

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Bowling Green Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1561 Newton Ave. Bowling Green, KY 42104	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47798</p> <p>Based on interview, record review, and review of the facility's policies, the facility failed to protect one of seven sampled residents (Resident (R)1) from physical abuse. On 09/10/2024 staff witnessed R2 hit R1 on the cheek.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Abuse Prohibition Standard of Practice, revised 07/2022, revealed the facility would prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigating of alleged violations in accordance with Federal and State laws.</p> <p>Review of R2's Facesheet revealed the facility admitted R2 on 04/27/2022 with diagnoses that included schizoaffective disorder, depressive type, cognitive communication deficit, and dementia in other diseases classified elsewhere.</p> <p>Review of R2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/05/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. Further review of Section E (Behavior) of the MDS revealed R2 had not exhibited any behaviors during the review period.</p> <p>Review of R1's Facesheet revealed the facility admitted R1 on 09/22/2022 with diagnoses that included alcohol dependence with alcohol-induced persisting amnesic disorder, psychotic disorder with delusions and dementia.</p> <p>Review of R1's Quarterly MDS with an ARD of 08/03/2024 revealed the R1 had a BIMS score of an eight out of 15, indicating moderate cognitive impairment.</p> <p>Review of the facility's Investigation Initial Report, dated 09/10/2024, revealed Certified Nursing Assistant (CNA) 1 witnessed R2 hit his roommate, R1 on the cheek.</p> <p>Review of R2's Care Plan revealed the facility developed a care plan for behaviors on 04/27/2022. However, further review of the document revealed there was no documented evidence the care plan was revised after the resident to resident altercation on 09/10/2024.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Investigation Five Day Report, dated 09/16/2024, revealed R1 stated he had been bickering with R2 when R2 suddenly hit him on the cheek. R1 stated he was not injured and he did feel safe in the facility but he wanted a new roommate. Further review revealed R2 was moved to another room. The 5 day report further revealed staff stated R1 and R2 had been long time roommate and there had been no problems had been noted in the past. R2 was placed on every 15 minute checks for 24 hours to ensure no other behavioral variances occurred. R1 was monitored for pain, skin, and psychosocial distress, which none were noted.</p> <p>During an interview with R2 on 10/01/2024 at 4:00 PM, he stated he moved rooms several months ago because he did not get along with his previous roommate very well. R2 stated R1 would do things to annoy him. R2 stated he didn't argue with R1 but he did not like things that R1 did such as rolling his tray around the room when it should have been left alone. R2 stated he never had a physical altercation with R1. R2 stated he had seen R1 in the hall and in the dining room since he changed rooms and there had not been any issues.</p> <p>During an interview with CNA 1 on 10/01/2024 at 3:25 PM, she stated she heard a loud noise such as an argument and went to R1 and R2's room. CNA 1 stated she observed R1 in his wheelchair at the bathroom door and R2 was standing over him and proceeded to slap R1 on the cheek. CNA 1 stated she immediately separated R1 and R2 and removed R1 from the room to keep him safe. CNA 1 stated she did not know of any arguments between the two residents in the past and none since this incident. CNA 1 stated R2 was moved to another room and do occasionally see each other in the hall but neither seem to even recognize the other due to their memory issues. CNA 1 further stated she did not think either resident even remembered the incident happening.</p> <p>During an interview with the Director of Nursing (DON) on 10/03/2024 at 11:02 AM, she stated R1 and R2 were separated immediately and R1 was brought to the nurses station and assessed immediately. The DON stated R1 denied any physical injuries but did not really have any recollection of the event. She stated R2 was moved to another hall. The DON stated R2 had no behavioral problems in the past and he had no recollection of anything happening between himself and R1.</p> <p>During an interview with the Administrator on 10/03/2024 at 10/03/2024, she stated R2 had no prior behavioral problems and had none since the incident with R1. She stated R2 denied hitting R1 immediately after the incident. The Administrator stated if CNA 1 had not witnessed the altercation, the facility would have unsubstantiated it.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>47798</p> <p>Based on observation, interview, record review and review of facility policy, it was determined the facility failed to revise the Comprehensive Care Plan following a behavioral change for Resident #2 (R2).</p> <p>Review of R2's Comprehensive Care Plan revealed the care plan was not revised to include interventions for change in behavior.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Comprehensive Care Plans Standard of Practice, dated 10/2020 and reviewed 10/2020, revealed an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs would be developed for each resident. The protocol stated care plans would be reviewed and updated when there was a significant change in the resident's condition or when a desired outcome was not met, and that assessments were ongoing and care plans would be revised as information about the resident and resident's condition may change.</p> <p>Review of R2's Facesheet revealed the facility admitted R2 on 04/27/2022 with diagnoses that included schizoaffective disorder, depressive type, cognitive communication deficit, and dementia in other diseases classified elsewhere.</p> <p>Review of R2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/05/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. Further review of Section E (Behavior) of the MDS revealed R2 had not exhibited any behaviors during the review period.</p> <p>Review of the facility's Investigation Initial Report, dated 09/10/2024, revealed Certified Nursing Assistant (CNA) 1 witnessed R2 hit his roommate, R1 on the cheek.</p> <p>Review of the facility's Investigation Five Day Report, dated 09/16/2024, revealed R1 stated he had been bickering with R2 when R2 suddenly hit him on the cheek. R1 stated he was not injured and he did feel safe in the facility but he wanted a new roommate. Further review revealed R2 was moved to another room. The 5 day report further revealed staff stated R1 and R2 had been long time roommate and there had been no problems had been noted in the past. R2 was placed on every 15 minute checks for 24 hours to ensure no other behavioral variances occurred. R1 was monitored for pain, skin, and psychosocial distress, which none were noted.</p> <p>Review of R2's Care Plan revealed the facility developed a care plan for behaviors on 04/27/2022. However, further review of the document revealed there was no documented evidence the care plan was revised after the resident to resident altercation on 09/10/2024.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with R2 on 10/01/2024 at 4:00 PM, he stated he moved rooms one-two months ago because he did not get along with his previous roommate very well. R2 stated R1 would do things to annoy him. R2 stated he didn't argue with R1 but he did not like things that R1 did such as rolling his tray around the room when it should have been left alone. R2 stated he never had a physical altercation with R1. R2 stated he had seen R1 in the hall and in the dining room since he changed rooms and there had not been any issues.</p> <p>During an interview with CNA 1 on 10/01/2024 at 3:25 PM, she stated she heard a loud noise such as an argument and went to R1 and R2's room. CNA 1 stated she observed R1 in his wheelchair at the bathroom door and R2 was standing over him and proceeded to slap R1 on the cheek. CNA 1 stated she immediately separated R1 and R2 and removed R1 from the room to keep him safe. CNA 1 stated she did not know of any arguments between the two residents in the past and none since this incident. CNA 1 stated R2 was moved to another room and do occasionally see each other in the hall but neither seem to even recognize the other due to their memory issues. CNA 1 further stated she did not think either resident even remembered the incident happening.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 10/02/2024 at 3:38 PM, she stated the care plan was to let everyone know how to care for the resident. The ADON stated if anything changed with the resident, the care plan should be revised immediately by the nurse on the floor or the person that found the problem. The ADON stated if the care plan was not revised, staff would have a hard time knowing how to care for the resident.</p> <p>During an interview with the MDS Coordinator on 10/02/2024 at 3:56 PM, she stated she was responsible for developing the comprehensive care plan, reviewing the care plan during clinical meeting and ensure the care plans had the appropriate interventions. The MDS coordinator stated R2's behavioral care plan should have been updated by the nurse on the floor. She further stated the Interdisciplinary team (IDT) should have discussed the incident during clinical meeting the following morning and if the care plan had not been updated or an intervention added, it should have been caught and added at that time. The MDS coordinator further stated if this was not done, R2 could have had continued behaviors that were not addressed.</p> <p>During an interview with the Director of Nursing on 10/03/2024 at 11:02 AM, she stated R2 should have had a problem of physical aggression added to his care plan with an appropriate intervention. The DON stated she expected the care plan to be updated and revised to allow staff to know how to care for and/or intervene with the resident correctly. The DON stated if the care plan was not revised, it could be detrimental to the resident and staff would not know how to provide care to the residents. The DON further stated the facility was in process of training the floor nurses to add interventions to the care plan. She continued to state that the IDT would discuss the care plan and edit with appropriate interventions if needed.</p> <p>During an interview with the Administrator on 10/03/2024 at 10/03/2024, she stated the care plan was to provide a guide for staff to instruct them on care for the residents. She stated if the care plan was not revised, staff may not know how to properly care for the residents. She further stated any of the nursing administration or floor staff could update a care plan and it should be done immediately.</p>		