - Actual harm

Residents Affected - Some

In interview with R27's daughter-in-law on 09/25/2024 at 5:35 PM, she stated she and her husband, visited R27 one to two times a week. She stated she just did not feel staff were checking on R27 routinely or like they should due to too many falls experienced by the resident. The daughter-in-law stated on her visits, she had found the resident lying in bed soaked with urine and stool, pouring down her legs. She stated staff had just recently placed the floor mats on the floor by R27's, because the mats had not been there prior to the past weekend. The daughter-in-law stated it would have been nice if the mats had been down when R27 attempted to get up on her own out of bed and fell sustaining a fractured hip.

In interview with R27's Representative on 09/28/2024 at 1:40 PM, he stated the resident had declined in the past year and was now wheelchair bound, too unstable to stand, incontinent of bowel and bladder and required more assistance. He stated staff contacted him over and over about finding R27 lying on the floor, after trying to go to the bathroom on her own. The Representative stated R27 would ring her call bell, but obviously they (staff) were not coming, or not in a sufficient time because the last fall, she broke her hip. He stated he felt if R27 had fallen that many times attempting to get up on her own. The Representative stated staff should have done something sooner for prevention of falls, instead of waiting until after she had another fall with a hip fracture before putting mats on the floor at the resident's bedside.

During an interview with Licensed Practical Nurse (LPN) 4, on 08/29/2024 at 3:31 PM, she stated when R27 sustained the fall she had been caring for the resident. She stated R27 had been attempting to transfer without assistance when she had the fall from the bed and injured her hip resulting in the fracture. The LPN stated staff were aware R27 got up and down by herself at times; although, the resident required assistance. She stated staff could not stop R27 from getting up (on her own) even though they had tried to reeducate her. LPN4 stated, unfortunately, this last fall ended up in a fracture, and the resident was now bedridden.

During interview with Certified Nursing Assistant (CNA) 4, on 08/29/2024 at 2:00 PM, she stated R27 required one (1) person assist when getting out of bed and transferring to a wheelchair. She stated however, before R27's fall with the fracture, she had been able to get up and do for herself and staff checked on the resident at least every two (2) hours.

During continued interview with CNA4, on 08/29/2024 at 2:00 PM, she stated the nurses and Clinical Coordinators (CCs) should review areas that caused the resident's fall, such as with R27 and her trying to get up without assistance, and reaching for her personal need items. CNA4 stated R27 required one (1) assist with staff help when getting up out of bed and with transfer to wheelchair; although, before her fall she was really independent and was able to get up and do for herself. Before, R27 only required assist with bathing, and transfer assist from bed to chair. She stated staff would check on R27 at least every two (2) hours; however, the resident was out of her room a lot in her wheelchair.

During an interview with LPN1, on 08/29/2024 at 2:50 PM, she stated, R27 was usually up in her wheelchair and out and about in the facility. She stated however, since R27's injury (hip fracture), the resident had been more reserved and quieter, and was just giving up and staying in her bed and room a lot more. LPN1 stated before the fall, R27 required two (2) staff to assist with all care areas. She stated the nurses and leadership were responsible for trying to figure out what caused the resident's falls and ensure care plans were updated/revised with interventions that were implemented and effective.

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| F 0657<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | In interview with Minimum Data Set Nurse (MDS) 1 on 09/30/2024 at 9:50 AM, he stated he was not sure as to why interventions were not being reviewed/revised and implemented appropriately. He stated, in reference to R27, the interventions at that time were generalized, not resident specific related to the resident's falls. MDS1 stated he felt there had been a lot of errors, such as important documentation missing from the incident reports, and nurses not initiating immediate interventions after the falls.<br><br>5. Review of R274's, Admission Record revealed the facility admitted the resident on 01/11/2013, with diagnoses of aphasia, anxiety disorder, vision loss, Alzheimer's disease, and dementia. Further review revealed R274 had contractures of the: left and right shoulders, elbows, hands and knees.<br><br>Review of R274's Quarterly MDS with an ARD of 02/23/2022 revealed the resident had a severe vision impairment and was totally dependent on two plus persons for personal hygiene and bathing.<br><br>Review of R274's CCP dated 12/06/2021, revealed no documented evidence the facility updated/revised the care plan for the resident's bathing needs related to the multiple contractures. Additionally, there was no documented evidence the facility ensured interventions were in place to prevent accidents during bathing for R274, even though the resident was severely contracted.<br><br>Review of R274's hospital records dated 07/09/2022, revealed the resident sustained an angulated spiral fracture of the midshaft of the humorous at the facility. Further review revealed that injury was initially identified as an injury of unknown source and later determined to have occurred on 07/06/2022 when staff bathed the resident.<br><br>6. Review of R51's, Admission Record revealed the facility admitted the resident on 02/13/2024, with diagnoses that included: unspecified dementia, anxiety disorder, Parkinson's disease, other lack of coordination, essential tremor, generalized muscle weakness, and unsteadiness on feet.<br><br>Review of the facility's, Quarterly MDS Assessment with an ARD of 08/21/2024 for R51, revealed the facility identified R51 to have had three falls since the previous assessment.<br><br>Review of the facility's incident reports, dated 03/02/2024 through 09/12/2024, for R51 revealed the resident sustained 35 falls during that timeframe without serious injury. Further review revealed the facility failed to evaluate the falls for causal factors and failed to ensure R51's care plans were revised/updated to include individualized resident-centered care plan interventions to prevent falls for the resident.<br><br>Review of the facility's CCP for R51 dated 02/13/2024, revealed the facility identified a care plan for the resident as at risk for falls related to history of falls, age, and diagnosis of Parkinson's disease. Continued review revealed the goal was for R51 to have decreased risk for injury related to unavoidable falls through the next review. However, further review revealed the care plan interventions were not revised/updated with resident-centered interventions. In addition, the care plan review revealed the dates interventions were initiated did not correlate with R51's falls in the facility.<br><br>7. Review of R93's, Admission Record revealed the facility admitted the resident on 11/08/2022, with diagnoses to include anxiety, unspecified dementia, and chronic obstructive pulmonary disease (COPD).<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of the facility's, Quarterly MDS Assessment, dated 07/25/2024, revealed the facility assessed the resident to have a BIMS score of 11 out of 15 indicating the resident had moderate cognitive impairment. Continued review revealed R93 sustained two (2) or more falls since the previous assessment without injury. Further review revealed the facility assessed R93 as independent with chair/bed-to-chair transfer; and as able to ambulate ten (10) feet independently. In addition, the review revealed the facility also assessed R93 to require supervision or touching assistance with transfer to toilet.<br><br>Review of the facility's Fall Incident Reports, dated 06/06/2024 through 09/25/2024 revealed R93 sustained 27 falls in that time period.<br><br>Review of the facility's CCP for R93 revealed the facility initiated a falls care plan on 01/24/2024, for the resident as at risk for falls related to: a history of multiple falls during the reference period and prior to admission; the resident's cognitive impairment and physical limitations and inability to recognize her limitations or risks. Continued review revealed a goal initiated on 07/29/2024, for R93 to be protected from falls through the next review date with a target date of 11/10/2024. Further review revealed an intervention initiated on 08/23/2024, for R93 to be educated on asking for assistance even though the resident was moderately cognitively impaired. Additional review of the care plan revealed no documented evidence the facility revised/updated R93's CCP to include additional interventions to assist in preventing further falls for the resident.<br><br>8. Review of R75's, Admission Record revealed the facility admitted the resident on 06/15/2020, with diagnoses of tremors, Parkinson's disease, and neuropathy.<br><br>Review of the facility's Quarterly MDS with an ARD of 06/10/2024, revealed the facility assessed R75 to have a BIMS score of 15 out of 15, indicating R75 was cognitively intact.<br><br>Review of the facility's, Fall Risk Assessment for R75 dated 01/22/2024, 03/12/2024, 09/04/2024, and 09/10/2024, revealed the facility assessed the resident as at high risk for falls.<br><br>Review of R75's Progress Notes revealed the resident sustained 14 falls from 02/28/2024 through 09/23/2024.<br><br>Review of R75's CCP revealed the facility initiated a focus (care plan) on 03/12/2024 for the resident being at risk for falls. Continued review revealed the goal noted R75 would have a decreased risk for injury related to unavoidable falls. However, review of R75's CCP revealed no documented evidence the facility evaluated the 14 falls for causal factors in order to review/revise the resident's care plan interventions in order to prevent further falls.<br><br>During an interview, on 08/29/2024 at 2:00 PM, with CNA4, she stated each resident had a paper copy of their Kardex, located behind the nurse's station, which was the guide the CNAs used to provide resident care. CNA 4 stated the Kardex was to be reviewed each change of shift during rounds, and the nurses also told the CNAs if there were changes in a resident's care needs. The CNA stated after a resident sustained a fall, the nurse decided on an immediate fall intervention after consulting with other nurses, or a supervisor as needed for the fall intervention. CNA 4 stated residents' fall interventions were updated every day by the Clinical Coordinators (CCs) and the MDS Nurses added them to the CNAs' Kardex.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During an interview, on 08/29/2024 at 2:50 PM, with Licensed Practical Nurse (LPN) 1, she stated during the day, the CC, and the Director of Nursing (DON) were notified of any resident falls. She stated that after hours, the on-call supervisor was notified of the falls. LPN1 stated after a resident sustained a fall, she attempted to find out what the resident had been doing prior to the fall and reviewed the Kardex to see what interventions were already in place. She stated she then attempted to update/revise the resident's care plan and initiate a new immediate fall intervention. The LPN stated she added the new intervention to the incident report, which was completed for each fall. Per LPN 1's interview, the CC and DON then completed their part of the incident report after they determined the root cause of the fall and checked if the new intervention was appropriate and made changes/revisions if needed. She further stated sometimes one on one (1:1) supervision was needed for residents with a lot of falls, and she felt like there was enough staff to do that in order to provide closer monitoring.<br><br>During an interview on 08/29/2024 at 3:58 PM with the Clinical Coordinator (CC) 1, she stated she was in charge of the 100 Unit. She stated when a resident sustained a fall, she determined the cause of the fall, implemented an intervention to prevent recurrence, and updated the resident's care plan and Kardex with the new intervention. CC1 stated she also assessed the effectiveness of the new intervention. She stated if a resident had frequent falls, increased confusion, or increased behaviors, that might call for increased supervision. Per the CC's interview, in that case, there would be a need for a Physician's Order and that intervention would be added to the resident's CCP and Kardex. She stated all care plan interventions for residents should be dated in order to identify which interventions were added after which fall.<br><br>During an interview, on 08/30/2024 at 9:06 AM, with CC2, who was over the 200 unit, she stated when a resident sustained a fall, the CC or on-call supervisor collaborated with the nurse completing the incident report to decide on an immediate appropriate intervention. She stated all falls were then discussed during the Monday through Friday morning clinical meetings with the interdisciplinary team (IDT). CC2 stated during the morning meetings they discussed residents who experienced frequent falls, their care plans, the falls policy and fall interventions and revised residents' care plans as needed.<br><br>During an interview on 08/30/2024 at 9:30 AM with the MDS Nurse, he stated he completed residents' MDS Assessments on admission, annually, quarterly and with a significant change. He stated he developed or revised care plan interventions with the MDS Assessments. The MDS Nurse stated the facility worked together as an IDT related to revising residents' care plan interventions related to falls. He further stated staff were made aware of new fall interventions verbally by the CCs after the care plans were updated during the morning clinical meeting.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During an interview, on 08/29/2024 at 4:40 PM, with the DON, she stated after a resident's fall, the nurse caring for the resident was to complete a Fall Incident Report. She stated the nurse was to include the details of the fall, the cause of the fall, and the immediate intervention to prevent recurrence on the Fall Incident Report. The DON stated the Fall Incident Reports were reviewed by the CCs. She stated residents' CCP should be revised with appropriate interventions related to the root cause of a fall to prevent recurrence. The DON stated all leadership was involved in the discussion of falls during daily weekday clinical meetings and during monthly Quality Assurance (QA) meetings. Per the DON in interview, she stated she did believe some of the residents' falls could be prevented if the residents had 1:1 supervision and monitoring. She stated however, the facility just did not have the staff for that, as staffing was difficult to secure. During the interview related to interventi [TRUNCATED] |

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F 0689

Level of Harm - Actual harm

Residents Affected - Some

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974

Based on observation, interview, record review and review of the facility's policies, the facility failed to have an effective system to ensure adequate supervision and monitoring to prevent falls/accidents for eight (8) of ten (10) sampled residents reviewed for falls/accidents, Resident (R)10, R15, R27, R51, R75, R93, R111, and R274.

The facility had a total of 346 falls during the six (6) month time period from 02/28/2024 to 08/28/2024, and an additional 26 falls from 08/29/2024 to 09/25/2024. However, the facility failed to thoroughly investigate and evaluate the falls to determine the root cause of each fall; and, failed to develop individualized care plan interventions to prevent further falls/injuries for each resident.

The findings include:

Review of the facility's policy titled, Falls Management/Prevention, revised 07/2024, revealed the purpose of the policy was to establish a program to identify residents with risk factors that might place them at risk for falls. Policy review revealed its purpose also included establishing a program for managing those residents who experienced a fall to minimize the risk of a fall recurring or minimize the risk of injury related to a fall. Continued review revealed all residents were to be screened to identify possible risk factors that might place them at risk for falls. Per policy review, the facility was to evaluate those risks and implement interventions to reduce the risks, observe the interventions and modify the intervention as necessary.

Continued review of the Falls Management/Prevention, policy, revised 07/2024, revealed the facility was to investigate any resident fall to determine the root cause and put appropriate interventions in place to minimize the risk of recurrence and risk of injury related to a fall. Policy review revealed the facility was to complete a fall risk assessment for each resident on admission/readmission, quarterly and with any significant change. The policy review revealed upon completion of the risk assessments a plan was to be developed to address any risk factors identified. Further review revealed the facility was to notify the Physician and resident's representative when a fall occurred; complete an incident report; and complete a fall risk assessment of the resident every shift for 72 hours. The review revealed the current care plan interventions were to be reviewed/revised or if no plan of care was in place, one was to be developed to minimize the risk of recurrence and risk of injury related to a fall. In addition, tracking and trending was to occur for all falls.

Review of the facility's policy titled, Falls Prevention Program, revised 07/2024, revealed its purpose was to allow residents to be mobile safely. Per review of the policy section titled, After High-Risk Residents Are Identified, revealed the facility was required to implement or modify safety measures and refer the resident to occupational or physical therapy for evaluation as indicated.

1. Review of R10's Admission Record revealed the facility admitted the resident on 08/18/2022, with diagnoses which included unspecified dementia, and anxiety.

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of Rl0's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 02/20/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 99 indicating the resident was unable to complete the interview. Further review revealed the facility assessed Rl0 as having sustained two (2) or more falls since the previous assessment, two (2) with injury. Further review revealed the facility assessed R10 as dependent and as needing staff assistance with ambulation, toileting, transfer and dressing.<br><br>Review of Rl0's Fall Risk Assessment (FRA) dated 02/20/2024, revealed a score of 16, indicating the resident was at high risk for falls. Further review revealed R10 was intermittently confused, was chairbound, and required assist with elimination. In addition, the facility assessed the resident to have a balance problem when standing and to have had three (3) or more falls in the past three (3) months.<br><br>Review of the facility's Comprehensive Care Plan (CCP) revealed a care plan for falls dated 02/22/2024, related to the resident being at risk for falls due to having falls prior to admission, history of a fall resulting in a right hip fracture, dementia, forgetting his physical limitations, and attempting to get up without staff assistance. Per review, the goal dated 06/16/2024, stated R10 was to be protected from falls through the next review date with a target date of 09/18/2024. Continued review revealed interventions which included fall mats at bedside and a low rise chair. Further review revealed 26 interventions were in place on R10's care plan; however, it could not be determined which intervention were in response to which of the resident's falls. Additionally, review also revealed it could not be determined if interventions were implemented prior to the resident's fall or if the interventions were reviewed/revised after each fall.<br><br>Review of R10's Health Status Note dated 02/23/2024 at 4:35 PM, revealed the resident had been found sitting on the floor of his room in front of the doorway with his bed noted in the lowest position with the fall mat in place. Per review, Rl0 had not been wearing footwear and had been unable to explain how he fell . Continued review revealed a head-to-toe assessment was completed with redness and bruising noted to Rl0's right outer ankle with no inward or outward rotation noted to the bilateral lower extremities. Further review revealed R10 was noted to have pain on movement of his left leg/hip.<br><br>Review of the facility's Fall Incident Report, for the fall R10 sustained on 02/23/2024 fall, revealed no documented evidence the facility performed a root cause analysis (RCA) in order to evaluate whether the current fall interventions were implemented prior to the fall or to evaluate the need to modify interventions to prevent recurrence. Further review revealed it could not be determined if new fall interventions were implemented for the fall as R10's fall care plan interventions were not dated, and there was nothing noted indicating the resident sustained the fall with injury.<br><br>Review of R10's Health Status Note dated 02/23/2024 at 4:57 PM, revealed the resident was leaving the facility via stretcher with Emergency Medical Services (EMS) to the hospital emergency department (ED). Continued review revealed R10's representative was notified of the fall and transfer to the ED.<br><br>Review of R10's Health Status Note dated 02/23/2024 at 8:12 PM, revealed the Medical Director was notified the resident had been transferred to a local hospital and diagnosed with a fractured left femur.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of R10's hospital Discharge Summary dated 02/28/2024, revealed the resident had undergone hip surgery on 02/25/2024, for a left hemiarthroplasty (surgical procedure to replace the ball portion of the hip joint with an artificial surface, while leaving the socket intact). Further review revealed R10 was being discharged back to the facility.<br><br>Review of R10's Health Status Note at the facility dated 02/28/2024 at 6:08 PM, revealed the resident returned to the facility with sutures and a dressing in place to the left hip surgical site. Further review revealed R10 had a therapy evaluation ordered for getting out of the bed into the chair.<br><br>Review of the facility's Fall Risk assessment dated [DATE] for R10, revealed the resident scored 18 indicating R10 was at high risk for falls. Per review, R10 was disoriented times three (to person, place, and time) at all times and had sustained three (3) or more falls in the past three (3) months. Further review revealed R10 was chairbound and required assistance with elimination; had a balance problem while standing/walking; and required the use of an assistive device (type of device was not specified on the Assessment).<br><br>Review of the facility document titled, Incidents by Incident Type for the time period of 02/28/2024 through 08/28/2024, revealed R10 sustained nine (9) witnessed falls and ten (10) unwitnessed falls for a total of 19 falls during that six (6) month timeframe. Per review of the document, the falls occurred on the following dates: 04/25/2024; 05/07/2024; 05/09/2024; 05/20/2024; 05/29/2024; 06/07/2024; 06/16/2024; 06/21/2024; 07/18/2024; 07/18/2024; 07/24/2024; two falls on 07/28/2024; 07/31/2024; 08/01/2024; 08/04/2024; 08/12/2024; 08/15/2024; and 08/20/2024. 06/21/2024,07/18/2024,07/24/2024, 07/27/2024, 2 falls on 07/28/2024,07/31/2024,08/01/2024,08/04/2024, 08/12/2024,08/15/2024, and 08/20/2024. The facility provided Facility Incident Reports (FIRs) for all of R10's falls listed above. However, review of the facility's documentation and review of R10's medical record revealed no documented evidence the facility performed RCA for all the resident's falls in order to evaluate if fall interventions had been implemented or to evaluate the need to modify interventions to prevent recurrence. Additionally, review revealed it could not be determined if there were new fall interventions implemented for the falls as the falls care plan interventions were undated.<br><br>Observation on 08/25/2024 at 12:00 PM, revealed R10 sitting up on the bed being assisted with the lunch meal by an aide. Continued observation revealed no visual evidence fall mats or a low rise chair were at R10's bedside, as per the resident's care plan.<br><br>Observation on 08/26/24 at 10:40 AM, revealed R10 was lying on the bed on his right side with knees drawn up. The resident did not respond to the State Survey Agency (SSA) Surveyor's greeting or questions. Further observation revealed no fall mats or low rise chair were visible at R10's bedside (as per the resident's care plan).<br><br>In interview on 09/25/2024 at 2:47 PM, and review of R10's falls, with MDS Nurse 1, he stated there was not enough information on the FIRs to determine if the care plan interventions in place for the resident at the time of each fall were being implemented. He stated there was also not enough information determine whether the care plan interventions had been reviewed prior to determining if a new fall intervention was needed. MDS Nurse 1 stated in effort to reduce the number of falls and decide on appropriate fall intervention for any resident, the fall interventions in place at the time of the fall, should be reviewed to decide if they were effective or not.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Barbourville Health and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 65 Minton Hickory Farm Road Barbourville, KY 40906 | |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | 2. Review of the facility's Admission Record for R15 revealed the facility admitted the resident on 09/16/2019, with diagnoses including dementia, Alzheimer's, paranoid schizophrenia, history of falls, osteoarthritis, osteopenia, history of left hip fracture, history of cerebrovascular accident, and lack of coordination.<br><br>Review of the facility's Quarterly MDS Assessment with an ARD date of 04/12/2024, revealed the facility assessed R15 as having a BIMS of 99, indicating the resident was unable to complete the interview. Further review revealed the facility also assessed R15 as dependent and needing substantial maximum assistance of staff with ambulation, toileting, transfer, and dressing.<br><br>Review of the facility's Fall Risk assessment dated [DATE] for R15, revealed a score of 12, indicating the resident was at high risk for falls. Per review, the criteria for R15 being at high risk for falls included: being intermittently confused; being chairbound and requiring assist with elimination; and not being ambulatory.<br><br>Review of the facility's Fall Risk Assessment (FRA) history noted for R15 revealed no documented evidence of a quarterly FRA completed after the 01/12/2024 assessment, as required per facility policy, to identify risks and hazards related to falls.<br><br>Review of the Comprehensive Care Plan (CCP) for R15 revealed the facility care planned the resident for falls, (with an initial date of 01/16/2024). Continued review revealed R15 was at high risk for falls due to her diagnoses of history of falls, history of left hip fracture, history of cerebrovascular accident, medication use, impaired cognition, and requiring total staff assistance to complete activities of daily living. Per review, the goal dated 05/09/2024, revealed R15 was to be protected from falls through the next review period with a target date of 11/19/2024. Further review of the falls care plan revealed 14 interventions in place which were undated. Further review of R15's care plan initiated on 01/16/2024, revealed the interventions referenced the call light being within the resident's reach twice.<br><br>Record review revealed on 04/29/2024, R15 sustained a fall which resulted in a closed comminuted left humeral fracture. However, there was no documented evidence the facility investigated the incident to determine the root cause of the fall.<br><br>Review of the facility's Incident Note with an effective date of 04/30/2024 at 7:08 PM for R15, documented by Registered Nurse (RN) 6, revealed she had been called into the resident's room by the 200-unit Supervisor and an (unidentified) Certified Nursing Assistant (CNA) informed her R15's arm needed to be assessed. Per review, upon arrival to R15's room, RN 6 observed the resident lying on her back on the fall mat next to the bed. Continued review revealed R15 moaned and verbalized profanity when her arm was touched, with calming measures provided during the assessment. Further review revealed R15 had redness and swelling noted at the shoulder area which was warm to the touch, with a smaller discolored area noted to the inner shoulder area. Review further revealed R15 was noted to have redness without swelling above and inside the antecubital area. In addition, review revealed an order was obtained to transfer R15 to the local ED for further evaluation, and the resident was transferred to the hospital.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of R15's Health Status Note with an effective date of 04/30/2024 at 9:50 PM (created as a late entry note), documented by RN 1, revealed on 04/29/2024 at 10:00 PM, he was approached by a CNA and was informed R15 was lying on the floor. Per review, RN1 documented Licensed Practical Nurse (LPN) 2 went to R15's room where the resident was lying on her back next to her bed on the fall mat. Continued review revealed staff assessed R15 head-to-toe for injury and none were found, and the resident was assisted back to bed. Further review revealed R15 had no complaints of pain or discomfort, and the bed was placed in the lowest position with the call bell within reach.<br><br>Review of R15's hospital Nursing assessment dated [DATE], revealed the resident was assessed as: alert and disoriented to person, place, and time; cognitively impaired; combative; agitated and physically aggressive. Continued review revealed the skin to R15's left upper extremity was assessed as bruised and swollen. Further review revealed R15 got her arm tangled up in bed sheets and had a spiral humeral fracture (a bone break occurring from a twisting injury) which was comminuted (a bone broken into three or more pieces) and displaced.<br><br>RN1 stated in interview, on 08/26/2024 at 3:06 PM, the night R15 fell (04/29/2024) a CNA (he could not recall which CNA) informed him and LPN2 the resident had sustained a fall. He stated LPN 2 assessed R15 for him and informed him the resident had no injuries and no pain and seemed alright. RN1 stated when he passed R15's at 6:00 AM on 04/30/2024, he did not notice anything out of the ordinary with the resident. He stated he was the nurse assigned to R15 that evening (04/29/2024) and had not been aware of any injury to the resident until the next day when he returned to work. The RN stated due to poor communication between himself and LPN2 they failed to notify R15's doctor, and responsible party (RP). He further stated they also failed to document R15's fall in the progress notes, fill out an incident form, and notify the oncoming shift of the resident's fall.<br><br>Review of the facility's Long-Term Care Facility-Self-Reported Incident Form, completed by the Administrator, revealed that R15 had been sent to the hospital for bruising and swelling of the left upper extremity on 04/30/2024 at 1:00 PM. Continued review revealed the hospital x-ray identified a fracture of the resident's left humerus. Per review, the injury was reported to the Department of Community Based Services (DCBS) on 04/30/2024 at 3:43 PM, as an injury of unknown origin. Further review revealed the cause of the injury was not identified until 04/30/2024, when the midnight shift staff arrived and reported R15 had sustained a fall on 04/29/2024 at 10:00 PM. In addition, the Administrator noted due to miscommunication between RN1 and LPN2 they failed to: complete the incident report; failed to notify the Medical Director and resident's Guardian; and failed to report the fall to the oncoming shift.<br><br>Review of the facility's, Interdisciplinary Meeting dated 05/02/2024, labeled as the Root Cause Analysis (RCA) for R15, revealed no documented evidence of the root cause of the resident's fall. Per review, it was noted R15 required a shower on 04/29/2024 after a bowel movement for hygienic reasons between 7:30 PM to 8:30 PM. Continued review revealed the Interdisciplinary Team (IDT) addressed R15's preference for morning showers and that the resident became more agitated as the day progressed. However, further review revealed no documentation of any behaviors by R15 that preceded the fall. Additional review revealed R15's CCP was to be updated to show her morning (AM) shower preference and that her bed should be in the lowest position with no side rails.<br><br>Observation of R15 on 09/26/2024 at 8:56 AM, revealed the resident lying on her bed with the call light placed on the recliner out of the resident's reach. At the time of observation, R15 stated she was looking for the white thing wrapped in tape that made people come.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | An additional observation of R15 on 09/26/2024 at 7:05 PM, revealed R15 lying on her bed with the call light out of the resident's reach in the recliner.<br><br>In interview with the Quality Nurse/Staff Development Coordinator/Infection Prevention Nurse (QN/SDC/IP), on 08/29/2024 at 1:00 PM, she stated it was the facility's expectation for all falls to be reported to the on-call Supervisor, the resident's representative, and the Nurse Practitioner (NP).<br><br>In interview on 08/30/2024 at 8:49 AM, the Director of Nursing (DON) stated RN1 and LPN2 should have clarified who was going to complete the fall investigation and notification to the provider and the resident's responsible party. She stated the two nurses thought the other one had reported the fall to the (medical) provider and the resident's representative. Per the DON's interview, it was the facility's policy and expectation for all resident falls to be reported to the NP, resident's representative, and the supervisor, and for an incident report to be completed. She further stated LPN2 and RN1 were re-educated on notifying the provider and the resident's responsible party, as well as completing the necessary documentation after a resident's fall.<br><br>In interview on 08/30/2024 at 10:00 AM, the Administrator stated it was the facility's policy and expectation for all resident falls to have an incident report completed.<br><br>In interview on 08/30/2024 at 11:18 AM, the NP stated she was in the facility five days a week to assess residents for acute issues or complaints, and post falls. She stated she was (first) notified of R15's fall on 04/30/2024 when she arrived at the facility. The NP further stated when any resident fell , the (medical) provider on call should be notified immediately.<br><br>In interview on 09/26/2024 at 9:18 AM, RN7 stated call lights should be placed within a resident's reach to ensure the resident could make their needs known to staff. The RN stated that prevented a resident from attempting a task alone that could lead to an injury.<br><br>3. Review of the facility's, Admission Record for R111 revealed the facility admitted the resident on 01/22/2024, with diagnoses including unspecified fracture of the left acetabulum (hip), unspecified dementia, muscle weakness, and lack of coordination.<br><br>Review of the facility's Quarterly MDS with an ARD of 04/30/2024 for R111, revealed the facility assessed the resident to have a BIMS score of five, which indicated the resident had severe cognitive impairment. Continued review of the MDS revealed the facility also assessed R111 to have had two or more falls since the previous assessment and was dependent on maximum staff assistance with ambulation, transfers, toileting, and dressing.<br><br>Review of the facility's Fall Risk assessment dated [DATE] for R111, revealed a score of 15 which indicated the resident was a high fall risk. Continued review of the Assessment revealed the facility also assessed R111: to have intermittent confusion with one to two falls in the past three months; as ambulatory; to have incontinence; and to require the use of an assistive device.<br><br>Review of the facility's Fall Risk Assessment for R111 dated 03/30/2024, revealed the document was marked incomplete and the resident's risks and hazards related to falls were not identified. Per record review, prior to the 03/30/2024 Fall Risk Assessment, R111 had sustained four falls: one on 03/11/2024, which resulted in a knot on the back of the resident's head; one on 03/14/2024, which resulted in no injury; and two falls on 03/16/2024 with no injuries.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of the facility's CCP initiated on 01/23/2024, revealed the facility care planned R111 as at risk for falls related to a history of falls, impaired cognition, decreased physical mobility, incontinent of bowel and bladder, and history of fractures. Per review, the goal was for R111 to be protected from falls through the next review date of 05/09/2024. Continued review revealed interventions that included a pommel cushion (a specialized cushion to promote proper positioning), dycem (a non-slip material), and anti-tippers to R111's wheelchair; and side rails up; bolsters to the bed with the bed in the lowest position; fall mats in place beside the bed; and green tape to the call light which was to be within reach. Further review revealed R111's interventions were not resident-centered and the dates the interventions were initiated did not correlate with the falls the resident sustained in the facility.<br><br>Review of the facility's document titled, Incidents by Incident Type, dated 02/28/2024 through 08/28/2024, revealed R111 sustained two witnessed falls and 14 unwitnessed falls for a total of 16 falls during that time period.<br><br>Review of the facility incident reports (FIRs) dated 03/11/2024, 03/14/2024, 03/16/2024, 04/14/2024, 04/26/2024, 04/30/2024, 05/28/2024, 05/09/2024, 05/12/2024, 05/19/2024, 05/23/2024, 06/09/2024, revealed R111 sustained falls without serious injury while in the facility. Further review revealed no evidence the facility determined the root cause of the resident's falls or developed individualized care plan interventions for R111 to prevent additional falls/injury to the resident.<br><br>Review of the facility's FIR dated 06/14/2024, revealed R111 had sustained an unwitnessed fall in her room. Further review revealed R111 was screaming and saying her hip was killing her. Additional review revealed R111 was sent to the emergency room (ER) for evaluation.<br><br>Review of the facility's, Health Status Note for R111 dated 06/14/2024 at 7:05 AM, revealed the resident screamed every time she tried to move her hip and the resident's right foot had an outward rotation. Continued review revealed R111 was observed holding the front area of her hip screaming with pain. Per review, the Physician on call was made aware of R111's pain with new orders received to send the resident to the ED for evaluation of her right hip and leg. EMS was notified to transport R111 to the ED for evaluation and report was given to the ED.<br><br>Review of R111's hospital Discharge Summary dated 06/21/2024, revealed the resident had an readmitted [DATE] for a right hip fracture with an open reduction and internal fixation repair on 06/16/2024. Continued review revealed R111 was cleared for discharge back to the facility with weight bearing as tolerated to her right lower extremity and dressing changes as ordered.<br><br>Additional review of R111's CCP revealed there was no documented evidence the facility determined the cause of the resident's fall on 06/14/2024 and no evidence of new interventions implemented to prevent falls for the resident.<br><br>Review of the FIRs dated 07/26/2024 and 08/17/2024, revealed R111 had sustained additional unwitnessed falls in the facility. Further review revealed there was no documented evidence the facility determined the cause of R111's falls or implemented individualized care plan interventions to prevent further falls for the resident.<br><br>Observation of R111 on 08/26/2024 at 1:35 PM and on 08/27/2024 at 10:00 AM, revealed the resident sitting up in a wheelchair.<br><br>(continued on next page) |

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F 0689

Level of Harm - Actual harm

Residents Affected - Some

Observations of R111 on 09/25/2024 at 12:34 PM; 09/26/2024 at 9:00 AM; and on 09/27/2024 at 8:50 AM However, further observation revealed no pommel cushion was observed in R111's wheelchair.

Observation of R111 on 09/30/2024 at 8:45 AM, revealed the resident lying on the bed with family at bedside. Further observation revealed dycem in R111's wheelchair, but no pommel cushion was on the wheelchair seat.

In interview on 09/25/2024 at 12:34 PM with R111, revealed she knew she had fallen and broken her hip, but could not remember when she had fallen. R111 stated she had learned' her lesson and knew to ask for help before getting up out of the wheelchair.

In interview with Family Member (FM) 5 on 09/26/2024 at 12:33 PM, she stated she was aware of R111's issue with falling as the resident had fallen at home and that's why we brought her here. FM 5 stated R111 had fallen at home and fractured her pelvis and left hip before coming to the nursing facility. She stated she was not sure about the facility staffing being an issue, but stated she had seen fewer staff members on weekends compared to staff on the weekdays. The FM further stated she was aware call lights took longer to be answered by staff on the weekends.

In interview with Clinical Coordinator (CC) 1 on 09/26/2024 at 3:12 PM, she stated she had been the CC for about nine months and was aware R111 had sustained multiple falls. CC1 stated scheduled toileting, call light within reach, and bed in lowest position were routine interventions for all residents, so those interventions would not be considered individualized. She stated most of R111's interventions were not effective as the resident had multiple falls and looking back now, she saw the same interventions being put in place with no real evaluation of the effectiveness of those interventions. CC1 stated the incident reports were changed after the State Survey Agency (SSA) Surveyors left the facility the last time as we realized you can't prevent future falls if you don't know what happened before. CC1 also stated performing the root cause analysis for all falls was not put in place by the facility until September 2024.

4. Review of R27's admission record revealed the facility admitted the resident on 06/21/2016, with diagnoses that included a history of falls prior to admission, spondylosis without myelopathy of lumbar spinal region, generalized muscle weakness, difficulty in walking, and osteoarthritis.

Review of the facility's Fall Risk Assessments for R27 dated 02/02/2024 at 3:20 PM, and 03/11/2024 at 1:32 PM, revealed the facility assessed the resident as a high risk for falls.

Review of the Quarterly MDS Assessment with an ARD of 06/11/2024 for R27, revealed the facility assessed the resident as having a BIMS score of 11 out of 15, which indicated moderate cognitive impairment. Continued review of the MDS assessment specific to behaviors revealed R27 had a history of rummaging. Per review, the facility assessed R27 to require supervision/touching assist with chair/bed to chair (wheelchair) transfer, and toileting related to incontinence of bowel and bladder; and moderate assist with shower/bathing care. In addition, review of the MDS fall history assessment for R27, since admission, revealed one fall with no injury. However, review of the facility's fall incident reports revealed R27 sustained a total of three falls from admission through the assessment date of 06/11/2024.

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of R27's CCP revealed on 03/13/2024 staff identified the resident as at high risk for injury related to falls. Review of R27's care plan, revealed the care plan was not fully developed with individualized, resident specific interventions to prevent reoccurrence of the multiple falls the resident encountered related to self-transfers and falling out of bed. In addition, there was no documented evidence an RCA had been performed in order to evaluate if interventions were implemented prior to a fall or reviewed/revised after a fall.<br><br>Review of the facility's Fall Incident Reports, dated 03/25/2024,05/25/2024, 06/01/2024, and 06/23/2024 revealed the resident sustained falls in the facility without serious injuries. However, review further revealed no documented evidence the facility thoroughly investigated the falls to determine the root cause of R27's falls, nor that individualized care plan interventions were developed/implemented to prevent further falls for the resident.<br><br>Review of the Provider Progress Note dated 08/02/2024 at 9:59 AM for R27, revealed the resident had sustained a fall from the bed on 07/31/2024, with complaints of right leg/hip pain with movement.<br><br>Review of the facility's Health Status Note dated 08/02/2024 at 1:20 PM for R27, revealed the resident complaining of pain in the right hip. Continued review revealed the Physician was made aware with a new order for x-ray of R27's right hip and leg.<br><br>Review of the Express Mobile Diagnostic Services x-ray report dated 08/02/2024 at 5:28 PM, revealed R 27 had an impacted sub-capital femoral neck fracture (a type of hip fracture that occurs at the junction of the femoral head and neck).<br><br>Review of the Emergency to Hospital-Admission Discharge Summary dated 08/08/2024 for R27, revealed the resident presented initially with a fall from the skilled nursing facility with a right femoral neck fracture. Per review of the Summary, Orthopedic Surgery was consulted and after discussion with the surgery team and family a decision was made to manage the fracture nonoperatively with weight bearing as tolerated and pain control PRN (as needed).<br><br>Review of R27's CCP Risk for Falls with an initiated date of 06/12/2024, revealed a revised fall intervention (hand-written) dated 07/31/2024, to have the bed in the lowest position. Continued review revealed there were no additional newly documented fall interventions initiated for R27 after the fall with a hip fracture on 07/31/2024. Per review, there were no new interventions related to R27's hospital discharge recommendations, dated 08/08/2024, in regards to R27's decline in mental status, and Activities of Daily Living (ADL) function or change in assistance requirement. Furthermore, there was no documented evidence an updated fall risk assessment was completed after R27's fall with fracture.<br><br>During interview with R27 on 09/25/2024 at 12:40 PM, she stated the only problem she had was that the aides just took their time, no hurry getting to you. R27 stated she could use the call light, but the aides would only come when they wanted too, so she would took herself to the bathroom. She stated she could recall a little about her falls. R27 stated, they were slow about taking me to the bathroom and my tail hit the floor and I broke my hip.<br><br>During interview with R27's daughter-in-law on 09/25/2024 at 5:35 PM, she stated she and her husband visited the resident one to two times a week. She stated she just did not feel the staff were checking on R27 routinely or like they should because the resident had experienced too man [TRUNCATED] |

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| F 0835<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>46651<br><br>Based on observation, interview, and record review, the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for the management of falls for five of ten sampled residents, (Residents (R)10, R15, R93, R111, and R274).<br><br>Review of the facility's document titled, Incidents by Incident Type, dated 02/28/2024 through 08/28/2024 revealed the facility noted 44 witnessed falls and 302 unwitnessed falls for a total of 346 fall during that six month time period. Further review revealed 42 of the 346 falls had an injury noted.<br><br>However, the facility's administration failed to evaluate the falls through Root Cause Analysis (RCA) to determine the cause of the falls in order to review/revise the residents' comprehensive care plans with interventions to assist in prevention of further falls or to prevent further injuries from falls. Refer to F689 and F657.<br><br>The findings include:<br><br>Review of the facility's, Job Description-Administrator, on page four (4) under the Miscellaneous Section revealed the Administrator was to assure all residents received care in a manner and an environment that maintained or enhanced their quality of life. Continued review revealed the Administrator would also serve on the Quality Assurance and Assessment Committee as directed. Further review revealed the Administrator additionally was to assure each resident received the necessary nursing, medical and psycho-social services to attain and maintain the highest possible mental and physical functional status as defined by their comprehensive assessment and care p<br><br>On 02/23/2024, R10 sustained a fall which resulted in a fractured left femur and subsequent surgery to replace the femoral head with a prosthesis on 02/25/2024. From 04/25/2024 through 08/20/2024, R10 sustained 19 more falls with no documented evidence the facility investigated to determine the root cause of the falls.<br><br>On 04/30/2024, R15 sustained a fall which resulted in a closed comminuted (a bone breaking in pieces) left humeral fracture with no documented evidence a root cause analysis was conducted for the fall.<br><br>On 06/24/2024, R111 sustained a fall which resulted in a fracture of the right hip. From 03/11/2024 through 08/17/2024, R111 experienced a total of sixteen (16) falls with no documented evidence the facility determined the root cause of the falls.<br><br>On 07/09/2024, R274 was diagnosed with a fracture of the left humerus with no documented evidence a root cause analysis was conducted to determine the cause of the injury.<br><br>R93 sustained 18 falls from 06/06/2024 through 8/25/2024, with no documented evidence root cause analysis was conducted for the falls.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Barbourville Health and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 65 Minton Hickory Farm Road Barbourville, KY 40906 | |

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| F 0835<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | In interview on 08/29/2024 at 2:50 PM with Licensed Practical Nurse (LPN) 1 she stated she had worked at the facility for eight years and usually worked on the 200 unit. LPN1 stated she felt the facility's nursing staff and leadership could not identify the missing link that would solve the falls problem.<br><br>In interview on 08/29/2024 at 3:31 PM with LPN 4 she stated she had worked at the facility for a year and a half. LPN 4 stated she thought there were four to five falls a day at the facility; however, she did not think that (number) was alarming.<br><br>In interview on 08/30/2024 at 9:30 AM with the MDS Nurse, he stated he had been in his role since May/2024. He stated he was not sure of the number of facility falls for the past six months. The MDS Nurse further stated he would have to find out who the person responsible for tracking and trending of the falls.<br><br>In interview on 08/29/2024 at 1:00 PM with the Quality Nurse/Staff Development Coordinator/Infection Prevention Nurse (QN/SDC/IP) she stated she attended the facility's QAPI meetings and quarterly met with the team and falls were addressed (at those meetings). The QN/SDC/IP stated she did not know how many resident falls had occurred in the facility in the past six months. Per the QN/SDC/IP, the Administrator did the tracking and trending of falls.<br><br>In interview on 08/30/2024 at 11:18 AM with the NP, she stated she had worked at the facility for almost two years, and was in the facility five days a week. Per the NP, she was notified of a resident's fall if it happened during her on call week, which was once every six weeks. She stated she attended the facility's IDT meetings, but was not a part of any discussion on falls. She stated she had never been in an IDT where repeated falls for residents was discussed. She stated she had never been invited to a discussion about falls.<br><br>In interview on 08/29/2024 at 4:40 PM with the DON, she stated she had been in her role for two and a half years. She stated the fall incident report was completed by the nurse caring for the resident at the time of the fall. Per the DON, the incident report included the fall details, possible cause, and an immediate intervention. She stated the incident report was reviewed by the CCs and all falls were discussed every morning in the morning meeting. The DON further stated the tracking and trending of falls was completed by the Administrator.<br><br>In interview on 08/30/2024 at 3:23 PM with the Medical Director, he stated he had been the facility's Medical Director for about eight years. He stated he was in the facility routinely at least once a month. Per the Medical Director, he was provided a report in the facility's QAPI meetings for (residents') falls. The Medical Director stated in general, the NP had a better idea of what to do for individual residents because she knew them better.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | In interview on 08/29/2024 at 12:45 PM with the Administrator, she stated she was responsible for the tracking and trending of falls based on the reports she pulled from the facility's electronic charting system where the incident reports were entered by staff after a resident's fall. The Administrator stated the (falls) analysis included: the resident; time of the fall; area of the fall; what the resident was doing; intervention placed; and any injury. She stated the facility had a Performance Improvement Plan (PIP) in process (currently) for falls; however, she gave no date of initiation of the PIP. According to the Administrator, she knew there were a large number of residents' falls in the facility in May/2024. However, she stated the facility did not begin investigating each resident's fall to determine the cause of the fall until August/2024 (after the State Survey Agency (SSA) identified the problem)<br><br>Review of the facility's QAPI documentation on 09/25/2024 revealed the facility had not began reviewing residents' falls until August/2024. |

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| F 0865<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>46651<br><br>49360<br><br>Based on observation, interview, record review, review of the facility's fall report documentation and Quality Assurance Performance Improvement (QAPI) Policy, the facility failed to maintain an effective, comprehensive, data driven QAPI program which focused on criteria for outcomes and quality of life related to falls for 8 of 10 sampled residents, (Residents (R)10, R15, R27, R57, R75, R93, R111, and R274.<br><br>Review of the facility's Incidents by Incident Type, documentation dated 02/28/2024 through 08/28/2024, revealed the facility had a total of 346 resident falls during that six-month timeframe. Review of the facility's QAPI documentation however, revealed no documented evidence the facility brought the issue of multiple residents' falls to the QAPI Committee prior to August 2024. The facility's QAPI program failed to develop and implement plans with corrective actions, such as performing RCA, in order to decrease the number of residents' falls and any additional fall related injuries of the residents. Refer to F689 and F657.<br><br>The findings include:<br><br>Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Policy, revised on 03/2019, revealed its governing body and administration, in the interest of providing high quality resident care, were to support and maintain an effective facility wide QAPI program. Per policy review, the professional and administrative staff were to monitor and evaluate the appropriateness of resident care and clinical performance of the resident care staff. Continued review revealed the Administrator was responsible for the establishment and maintenance of the facility's QAPI program with input from professional and ancillary staff of the facility as necessary. Review of the policy revealed the QAPI program was to include administration, resident assessment, and comprehensive resident care planning. Per policy review, through QAPI monitoring and the (QAPI) Committee review there was to be review of incidents, accidents and unusual occurrences. Policy review revealed the QAPI Committee was to prioritize topics for Performance Improvement Plans (PIPs) based on the current needs of the facility. Further review additionally revealed the PIP team was to carry out the action plan in an attempt to prevent future events and promote sustained improvements through identifying RCA as possible. In addition, policy review revealed the QAPI Committee was to meet quarterly to review continuous quality improvement (CQI) activities, recommend action to address concerns, and follow up on the status of all recommendations.<br><br>Review of the facility's document titled, Key Personnel and QA Committee, revealed the members of the team included: the Administrator, Director of Nursing (DON), Clinical Coordinators (CCs), the Minimum Data Set (MDS) Coordinators, the Infection Preventionist (IP)/Staff Development Coordinator (SDC), the Activity Director (AD), the Director of Social Services (DSS), the Maintenance Director (Maint), the Dietary Manager (DM), the Housekeeping Director (HD), Accounts Receivable (AR), Medical Records (MR), the Nursing Secretary (NS) and the Medical Director (MD).<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of the facility's document for falls titled, Incidents by Incident Type, dated 02/28/2024 through 08/28/2024, revealed the facility had a total of 346 falls during that six-month timeframe, 302 unwitnessed falls and 44 witnessed falls. Record review revealed the facility's analysis of the fall incidences by month detailed: 44 falls in 03/2024; 36 falls in 04/2024; 91 falls in 05/2024; 50 falls in 06/2024; 71 falls in 07/2024; and 45 falls that occurred from 08/01/2024 through 08/28/2024. However, further review of the facility's documents revealed the facility's Administration failed to provide documentation of the facility investigating each resident's falls and performing RCA to identify the root cause of the large number of falls. Additionally, the facility's Administration failed to provide documented evidence of the development and implementation of interventions to prevent or reduce further resident falls and injury.<br><br>On 02/23/2024, R10 sustained a fall which resulted in a fractured left femur and subsequent surgery to replace the femoral head with a prosthesis on 02/25/2024. R10 sustained 19 more falls, from 04/25/2024 through 08/20/2024, with no documented evidence the facility investigated the falls and performed root cause analysis (RCA) to determine the root cause of the falls.<br><br>On 04/30/2024, R15 sustained a fall which resulted in a closed comminuted (a bone breaking in pieces) left humeral fracture with no documented evidence RCA was conducted for the fall.<br><br>From 03/11/2024 through 08/17/2024, R111 experienced a total of 16 falls with no documented evidence the facility determined the root cause of the falls. On 06/24/2024, R111 sustained a fall which resulted in a fracture of the right hip.<br><br>On 07/09/2024, R274 was diagnosed with a fracture of the left humerus with no documented evidence RCA was conducted to determine the cause of the injury.<br><br>R93 sustained 18 falls from 06/06/2024 through 8/25/2024, with no documented evidence RCA was conducted of the falls.<br><br>Review of the facility's QAPI documentation on 09/25/2024 revealed the facility began reviewing residents' falls in August 2024. Further review revealed no documented evidence the facility brought the issue of multiple residents' falls to the QAPI Committee prior to August 2024.<br><br>In interview with the 100 Unit Clinical Coordinator (CC) on 08/29/2024 at 3:58 PM, she stated nurses were responsible for completing the Fall Incident Reports and she reviewed the Reports and then sent them to the DON. The CC stated she did not know what the DON did with the Fall Incident Reports from there. She further stated the Administrator tracked and trended residents' falls.<br><br>An interview with the Minimum Data Set (MDS) Nurse 1 on 08/30/2024 at 9:30 AM, revealed the facility's fall incidents were no different than anywhere else and he did not feel like there were a lot of falls at the facility. The MDS Nurse stated he was not sure of the number of residents' falls that had occurred over the last six months and was not sure who was responsible for monitoring interventions to ensure they were effective. He stated he was aware of one resident who had been placed on 1:1 supervision and now had decreased falls as a result. The MDS Nurse stated he was not aware who had the responsibility for tracking and trending of residents' falls.<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | In interview with the Quality Nurse/Staff Development Coordinator/Infection Preventionist (QN/SDC/IP) on 08/29/2024 at 1:00 PM, she stated she was present at the QAPI (Committee) meetings. She stated she also met with the team where they discussed falls but, she did not know the number of falls occurring (in the past six months). The QN/SDC/IP further stated tracking and trending of residents' falls was done by the Administrator.<br><br>In interview on 08/29/2024 at 4:40 PM, with the DON, she stated the Fall Incident Report was completed by the nurse caring for the resident who sustained a fall. She stated the Incident Report included the fall details, the possible cause, and an immediate intervention to implement. The DON stated the Incident Report was reviewed by the CCs and all resident falls were discussed every day in the morning meetings. She stated the tracking and trending of falls was completed by the Administrator. Per the DON, she reviewed the falls, the documentation, and fall interventions for appropriateness and effectiveness with the Interdisciplinary Team (IDT). The DON stated the facility just did not have the staff to provide 1:1 supervision for residents because staffing was difficult to secure.<br><br>In interview with the Administrator on 08/29/2024 at 12:45 PM, she stated she had the responsibility of tracking and trending residents' falls. The Administrator stated her tracking and trending of falls was based on the reports she pulled from Point Click Care (PCC), the facility's electronic charting system) where staff entered the Incident Reports related to falls. She stated falls analysis incorporated the following information: the resident sustaining the fall; time of the fall and what the resident had been doing at the time of fall; area of the fall; any injury; and any intervention(s) put in place. Per the Administrator, all residents sustaining falls were discussed in the daily clinical meetings and the CCs and the Therapy Director (TD) were included in those meeting in order to work on developing interventions for those residents. She further stated the facility had a Performance Improvement Plan (PIP) in place for all the falls; however, she did not include the date the PIP was initiated.<br><br>In another interview on 08/30/2024 at 10:00 AM, the Administrator stated the big picture (for the facility's falls) was falls were being reviewed broadly before, but now staff met and discussed falls during the daily and weekly meetings. She stated she was aware there were a large number of falls in the facility in May 2024; however, the facility did not begin investigating each resident fall to determine the cause of the fall until August 2024, after the State Survey Agency (SSA) identified the problem.<br><br>During an interview with the Nurse Consultant and Administrator on 08/30/2024 at 10:35 AM, the QAPI information on tracking and trending of falls for 05/2024, 06/2024 and 07/2024 was provided.<br><br>Review of the facility's QAPI documentation provided titled, Falls Track and Trend for May/2024, June/2024 and July/2024 revealed it comprised: the residents' names and room numbers; and the date, time and location of the fall. Continued review revealed the documentation also noted what immediate action was taken, whether a fall was witnessed or unwitnessed, and any predisposing environmental or physiological factors. However, further review revealed no documented evidence a RCA was included for the resident falls on the Falls Track and Trend for May/2024, June/2024 and July/2024 documentation.<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | An interview with the Nurse Practitioner (NP) on 08/30/2024 at 11:18 AM, revealed she was notified of a resident's fall if it happened during her on call week which was once every six weeks. She stated she saw the residents for post fall assessments and attended the facility's IDT meetings; however, she was not a part of any fall's discussion. The NP stated the IDT meeting topics varied; however, there had been no discussion of resident falls in the meetings (she attended). She stated repeated resident falls were discussed in the facility's QAPI meetings, where the Medical Director was part of residents' falls discussion. The NP further stated she had never been invited to any meetings where (residents') falls were discussed.<br><br>In interview with the Medical Director on 08/30/2024 at 3:23 PM, he stated routinely he was in the facility at least once a month. He stated he attended the QAPI (Committee) meetings and was given a report of residents' falls in those meetings that were provided by the Nursing Department. The Administrator stated the report he received included what resident or staff education needed to be done, and what care plan interventions needed to change for the (involved) resident. He further stated the NP had a better idea of what individual residents needed as she knew the residents better. In additional, he stated he expected reporting of falls and documentation to be completed. |