

		185228	D. WING	4/24/14	03/21/2014
NAME OF PROVIDER OR SUPPLIER WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240 <i>POC #3 Approved By Jina Holloway, RN, MA</i>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
F 000	INITIAL COMMENTS A Recertification Survey and an Abbreviated Survey investigating complaint #KY21460 was conducted 03/18/14 through 03/21/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with highest Scope and Severity of a "G". Complaint #KY21460 was substantiated with deficiencies cited. On 03/04/14, Resident #11 sustained a fall when attempting to transfer unassisted from the bed. The resident was care planned for a bed sensor alarm; however, the alarm was not turned on and did not sound to alert staff the resident was attempting to transfer. Resident #11 fell from the bed and sustained a fracture to the right fifth finger and a laceration to the right hand that required stitches and a splint. Review of the February and March 2014 Medication Administration Records (MARs) revealed the resident required an increase in pain medication from twice a month to everyday from 03/04/14 through 03/19/14, except for one day. In addition, Resident #11 was care planned for a seat belt alarm; an observation, on 03/18/14 at 9:22 AM, revealed the resident was sitting in the dining room in a Broda chair with a seat belt alarm that was not turned on and not functional.	F 000			
F 221 SS=0	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 was reassessed by the Unit Charge Nurse on 03/20/14 and the alarming seatbelt was discontinued with the care plan updated to reflect the change in devices.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Deeman

TITLE
NHA

(X6) DATE
4/23/14

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.

		A. BUILDING		
		185228	B. WING	03/21/2014
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F 221	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure one (1) of twenty-three (23) sampled residents (Resident #1) was free from physical restraints. The facility failed to assess to identify if the seatbelt was a restraint for Resident #1. The findings include: A policy titled, "Standard Operating Procedure No: 7J, Subject: High Risk Situations: Medical Physical Restraint", updated July 2009, defined physical restraint as any physical or mechanical device, material or equipment attached or adjacent to the resident's body that cannot be removed easily and which restricts freedom of movement or normal access to one's body. Further review of the policy revealed restraints were to be used only for residents' medical symptoms or emergencies and were not to be used in a manner that caused undue physical discomfort, harm or pain to the resident, restraints are not to be used for discipline or staff convenience. A list of approved forms of restraints included the quick release seat belt. The policy further stated all restraint usage would require a physician's order to relate the type of restraint usage, the specific reason for the restraints, and the specified length of time; and, restraints were implemented only after a complete assessment of the resident by the licensed nurse, and the assessment must determine the presence of a specific medical symptom, how the use of the restraint would treat the medical symptoms and protect the resident's	F 221	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <u>All new admissions will be reviewed by the admitting nurse on admission for the need of any type of assistive device which could be considered a restraint. Should any type of device be in use, a Restraint Assessment Form (Attachment A) will be completed. All residents in the facility will have restraint assessments completed by the unit charge nurse upon initiation of a restraint, on quarterly review and with any change of condition. (Refer to Attachment A). These admission assessments will be reviewed for completion by the Unit Administrative Nurse/ RN Coordinator #1 and #2. The Incident Management Committee (Director of Nursing, Assistant Director of Nursing, Clinical Coordinator, Staffing Coordinator, Incident Management Nurse, Infection Control Nurse, Admitting Nurse for (ADN) Coordinators) will review the assessments for continued need of the device daily Monday through Friday and the Staff Facility Charge Nurse will review on weekends and holidays.</u> What measures will be put into place, or what systematic changes you will make to ensure that the deficient practice does not recur? All residents in the facility were assessed on 03/25/14, reassessed on 4-8-14 and on 4/11/14 by the Administrative Nurses which included the Director of Nursing (DON), Assistant Director of Nursing (ADON), the RN Coordinators, Clinical Coordinator, Infection Control Nurse, Incident Management Nurse and the Staffing Coordinator for the need of assistive devices which could be considered a restraint. Assistive device forms were completed for each resident who required some type of change in assistive device and/or who had discontinuation of a device (refer to attachment B). There were no other restraints identified in the facility.	

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F 221	<p>Continued From page 2</p> <p>safety and to assist the resident to attain or maintain his/her highest practical level of physical and psychosocial well being.</p> <p>Record review revealed the facility admitted Resident #1 on 06/07/11 with diagnoses which included Dementia, Mood Disorder, Hypertension, Anemia, and possible Parkinson's Disease.</p> <p>Observation, on 03/19/14 at 11:27 AM, revealed Resident #1 sitting in the Activity Room in a wheelchair with a seatbelt in use. When prompted by Certified Nurse Aide (CNA) #9, the resident was unable to release the seat belt on command. The CNA prompted Resident #1 to release the seat belt five (5) times; however, the resident was unable to release the seatbelt. Further observation, on 03/19/14 at 3:55 PM, revealed Resident #1 was in the hallway in front of the Nurse's Station. When Licensed Practical Nurse (LPN) #6 prompted Resident #1 to release the seatbelt, the resident was unable to release the seatbelt.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/15/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) coded as ninety-nine (99). Further review revealed physical restraints were coded as not used. Review of the Assistive/Safety Device Assessment, dated 01/21/14, revealed Resident #1 was not assessed for the use of a quick release seat belt. Further review of the assessment revealed the facility failed to identify the specific medical symptom for restraint use, how the use of the restraint would treat the medical symptom, protect the resident's safety to</p>	F 221	<p>All direct care staff (Certified Nursing Assistants (CNA), Registered Nurses (RN), Licensed Practical Nurses (LPN) and Certified Medication Aides (CMA)) were in-serviced by the MDS Coordinators #1 and #2 and the Staff Facility Charge Nurse beginning on 04/02/14 and completed by 04/17/14 regarding revisions to the Western State Nursing Facility (Standard Operating Procedure #77: High Risk Situations; Medical Physical Restraints). The revisions added were in the definition of a physical restraint which included "remove easily and consistently". Also on page 4 #14 the policy was updated to include "The Staff Facility Charge Nurse will contact the Administrator on Call (AOC) to review the need for a restraint" (Refer to attachment C). Education was provided regarding the protocol and necessary steps to follow should a restraint be deemed necessary. The CNAs, RNs, LPNs and CMAs also had clarification presented on the definition of what constitutes a physical restraint by the MDS Coordinators #1 and #2 and the Staff Facility Charge Nurse on 04/02/14 and completed by 04/17/14. All licensed staff will be in-serviced regarding Restraint Assessment Form (Attachment B), beginning on 4/16/14 and completed on 4/17/14 by the Administrative Nurses (DON, AOCN, Clinical Coordinator, Incident Manager, Infection Control Nurse, and Staff Development Coordinator). Any CNAs, LPNs, RNs or CMAs not present will be in-serviced upon return to work. The Administrative On Call (AOC) staff which includes the Administrator, the Director of Nursing, Assistant Administrator, Facility Administrator, Clinical Coordinator, MDS Coordinators, and Social Services Director were all in-serviced on the above policy on 4/8/14 and completed by 04/09/14 by the AOCN. (Refer to attachment C).</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance will be put into place?</p>		

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F 221	Continued From page 3 assist the resident in attaining or maintaining his/her highest practical level of physical and psychosocial well being. Review of Resident #1's Comprehensive Care Plan, dated 01/21/14, revealed Resident #1 was not care planned for the use of Physical Restraints. Interview, on 03/21/14 at 9:58 AM with CNA #9, revealed he/she had worked with Resident #1 for approximately a year and the resident had the quick release seat belt in place since then. CNA #9 stated Resident #1 had released the wheelchair seat belt in the past but was not always able to do it on command. Interview, on 03/19/14 at 3:58 PM with LPN #6, revealed if a resident was unable to release a seat belt it would be considered a restraint. LPN #6 stated Resident #1 had released the wheelchair seat belt in the past but was not always able to do it on command. Further interview revealed there was no physician's order for the quick release seat belt. Interview with the Staffing Director, on 03/21/14 at 10:21 AM, revealed residents were assessed for the safe use of a device before any device was implemented. Additionally, if the resident could not release the quick release seat belt it would be considered a restraint. Interview with the Director of Nursing (DON), on 03/20/14 at 4:15 PM, revealed Resident #1 did not have a physician's order for the quick release seat belt and was not assessed or care planned for the use of a restraint and one should not have been in place.	F 221	Any resident who has any type of safety/assistive device (refer to Attachment B) or restraint put into place will be reviewed on a daily basis by the Incident Management Team Committee (Director of Nursing, Assistant Director of Nursing, Clinical Coordinator, Staffing Coordinator, Incident Management Nurse, Infection Control Nurse, Minimum Care Set (MCS) Coordinators) to ensure the policy is followed and to review continued need for placement. This review will be conducted Monday through Friday at the morning meeting. On weekends and holidays the Staff Facility Charge Nurse (SFCN) will conduct an Incident Management Meeting with other charge nurses for the appropriateness of any device. The results of the weekend review will be discussed in the Incident Management meeting each Monday (Refer to attachment B). On 04/10/14, monitoring was initiated with all direct care staff (Refer to page 3) with interviews conducted by the Administrative Nurses (Refer to page 3) in regards to their knowledge of facility policies and procedures regarding restraints and definition of restraints (refer to Attachment C). These audits will also be reviewed by the Incident management Coordinator/Director of Nursing daily Monday through Friday to ensure any concerns have been addressed with teaching and education. Any restraint in the facility will be reported at each Quality Assurance Committee Meeting each quarter per the Director of Nursing with follow up action plan developed as needed. This will continue for 12 months.	4/18/14

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F 282 SS=G	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of an Emergency Room Diagnostic Imaging Report and the facility's Nursing Service Standards of Operation, it was determined the facility failed to provide care in accordance with each resident's plan of care for one (1) of twenty-three (23) sampled residents (Resident #11); and, one (1) unsampled resident (Resident A).</p> <p>On 03/04/14, Resident #11 sustained a fall when attempting to transfer unassisted from the bed. The resident was care planned for a bed sensor alarm; however, the alarm was not turned on and did not sound to alert staff the resident was attempting to transfer. Resident #11 fell from the bed and sustained a fracture to the right fifth finger and a laceration to the right hand that required stitches and a splint.</p> <p>Review of the February and March 2014 Medication Administration Records (MARs) revealed the resident required an increase in pain medication from twice a month to everyday, but one day, from 03/04/14 through 03/19/14. In addition, Resident #11 was care planned for a seat belt alarm; however, observation, on 03/18/14 at 9:22 AM, revealed the resident was sitting in the dining room in a Broda chair with a</p>	F 282	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #11 and Resident A were assessed by the Administrative Nurses, which included the Director of Nursing (DON), Assistant Director of Nursing (ADON), Clinical Coordinator, MDS Coordinators, Infection Control Nurse, Incident Management Nurse, and Staffing Coordinator on 03/20/14. Resident #11's bed sensor alarm, clip alarm and seat belt alarm were all discontinued and the care plan was updated. Resident A was assessed and the clip alarm, while in bed, was discontinued and the care plan updated. Education and corrective action was presented, on 03/20/14, per the Unit Charge Nurse with the involved certified Nursing Assistant (CNA), who failed to ensure the care plans were followed for Residents #11 and A. The Unit Administrative Nurse completed education and corrective action with the unit charge nurses for failing to supervise the direct care staff and ensure interventions in place and functioning.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p><u>To prevent further deficient practice, a new admission assessment was developed and will be completed on all new admissions to the facility. The residents will be assessed immediately upon admission by the admitting nurse for need of any type of assistive device for resident safety. (Refer to Attachment B) These assessment forms will be reviewed by the MDS Coordinators/Incident Management Coordinator for completion and accuracy daily Monday through Friday. Direct care staff (Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nurse Aides (CNA), and Certified Medication Aides (CMA)) will be assigned to complete units by the Staffing Coordinator / Staff Facility Charge Nurse so that the CNA/CMA will be more familiar with each resident's care needs.</u></p>		

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F 282	Continued From page 7 fracture to the proximal fifth (5th) phalanx (finger). Review of the Nurse's Notes, dated 03/04/14 at 9:30 AM, revealed the resident returned to the facility with a splint to the right hand and four (4) sutures. Review of the February and March 2014 Medication Administration Records (MARs) revealed the resident required an increase in pain medication (Tylenol 650 milligrams (mg) as needed for pain) from twice a month to everyday, but one, from 03/04/14 through 03/19/14. Interview with CNA #2, on 03/19/14 at 1:45 PM, revealed the resident was care planned for the bed alarm and it should have been turned on to alert staff when the resident attempted to get up unassisted. CNA #2 stated she had checked Resident #11's bed alarm at 3:00 AM prior to going to lunch and it was on and functioning. When she returned from lunch, the resident had fallen from the bed and it was reported to her by the Charge Nurse the alarm did not sound because it was not turned on. She stated she had no idea how the alarm got turned off because the resident was unable to turn the alarm off. Interview with CNA #3, on 03/19/14 at 1:10 PM, revealed she was in the room next door to Resident #11's room and heard Resident #11 yelling. She stated when she came around the corner, the resident was sitting on the mat beside the bed on the floor with blood on his/her hand and the bed alarm was not sounding. She revealed she went to the door and yelled for help and the Charge Nurse came to assess the resident. The physician was called, and the resident was sent to the hospital for evaluation.	F 282	Any direct care staff (<u>Registered Nurses (RNs), Licensed Practical Nurses (LPNs, Certified Nurse Aides (CNAs), and Certified Nursing Assistants (CNAs)</u> (Refer to page 7) not present will be in-serviced upon return to work. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance will be put into place? The Unit Charge Nurse will make rounds throughout the shift to ensure care is being provided per the resident's Comprehensive Plan of Care and recorded on the Treatment Administration Record (TAR). The TAR will be updated to include: "The care plan interventions are in place and functioning" (Refer to attachment G). The TAR will be initialed by the Unit Charge Nurse signifying that the care plan is being followed. This will occur each shift. An audit will be completed for these residents on each unit each shift times one (1) month to ensure care is provided per the care plan. This will be conducted by the Unit Charge Nurse who will audit assigned peer's unit (Refer to attachment H). Then one resident each shift will be audited by each Unit Charge Nurses' peer. This will occur times four (4) months. One resident for one shift will then be randomly monitored times four (4) months by the Unit Charge Nurses' peer. One resident per week on each shift will be monitored times three (3) months. This will begin on 04/11/14. The Administrative Nurse for each unit will make rounds two times per day on their assigned unit to ensure the care plan is being followed (Refer to attachment I). This will be conducted Monday through Friday. Audits will be conducted twice a day times three months then one time a day for three months, then one time a week for six months.		

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F 282	<p>Continued From page 8</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 03/19/14 at 10:50 AM, revealed the resident was care planned for risk of falls and the care plan should have been followed for the bed sensor alarm. LPN #3 stated when she entered the room, the resident was sitting on the floor, on the mat, beside the bed and had blood on his/her hand. She stated she asked CNA #3 if the bed alarm sounded and was told the alarm was turned off. The resident was assessed and noted to have a laceration to the right hand, abrasion to the right knee, and complained of pain in the right hand.</p> <p>2. Record review revealed the facility admitted Resident A on 07/31/13 with diagnoses which included Paranoid Schizophrenia, Alzheimer's Type Dementia with Behavioral Disturbances, Insomnia, Anemia, and Arthritis.</p> <p>Review of the Admission MDS assessment, dated 08/06/13, revealed the facility assessed Resident A's cognition as cognitively intact with a BIMS score of fifteen (15) and requiring extensive assistance with transfer and ambulation.</p> <p>Review of the Comprehensive Care Plan for Potential Risk for Falls, dated 02/12/14, revealed an intervention for a clip alarm on at all times.</p> <p>Observation, on 03/18/14 at 6:17 AM and 11:20 AM, revealed Resident A was in bed with a clip alarm that was not attached to the resident.</p> <p>Interview, on 03/18/14 at 11:25 AM with LPN #4, revealed Resident A should have a clip alarm on at all times.</p> <p>Interview, on 03/18/14 at 11:25 AM with CNA #1, revealed she had put Resident A back to bed and</p>	F 282	<p>The weekend Staff Facility Charge Nurse will make rounds on the weekends twice a day on each unit to ensure the care plan is being followed (Refer to attachment H). Additionally, off shift visits will be made by Administrative Nurses (refer to page 5) twice a week on random shifts at random times to ensure care plans are followed (Refer to attachment I). A compliance check list will be completed by the unit Administrative Nurse who makes rounds. This will begin on 04/10/14. Any identified concerns will be addressed immediately with involved staff as well as the Unit Charge Nurse and the Staff Facility Charge Nurse. This will occur for one month or until there are no identified issues. These audits will also be reviewed by the Director of Nursing/Assistant Director of Nursing daily Monday through Friday to ensure any concerns have been addressed with teaching and education. The results of the Care Monitoring Form and the Administrative Nurse Audit form (Refer to attachment K and L) will be reported to the Quality Assurance Committee by the Director of Nursing/Assistant Director of Nursing quarterly for 12 months with any performance plans necessary initiated.</p>	4/18/14	

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F 282	Continued From page 9 she thought she had put the clip alarm on the resident. She stated LPN #4 had told her the clip alarm was not attached to the resident. Interview with the Director of Nursing (DON), on 03/19/14 at 1:05 PM, revealed the care plans should be followed by the CNAs. She stated the alarms were checked by the CNAs and signed off on the Unit Staff Assignment Sheet by the CNAs. She revealed the Charge Nurse on duty should confirm the alarms were on and functioning properly.		F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure it was determined the facility failed to ensure the appropriate care and services for one (1) of twenty-three (23) sampled residents (Resident #9) related to an indwelling urinary catheter. The findings include:		F 315	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 03/20/14, Resident #9 was assessed by the Unit Charge Nurse to ensure the appropriate anchor was utilized to prevent the catheter and/or tubing from touching the floor. On 04/08/14 the Advanced Practice Registered Nurse assessed Resident #9 for the continued need for the catheter. On 04/09/14 the APRN held a telephone consultation with Resident #9's Urologist discussing the continued need for the catheter. The catheter was discontinued following the recommendations from the specialist. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <i>On admission all new residents with a catheter will be assessed for bladder function and continued need for a Foley catheter by the admitting nurse immediately upon admission. (Attachment-1) Should a resident already residing in the facility have a physician's order for placement of a Foley catheter that resident will have the catheter assessment form completed by the unit charge nurse immediately.</i>	

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F 315	Continued From page 10 Review of the facility's policy titled, "Standard Operating Procedure No: 1-1, Subject: Care of the Indwelling Catheter to Prevent Infections", dated October 2013, revealed the facility nursing personnel will closely monitor all residents with long term indwelling catheter placement and any resident with an indwelling catheter will have an individualized plan of care that includes interventions to reduce the potential risk for an infection and potential complications of the catheter use. Record review revealed the facility admitted Resident #9 on 05/01/04 with diagnoses which included Dementia, Schizophrenia, Mood Disorder, Seizures, and Urinary Retention. Observations, on 03/18/14 at 11:35 AM; on 03/19/14 at 8:58 AM, and 11:26 AM, revealed Resident #9 was sitting in a wheelchair at a table in the activity room with the urinary tubing on the floor. Review of an Annual Minimum Data Set (MDS) assessment, dated 02/05/14, revealed the facility assessed Resident #9's cognition as severely impaired with the Brief Interview for Mental Status (BIMS) coded as a ninety-nine (99). The facility also assessed the resident as requiring extensive assistance with Activities of Daily Living and needed an indwelling urinary catheter. Review of the Comprehensive Care Plan, dated 02/11/14, revealed the resident would not experience symptoms of blockage of the catheter, expulsion of the catheter, pain discomfort, or bleeding and the catheter would be anchored to prevent excessive tension on the catheter to reduce the risk for urethral tears or	F 315	<u>This form will also be completed quarterly by the unit charge nurses on all residents with catheters. The unit charge nurses will ensure direct care staff is aware of care plan interventions for the catheter to include anchoring the catheter and keeping tubing and catheter bags off of the floor. This information will be communicated directly to the staff with shift report and with any changes to the care plans per the Unit Charge Nurse.</u> What measures will be put into place, or what systematic changes you will make to ensure that the deficient practice does not recur? All direct care staff (Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants and Certified Medication Aides) were in-serviced on Policy Section V, SOP 11 (Refer to Attachment K). This in-servicing was presented by the Infection Control Nurse/Staff Facility Charge Nurse, on 04/03/14 and completed by 04/17/14. All the direct care staff (Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants and Certified Medication Aides) were in-serviced on the importance of keeping the catheter anchored to prevent dislodgement of the catheter and to prevent the catheter bag and catheter tubing from touching the floor for infection prevention. On 4-16-14, all licensed nurses were in-serviced on the new Catheter Assessment Form regarding the assessment of a new resident admission and all residents requiring a newly inserted catheter. (Refer to Attachment K-1). Any direct care staff (Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants and Certified Medication Aides) not present will be in-serviced upon return to work. The Treatment Record (TAR) was updated to include checking the catheter for placement, patency and anchoring every shift to ensure the catheter bag and tubing is not touching the floor (Refer to Attachment K-2).		

		185228	B. VING	03/21/2014	
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F 315	Continued From page 11 dislodging of the catheter and secure the catheter to facilitate the flow of urine. Review of a Nurse's Note, dated 03/08/14 at 6:30 PM, written by Licensed Practical Nurse (LPN) #5, revealed "Resident being transferred from dining room to room, wheel caught tubing from indwelling catheter, dislodging catheter" Further review revealed the LPN reinserted the catheter and the "procedure seemed to cause discomfort exhibited by combative/resistive behavior". Interview with LPN #5, on 03/20/14 at 3:20 PM, revealed on 03/08/14 she did not double check to see if the excess tubing from the catheter was secure before assisting Resident #9 from the dining room to his/her room. The LPN stated normally she would make sure the tubing was up above the crossbars of the wheelchair and put the excess tubing in the bag and secure it, but "I didn't on that day, and I don't remember why not". Interview with the Director of Nursing (DON), on 03/21/14 at 10:10 AM, revealed a stabilizing device should have been in place. The DON stated, "Staff was not following the care plan and we will address the care plan problem". She revealed an Intervention was added to place an anchoring device and the intervention should have been in place already.	F 315	The Administrative Nurse for their assigned unit/Staff Facility Charge Nurse will make rounds twice a day to ensure any resident with a catheter is assessed for the catheter to be secure and catheter bag and tubing not touching the floor. The Administrative Nurse Audit Form (Attachment I) and Staff Facility Charge Nurse Audit Form (Attachment H) will be completed Monday through Friday for each round beginning on 04/21/14. The Staff Facility Charge Nurse will conduct the audits on the weekend and holidays (refer to attachment H) beginning on 04/11/14. These audits will continue times six months. These audits will be turned in to the Director of Nursing/Assistant Director of Nursing on a daily basis Monday through Friday and will be reviewed to ensure policy and procedure is being followed. Any identified concerns will be addressed immediately by the DON/ADON to ensure any care issues are addressed with assigned staff with teaching and education provided. All results of the audits will be brought to Quality Assurance Meetings and presented by the Infection Control Nurse/Director of Nursing for six months with any performance improvement plans necessary initiated.	4/18/14	
F 323 SS=C	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?		

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F 323	Continued From page 12 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Emergency Room Diagnostic Imaging Report, the facility's Nursing Service Standards of Operation (Section: IV Provision of Clinical Professional Services: Subject Assistive/Safety Devices for Resident Safety), and the facility's Risk Management Program, it was determined the facility failed to provide adequate supervision and assistance devices to prevent accidents for one (1) of twenty-three sampled residents (Resident #11). On 03/04/14, Resident #11 had an unwitnessed fall from the bed. The resident attempted an unassisted transfer; the staff was not alerted due to the staff's failure to ensure the resident's bed sensor alarm was on and functioning. The resident sustained a fractured right fifth (5th) phalanx (finger), a laceration to the right hand that required stitches and an abrasion to the right knee. In addition, the resident required an increase in pain medication related to the injuries. Refer to F282. The findings include: Review of the Nursing Service Standards of Operation (Section: IV Provision of Clinical Professional Services: Subject Assistive/Safety Devices for Resident Safety), last revised 08/12, revealed the facility would assess the resident's individual needs for assistive/safety devices.	F 323	Resident #11 was assessed by the Administrative Nurses (the Director of Nursing (DON), Assistant Director of Nursing (ADON), the MDS Coordinators, Clinical Coordinator, Infection Control Nurse, Incident Management Coordinator and the Staffing Coordinator) for the need for alarming devices with regards to the resident's safety. All alarming devices were reviewed and safety measures put into place. Additionally, the assigned Unit Charge Nurse and the Certified Nurse Aides were given education and corrective as needed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <u>Prior to admission, the Social Services Director/Assistant Director will review the referral information to be able to question any safety concerns in the last sixty (60) days. This information will be reported by the Social Services Director/Assistant Director to the DON and the admitting nurse. New resident admissions with a history of safety concerns within the last 60 days will be placed on (NSO) Nursing Close Observation (which is within view of staff at all times) for 24 hours for resident safety. (Refer to Attachment B). After the 24 hours, a reassessment will be completed per the licensed nurse for need of continued NCO. Additionally, residents already residing in the facility, who have been identified with safety issues will have increased supervision assigned by the licensed nurse on the floor to protect the resident. In addition this will assist staff in increased safety awareness for that resident. Alarming devices were discontinued and replaced with alternate prevention measures including increased staff supervision and safety awareness. Prior to placement of any alarming device the licensed nurse will complete a Safety/Assistive Device form (Attachment B). The updated Assistive Device form are available in the Care Care Book on each hall which lists all safety/assistive devices.</u>		

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F 323	<p>Continued From page 13</p> <p>utilizing an interdisciplinary approach, to promote maximum independence for movement and positioning while providing optimal comfort and safety. Utilization of all assistive/safety devices would be addressed on the resident's plan of care and on the Unit Staff Assignment Sheet. The assigned care giver would monitor the resident's assistive/safety devices to ensure they are in place and functioning properly and denote the same by their signature on the Unit Staff Assignment Sheet.</p> <p>Review of the facility's Risk Management Program (Section: IV Provision of Clinical Professional Service), last revised 10/13, revealed the Falls Reduction Program would be noted on the assigned staffs' Unit Staff Assignment Sheet, bed sensor alarm to be placed on the resident's bed, chair alarm if the resident was chair bound, and other interventions according to resident's individual needs to prevent falls.</p> <p>Record review revealed the facility admitted Resident #11 on 08/20/13, with diagnoses which included Anxiety, Mental Retardation, Seizure Disorder, Anemia, Weight Loss, Constipation, Hypothyroidism, and Movement disorder. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 12/12/13, revealed the facility assessed Resident #11's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) coded as ninety-nine (99), and as requiring the limited assist of one (1) staff for transfers and extensive assistance of one (1) staff for ambulation.</p> <p>Review of the Comprehensive Care Plan for Potential for Injury, dated 12/18/13, and the Unit</p>	F 323	<p><i>These forms are updated with additions or discontinuation of any interventions for safety/assist devices on each shift by the Unit Charge Nurse. If a device is missing or not functioning properly, the assigned staff will report to the Unit Charge Nurse who will replace or remove/replace the device with a working device. This form will be reviewed by the Incident Management Committee (Facility Director, Assistant Facility Director, Facility Administrator, Social Services Director, Advanced Registered Nurse Practitioner, Safety Specialist, Maintenance Superintendent, Director of Nursing, Assistant Director of Nursing, Clinical Coordinator, Staffing Coordinator, Incident Management Coordinator, Infection Control Coordinator, and Minimum Data Set (MDS) Nurse) Monday through Friday in morning meeting. Discussion is held regarding assistive devices, continued use of the device, appropriateness of the device, and overall safety of each resident. The Staff Facility Charge Nurse will review on weekends and holidays. This form will become effective on 03/27/14 with any new admission, quarterly review, and with any new interventions to ensure immediate resident safety (Attachment B).</i></p> <p>What measures will be put into place, or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <p>All residents were reviewed for the need of alarming devices and assistive device forms were completed for each resident who had any type of change in assistive device. This was initiated on 03/24/14 and completed on 03/25/14, then reassessed with changes updated on the care plan on 04/08/14 and Revis on 4/15/14 by the Administrative Nurses (Refer to page 12), (Refer to attachment B).</p>		

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F 323	<p>Continued From page 14</p> <p>Staff Assignment Sheet, dated 03/03/14, revealed the resident was care planned for a bed sensor alarm and a seatbelt alarm.</p> <p>Observation, on 03/18/14 at 9:22 AM, revealed Resident #11 was sitting in the dining room in a Broda chair with a seatbelt alarm; however, further observation revealed the seatbelt alarm was not in the on position and was not functional.</p> <p>Review of the Post Fall Assessment, dated 03/04/14 at 3:50 AM, revealed Resident #11 had an unwitnessed fall from the bed which resulted in a laceration to the right hand and an abrasion to the right knee. The resident's bed sensor alarm was in place but was not turned on to alert staff when the resident attempted to transfer. The physician was called and an order was received to send the resident to the Emergency Room for treatment.</p> <p>Review of the Emergency Room Diagnostic Imaging Report, dated 03/04/14, revealed the resident sustained a fracture to the proximal fifth (5th) phalanx (finger). Review of a Nurse's Note, dated 03/04/14 at 9:30 AM, revealed the resident returned to the facility with a splint to the right hand and four (4) sutures, fracture to the right fifth (5th) phalanx (finger) with hand tender to touch and pain which required Tylenol (pain medication) 650 milligrams (mg) to be given.</p> <p>Review of the February and March 2014 Medication Administration Records (MARs) revealed the resident required an increase in Tylenol administration for pain from twice a month to everyday, but one day, from 03/04/14 through 03/19/14.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on</p>	F 323	<p>In-servicing was held by HDS Coordinator/Staff Facility Charge Nurse with all direct care staff to include: <u>Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Medication Aides (CMAs), and Certified Nurse Aides (CNAs)</u> regarding Policy IV, SOP 2E - Incident Management Assessment (Refer to attachment L) and Policy IV, 7A - High Risk Situations (Refer to attachment M) was discussed with emphasis on resident safety and to ensure assistive devices are in place and functioning. The in-service began on 04/01/14 and was completed by 04/11/14. All direct care staff (<u>Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Medication Aides (CMAs), and Certified Nurse Aides (CNAs)</u>) were issued an updated job description which included "providing overall safety for the residents". Staff signed the job description signifying that they were responsible for "provision of safety" for their residents (Refer to attachments N, O, P, and Q). <u>Training was conducted by Administrative Nurses (Refer to page 14 regarding new admission assessments to determine if residents require nursing close observation for safety. Also the importance of safety monitor for all residents in the facility was discussed. This training began on 4/16/14 and will be completed by 4/27/14. (Refer to Attachment B). Any direct care staff (refer to page 14) not present will be in-serviced upon return to work. Additionally, the unit assignments were changed in an effort to promote increased safety for all residents (Refer to attachment S). All CNAs and CMAs (refer to page 14) will be assigned a partner for providing care. The halls will be divided between the CNAs/CMAs, not resident specific to one staff member. Additionally, portable nursing stations were installed in the hallways opposite the dining rooms to allow for staff members assigned to that end of the hallway to be in view of assigned residents while completing documentation.</u></p>		

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F 323	Continued From page 15 03/19/14 at 1:45 PM, revealed she had checked Resident #11's bed alarm at 3:00 AM prior to going to lunch and it was on and functioning. She stated when she returned from lunch the resident had fallen from the bed. She stated the Charge Nurse informed her that the alarm did not sound because it was not turned on. CNA #2 stated she had no idea how the alarm got turned off because the resident was unable to turn the alarm off. Additionally, she revealed she had made rounds to check the resident's alarms a total of five (5) times during her shift and the alarm was on every time. Interview with CNA #3, on 03/19/14 at 1:10 PM, revealed she was doing rounds and checks on the alarms and was in the room next door to Resident #11 and heard the resident yelling. She stated when she came around the corner, the resident was sitting on the mat, beside the bed, on the floor with blood on his/her hand. She stated she went to the door and yelled for help and the Charge Nurse came to assess the resident. The Charge Nurse called the physician, and sent the resident to the hospital for evaluation. She revealed the resident was unable to explain what had happened related to his/her impaired cognition. Interview with Licensed Practical Nurse (LPN) #3, on 03/19/14 at 10:50 AM, revealed when she entered the room the resident was sitting on the floor, on the mat, beside the bed and had blood on his/her hand. She stated she asked CNA #3 if the bed alarm sounded and was told the alarm was turned off. She revealed she assessed the resident and noted a laceration to the right hand; an abrasion to the right knee; and, the resident complained of pain in the right hand. She stated	F 323	<i>The Administrative Nursus(refer to page 11) and Safety Coordinator have initiated a "FAST" team who will respond to all witnessed and unwitnessed falls immediately upon notification of a fall by the Assigned Unit Charge Nurse Monday through Friday to assist with determination of the root cause of any fall which occurs and to determine if a device is needed to protect the resident. This team will include the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Clinical Coordinator, Staff Development Coordinator, Incident Management, Infection Control and Safety Coordinator beginning on 04/11/14. The Staff Facility Charge Nurse will respond to any witnessed or unwitnessed fall on off-shifts and weekends immediately upon notification of a fall by the Assigned Unit Charge Nurse. The Unit Charge Nurse, the Incident Management Committee (Refer to page 14), and the assigned CNA/CMA (Refer to page 14) will meet to try to determine the root cause of any fall which occurs and to determine if a device is needed to assist with resident safety beginning on 04/11/14. The CNA/CMA (Refer to page 14) assigned to a resident who has a witnessed or unwitnessed fall and anyone who witnesses a fall will answer questions regarding the fall including environment, footwear, devices and other possible causative factors (Refer to Attachment 7) to assist with determination of the cause of the fall. The Unit Charge Nurse will also complete a Fall Investigation Root Cause Analysis Form (Refer to attachment U). The SPCN will co-sign the Root Cause Analysis Form signifying they were present for review and discussion of the fall beginning on 04/17/14. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance All Root Cause Forms associated with any fall will be reviewed by the Incident Management Team (Refer to page 14) Monday through Friday to ensure compliance by the direct care staff (Refer to page 15) in monitoring falls as well as to ensure the root cause is identified with safety measures placed.</i>		

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F 323	<p>Continued From page 16</p> <p>she called the physician and received an order to send the resident to the Emergency Room.</p> <p>Interview with the Medical Director/Resident #11's physician, on 03/20/14 at 12:32 PM, revealed the bed sensor alarm should have been on because it would have alerted staff that something was going on with the resident. He stated that he would not prescribe stronger pain medication for the resident related to an injury unless the current pain regimen was not effective. He stated in this case the Tylenol was effective even though there was an increased need for it after the injury.</p> <p>Interview with CNA #4 and CNA #5, on 03/20/14 at 8:30 AM and 8:35 AM, respectively, revealed they do not turn the alarms off for any reason including providing incontinent care. Both stated there was a silencer button on the alarm, if the alarm goes off during care it resets itself after the resident was stable on the sensor pad. The CNAs stated they should check the alarms every two (2) hours to ensure the alarms were in place and functioning.</p> <p>Interview with the Director of Nursing (DON), on 03/19/14 at 1:05 PM, revealed the alarms were checked by the CNAs and signed off on the Unit Staff Assignment Sheet by the CNA. She stated the Charge Nurse on duty should confirm the alarms were on and functioning properly every two (2) hours.</p>	F 323	<p>On the weekend and holidays the Staff Facility Charge Nurse will review the forms along with the charge nurses to attempt determination of the root cause of any fall with any safety issues addressed immediately beginning 04/17/14. The Incident Management Coordinator/Clinical Coordinator will review each fall Monday through Friday in the morning meeting with the Incident Management team (Refer to page 14) to gather information about all falls with determination of cause and interventions to protect the resident. On 04/17/14, the Employee Monitor Regarding Following Care Plans, Supervision, Restraints, and Catheters (Refer to attachment V) will begin. All direct care staff (Refer to page 14) will be interviewed to assess understanding of the training and in-services provided regarding resident care. This will be conducted by the Administrative Nurses (refer to page 13). Additional education and training will be provided should any issues be identified by the unit Administrative Nurse.</p> <p>These monitors will continue to be completed on four direct care staff every shift times two weeks. Then, three staff will be monitored every shift times two weeks. Then, one staff member every shift times two weeks will be monitored. One random staff member will be monitored daily times three months and then one staff member weekly times three months. Should any issues be identified the unit Administrative Nurse will provide education on the identified issue. These monitors will be turned in and reviewed by the Director of Nursing/Assistant Director of Nursing for any issues which need to be further addressed with follow-up or more education and training. The results of the audits and monitoring will be presented at the Quality Assurance Meeting by the Incident Management Coordinator/ Director of Nursing quarterly times 12 months with any performance plans necessary initiated.</p>	4/18/14	