

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185227	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Providence Pointe Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Marshall Court Paducah, KY 42001	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to provide adequate supervision and assistive devices to ensure the safety of its residents for 1 of 9 sampled residents (Resident (R)9).</p> <p>The findings include:</p> <p>Review of the facility policy titled, Safety and Supervision of Residents, revised 07/2017, revealed the interdisciplinary team (IDT) was to analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. Further review of the policy revealed the IDT care team was to target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.</p> <p>Review of the facility policy titled, Managing Fall and Fall Risk, revised 03/2018, revealed the facility should develop a resident-centered fall prevention plan in effort to reduce identified risk factor(s) of falls for each resident at risk or with a history of falls. Further review of the policy revealed if falling recurred despite initial interventions, staff were to implement additional or different interventions, or indicate why the current approach remained relevant.</p> <p>Review of the facesheet for R9 revealed the facility admitted the resident on 05/14/2025, with diagnoses that included urinary tract infection, traumatic brain injury, unsteadiness on feet, and repeated falls.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R9 to have a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating severe cognitive impairment.</p> <p>Review of the progress note dated 05/15/2025 at 10:27 AM, revealed R9 had been restless all morning and attempted to get out of bed to mow and continued to pull at abdominal binder and percutaneous endoscopic gastrostomy (PEG) tube.</p> <p>Review of the progress note dated 05/16/2025 at 11:51 PM, revealed R9 had been found lying on the floor in front of his wheelchair at 6:30 PM on 05/15/2026. Continued review revealed R9 had been unable to give a description of what happened due to confusion. Further review of the progress note revealed R9 stated he hit his head. In addition, review revealed R9 was sent to the emergency room (ER) for evaluation due to his history of a brain bleed.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility document titled, FSI Fall Scene Investigation Report, dated 05/16/2025, revealed the contributing factors of R9's fall were the amount of assistance in effect and mood or mental status. Further review of the document revealed the care plan had been updated, with the addition of a perimeter defining mattress.</p> <p>Review of the facility document titled, FSI Fall Scene Investigation Report dated 05/17/2025, revealed R9 sustained a fall on 05/17/2025 at 6:00 PM when the nurse observed the resident sliding out of bed onto the floor after he had been trying to get out of bed unassisted all shift. Per review, the contributing factors of the fall were noted as confusion related to a history of traumatic brain injury. Continued review revealed the document listed the initial intervention to prevent falls as being Fall mat placed to right side of bed. Further review of the document revealed the care plan had been updated with the addition of a fall mat on the floor on the right side of R9's bed.</p> <p>Review of the progress note dated 05/17/2025 at 8:38 PM, revealed R9 had been found in his room sitting on the bed, and had pulled his PEG tube out and the PEG tube was lying on the floor beside his continuous positive airway pressure (CPAP) machine. The PEG site was noted to be bleeding and R9 had been confused and hallucinating. Further review of the progress note revealed R9 was taken to the ER via EMS to be evaluated.</p> <p>Review of the progress note dated 05/23/2025 at 11:55 PM, revealed R9 continued to be confused and pulled his abdominal binder off and pulled on his PEG tube.</p> <p>Review of the IDT note dated 05/29/2025 at 3:35 PM, revealed R9 sustained a fall on 05/28/2025 at 7:55 PM. Per review of the note, R9 had been found lying on his back on the floor between his bed and the window with no injuries noted.</p> <p>Review of the facility document titled, FSI Fall Scene Investigation Report dated 05/28/2025, revealed the contributing factors to R9's fall were mood and mental status. Further review of the document revealed the resident' scare plan was revised with the addition of changing the room configuration with the right side of the bed against the wall.</p> <p>Review of the facility document titled, FSI Fall Scene Investigation Report, dated 05/29/2025, revealed R9 had an unwitnessed fall on 05/29/2025 at 9:05 PM. Per review, R9 fell across from the nurse's station, while attempting to transfer from his wheelchair to a regular chair and tripped over the foot rests of wheelchair. Continued review revealed staff had placed R9 in the wheelchair across from the nurse's station so they could keep an eye on the resident. Further review of the document revealed R9's care plan had been updated with the addition of removing the leg rests when sitting in his wheelchair.</p> <p>Review of the facility document titled, FSI Fall Scene Investigation Report, dated 06/03/2025, revealed R9 had an unwitnessed fall on 06/03/2025 at 6:30 AM. Per review, R9 had been found crawling in the hallway without a brief on and told staff he was looking for his puppy that got out of the house. Continued review revealed the contributing factor to fall R9's had been confusion. Further review of the document revealed R9's care plan had been updated with the addition of offering the resident a stuffed puppy for comfort.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the health status note dated 06/03/2025 at 10:45 AM, revealed the 300-hall Unit Manager (UM) documented speaking with R9's wife about the resident's frequent falls, anxiety, and not being able to sit still. Per review, the UM noted suggesting to the family they get a sitter or come spend more time in the facility with R9. Further review revealed R9's wife told the UM she was not able to provide a sitter or spend more time in the facility.</p> <p>Review of the facility document titled, FSI Fall Scene Investigation Report dated 06/06/2025, revealed R9 sustained a fall. Per review, on 06/06/2025 at 11:15 AM, the resident fell out of his wheelchair onto the floor while in the dining room attempting to self-transfer. Further review of the document revealed R9's care plan was updated with the addition of anti- roll backs placed on the wheelchair.</p> <p>Continued review of R9's electronic health record (EHR) revealed the resident was hospitalized on [DATE] due to pulling out his PEG tube earlier that morning. Review further revealed R9 returned to the facility at approximately 3:00 PM on 06/11/2025 after having the PEG tube replaced.</p> <p>Observation on 06/12/2025 at 8:30 AM, of R9 in his room revealed the resident lying on the bed with eyes closed and a one-to-one (1:1) supervision person present.</p> <p>Review of the 1:1 sitter logs for R9 revealed the resident had been on 1:1 supervision since 06/11/2025 at 3:30 PM (approximately the time he returned from the hospital).</p> <p>In interview with the Physical Therapy Assistant (PTA) 1 on 06/11/2025 at 9:30 AM, she stated she only treated R9 one time, and that had been for in-room treatment. She said R9 had not wanted to participate in the therapy. PTA 1 explained she had to get R9's wife to help him to participate in his therapy. She further stated that physical therapy was usually only helpful with improvement if the resident was able to follow direction and consistency.</p> <p>In interview on 06/11/2025 at 9:45 AM, the medical Nurse Practitioner (NP) stated R9 was on of her patients in conjunction with the doctor. She stated she had not been able to get a lot of information from R9 as he was not cognitive intact. The NP reported calling R9's wife to speak with her and a family friend about the resident. She said since R9 has been at the facility he had been pulled out his feeding tube a couple of times. The NP explained they had used an abdominal binder to keep R9's feeding tube out of reach. She stated as R9 had kept wheeling his wheelchair while attached to his feeding pump, they had changed his tube feedings to bolus feeding to keep him from pulling at it. The NP reported to her knowledge, R9 has not fallen, but had been found crawling on the floor. She stated the family wanted the facility to use restraints, such as side rails and lap buddies; however, they never ordered restraints at the facility. The NP said resident rights indicated a resident had the right to be free from restraints and also had the right to fall. She explained she asked the doctor for more information on all the options for R9 and said she did not think the resident was a good fit for the facility. The NP reported she thought R9 needed more 1:1 care. She stated she did not want to chemically restrain R9, but he would be better off if we can just keep him calm. The NP said R9's Exelon patch and Namenda (used to treat Alzheimer's disease), and his Buspar (an anti-anxiety medication) had all been increased. She further stated she thought the staff at the facility were really good about figuring out the cause of residents' falls and putting necessary interventions in place.</p> <p>(continued on next page)</p>		

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