

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

PRINTED: 01/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/06/2012
NAME OF PROVIDER OR SUPPLIER  WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240		
(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)	DATE COMPLETE	
F 000	INITIAL COMMENTS	F 000			
F 223 SS=G	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's Standard of Operating Procedures, and the Investigative Report, it was determined the facility failed to ensure residents were free from verbal, physical, and mental abuse for one resident (#10), in the selected sample of twenty-three residents. Certified Medication Technician (CMT) #1 witnessed Certified Nurse Aide (CNA) #1 hit Resident #10 across the face with a shoe, but failed to report the incident immediately to his supervisor. (Refer to F226. Resident #10 was crying after the incident and stated to CNA #1 'Don't hit me.' CNA #1</p>	F 223	<p>483.13 (b), 483.13(b) (1) (i) Free From Abuse/Involuntary Seclusion</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>A Body Audit was completed on Resident # 1 per the licensed nurse and the certified investigator at the time of the reported allegation of abuse on 12/20/11. There were no noted injuries. A Weekly Skin Assessment was completed as well on 12/25/11 per the Unit 33-1 licensed nurse, with no injuries noted. A disciplinary action was given by the DON in regards to failure to report an allegation of abuse upon discovery of the occurrence with Certified Medication Technician #1 along with in-servicing regarding immediate reporting of any allegation of abuse, neglect or exploitation on 01/09/12. (Refer to Attachment A.)</p> <p>CONTINUED ON PAGE 2</p>	2-21-12	

*Revised  
POC #3*

*Accepted 2/13/12 JH*

LABORATORY USE ONLY OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *JHA* DATE: *2/13/12*

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 disclosed to OAHs 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 disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	<p>Continued From page 1</p> <p>remained in the dining room with Resident #10 for 10-15 minutes before the incident was reported, causing psychosocial harm to the resident.</p> <p>The findings include:</p> <p>A review of the facility's Standard Operating Procedure "Incident Management/Abuse Protocol", revised 07/01/07, revealed adult abuse was defined as the willful infliction of injury, intimidation, or punishment that resulted in physical pain or injury, including mental injury or anguish.</p> <p>A review of the Final Investigative Report, completed 12/27/11, revealed CNA #7 reported to RN #1, on 12/20/11 at approximately 2:55 PM, that Resident #10 was crying. When the resident was questioned by RN #2, the resident reported someone had hit him/her. CMT #1 approached RN #2 at that time, and reported he witnessed CNA #1 hit Resident #10. An interview with CMT #1, on 01/05/12 at 2:15 PM, revealed the incident had occurred between 2:00 PM and 2:30 PM. CNA #1 was removed from direct care on 12/20/11 at 3:00 PM and terminated 12/22/11.</p> <p>An interview with CMT #1, on 01/05/12 at 2:20 PM, and on 01/06/12 at 2:00 PM, revealed he witnessed an incident on 12/20/11 between CNA #1 and Resident #10. Resident #10 was sitting in a chair between the dining room and television room, kicking his/her shoes across the hall. CNA #1 assisted Resident #10 to sit at a table in the dining room. He revealed CNA #1 took the resident's house shoe and "swiped" it across the resident's face, back and forth two times. He revealed the first "swipe" was loud enough to</p>	F 223	<p>483.13 (b), 483.13(b) (1) (I) Free From Abuse/Involuntary Seclusion</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>In order to identify other residents having the potential to be affected by the same deficiency practice, the corrective actions taken were as follows:</p> <p>The Incident Management Committee will complete a daily review 7 days a week to determine that all allegations of abuse, neglect and exploitation have been reported per the employee upon discovery of the incident to the next line supervisor or facility Administrator to ensure that residents are free from abuse. The review will include: The date reviewed, the date and time of the occurrence, the date and time incident was reported to the next line supervisor or facility Administrator (List name). (Refer to Attachment B-implemented on 2/14/12-).</p> <p>The revised process will be directed by the Incident Management Coordinator Monday-Friday and by the assigned Shift Facility Charge Nurse on weekends and holidays. The Director of Nursing will be responsible for ensuring the 7 day of the week review of the Western State Nursing Facility Incident Management Review, and Follow-up Form, is completed (Implemented on 02/14/12). (Refer to Attachment B-implemented on 2/14/12-).</p> <p>Continued on Page 3</p>	2-21-12	

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F 223	<p>Continued From page 2</p> <p>hear a "smack" from the plastic on the bottom of the shoe. He stated the resident was crying after the incident and stated to CNA #1 "Don't hit me." He revealed CNA #1 stated to the resident "There is no excuse for it. Is there?" CMT #1 revealed he did not report the incident as soon as it happened. CNA #1 walked away from the resident, but was stayed in the dining room. CMT #1 revealed, approximately "10-15 minutes" later, an employee from the next shift. CNA #7, noticed the resident was crying and she informed Registered Nurse (RN) #2 that something was going on with the resident. At that time, CMT #1 stated that he then reported the incident to RN #2. CMT #1 revealed he should have reported the incident as soon as it occurred, and should have asked CNA #1 to leave the situation. With the delay in reporting, he revealed it was possible for CNA #1 to have further contact with Resident #10 and other residents in the facility.</p> <p>An interview with CNA #7, on 01/05/12 at 3:30 PM, and on 01/06/12 at 1:45 PM, revealed she worked second shift on 12/20/11. At approximately 2:38 PM, she stated that she clocked in for her shift and put her purse behind the nurse's desk. She walked down the hallway and observed her resident rooms, as usual. She revealed Resident #10 was sitting in the dining room with CNA #1 sitting in front of the resident. She revealed the resident's eyes were red and he/she was visibly upset. She revealed the resident began to cry when spoken to, and was unable to express what was wrong. She stated "I had never seen him/her like this before." She revealed she asked the dayshift staff if anyone knew what was wrong with Resident #10, but no information was provided. She revealed CMT #1</p>	F 223	<p>The DON will initiate in-servicing on 02/13/12 with the Incident Management Committee to include the Incident Management Coordinator, MDS coordinators, Rehab coordinator, Staffing Coordinator, Social Services, Facility Administrator, Assistant Facility Administrator, and Director of Nursing in regards to the daily review of all allegations of abuse, neglect and exploitation to ensure all allegations have been reported per the employee upon discovery of the incident per policy. WSNF General Nursing Facility Manual (SOP #1-A).</p> <p>What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur.</p> <p>On 01/31/12 in-servicing began per the Incident Management Coordinator, with all staff in regards to WSNF's Abuse as per policy to include reporting requirements. WSNF General Nursing Facility Manual (SOP #1-A). In-servicing to be completed by 02/14/12.</p> <p>At the time of in-servicing all staff will sign the Zero Tolerance form for Abuse being made aware that failure to report abuse per facility policy shall be subject to disciplinary action up to and including dismissal (All staff on leave will be in-serviced and will sign the Zero Tolerance form for Abuse on return to work). (Refer to Attachment C.)</p>	2-21-12

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F 223	<p>Continued From page 3</p> <p>was in the doorway of the television room, but did not say anything at that time. She called RN #2 to the dining room for assistance with the resident, and RN #2 asked staff to stay in the building until it was determined what happened with the resident. Upon questioning by RN #2, CMT #1 gave a report of the witnessed incident.</p> <p>An interview with RN #2, on 01/05/12 at 3:55 PM, revealed he was the day shift nurse working on 12/20/11. He revealed CNA #7 called him to the dining room that day because Resident #10 was "really upset." He revealed the resident told him he/she was hit by someone, but did not want to say who hit him/her. He stated that CNA #1 was in the back of the dining room, on the opposite side of Resident #10. He notified his supervisor by phone. He revealed CMT #1 was in the doorway of the television room and appeared to be "flushed" and "shaky." RN #2 stated that CMT #1, at that time, reported the alleged abuse to Resident #10 by CNA #1. RN #2 revealed he called CNA #1 to the nurse's desk and she was taken off the floor.</p> <p>An interview with CNA #8, on 01/05/12 at 4:10 PM, revealed he was sitting in the dining room on 12/20/11 between 2:00 PM-2:30 PM. He revealed his back was to Resident #10 and CNA #1, and he heard a "pop" but did not turn around to see what caused the sound. He revealed the resident was upset about something, but he did not witness anything.</p> <p>An interview with CNA #1, on 01/05/12 at 11:45 PM, revealed on 12/20/11 Resident #10 was kicking his/her shoes off and she walked the resident to the dining room to calm down. She</p>	F 223	<p>How the corrective actions will be monitored to ensure the deficient practice will not recur.</p> <p>On 02/14/12, all staff will be interviewed by their immediate supervisor in regards to their knowledge of facility requirements for reporting resident abuse/neglect/exploitation which includes their responsibility of making a verbal report to the immediate supervisor, Facility Administrator or <u>assigned shift facility charge nurse</u>, upon discovery of the incident (as per facility policy) to be completed 2/20/12. (Refer to Attachment D.) All staff will be re-interviewed quarterly for two consecutive quarters then random audits completed quarterly on 25% of direct care staff. The results of the monitor will be reported to the Quality Assurance Committee by the DON with action plans developed for any issues of non-compliance.</p> <p>A report of the daily Incident Management Review Committee will be reviewed daily by the Don or <u>assigned shift facility charge nurse</u> if absent to include:</p> <p>The date of review date and time of discovery of alleged abuse/neglect/exploitation, date and time staff made aware (if reported by resident), date and time reported to the next line supervisor facility Administrator (list name), list reporting actions, date and time alleged perpetrator removed from direct care, date and time investigator assigned, was witnessed or receiving report of an allegation of abuse/neglect/exploitation reported upon discovery and if no the follow up action to ensure that the review process was completed and tracking and trending of identified problems with action plans developed and reported to the QA committee.</p>	2-21-12

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F 223	Continued From page 4 revealed the resident's shoes were taken away. She told the resident he/she could have them back after the resident calmed down. She denied hitting the resident with the shoe.  An interview with the Administrator and Assistant Administrator, on 01/06/12 at 2:46 PM, revealed a time frame, from the time the incident occurred to the time it was reported, could not be verified as the incident occurred at shift change.  A review of Resident #10's clinical record revealed the resident was admitted to the facility on 09/18/07 with diagnoses to include Bipolar Type Schizoaffective Disorder and Depressive Disorder. A review of the quarterly Minimum Data Set (MDS), dated 10/25/11, revealed the facility assessed the resident as moderately cognitively impaired.  An attempt to interview Resident #10, on 01/05/12 at 9:00 AM, revealed the resident was hard to understand at times, during the interview. He/She stated repeatedly "Everybody loves me" and "I love it here."	F 223			
F 226 SS=G	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's Standard of Operating Procedures, and the Final	F 226	483.13 (c) DEVELOP / IMPLEMENTING POLICIES & PROCEDURES  What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.  A disciplinary action was given per the DON to CMT #1 for failure to follow facility abuse policy( Western State Nursing Facility Policy SOP# 1-A) on 02/09/12 (Refer to Attachment --A) in reporting allegation of abuse upon discovery of occurrence.  An educational session was held with teaching by the Director of Nursing with the certified investigator of the failure to identify the delay in the initial reporting upon CMT #1's discovery the allegation of abuse on 02/09/12.	2-21-12	

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F 225	Continued From page 5  Investigative Report, it was determined the facility failed to ensure written policies and procedures were implemented that prohibit abuse of residents for one resident (#10). In the selected sample of twenty-three residents, Certified Medication Technician (CMT) #1 witnessed Certified Nurse Aide (CNA) #1 hit Resident #10 across the face with a shoe, but failed to report the allegation immediately to his supervisor. Resident #10 was crying after the incident and CNA #1 remained in the dining room for approximately 10-15 minutes. (Refer to F223) A final investigative report, completed 12/27/11, did not address the delay in reporting by CMT #1.  The findings include:  A review of the facility's Standard Operating Procedure "Incident Management/Abuse Protocol", revised 07/01/07, revealed the facility would immediately report and respond to any involvement, observation of, report of, or potential for an incident or event that indicated a resident injury, harm, abuse, neglect, or exploitation. The protocol revealed it was the responsibility of any staff person to make an immediate verbal report about an incident to the immediate supervisor and/or facility administrator or designee as soon as it was discovered. Any staff failing to report an incident immediately upon suspicion of abuse or neglect were considered in violation of the facility's policy and subject to appropriate disciplinary action, up to and including dismissal.  A review of the Final Investigative Report, completed 12/27/11, revealed CNA #1 was removed from direct care on 12/20/11 at 3:00 PM and terminated 12/22/11; however, there was no	F 226	How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken.  All residents have the potential to be affected by the same deficient practice, the corrective action taken are as follows:  On 02/13/12, the DON will re-inservice the facility certified investigators in regards to the facility's responsibilities to ensure that the Abuse Policy (Western State Nursing Facility SOP #1A) is implemented, which includes all allegations of abuse are reported upon discovery. The facility investigators will be inserviced as well on their responsibility to identify and report any delay in reports of allegation of abuse to the DON or Facility Administrator.  All staff will be provided reeducation regarding Western State Nursing Facility SOP #1-A in regards to initial reporting of any the allegation of abuse upon discovery to begin 1/31/12 completed by 02/6/12. (All employees on leave at the time of the reeducation will be inserviced upon first day of return to work).	2-21-12	

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F 226	<p>Continued From page 6</p> <p>Information regarding the delayed reporting by CMT #1.</p> <p>An interview with CMT #1, on 01/05/12 at 2:20 PM and on 01/06/12 at 2:00 PM, revealed he witnessed an incident of verbal and physical abuse on 12/20/11 between CNA #1 and Resident #10. CMT #1 revealed he did not report the incident as soon as it happened as he was "nervous." He revealed it was emotional and he could not believe the incident happened. He had been employed at the facility for six years, but never had to report an allegation of abuse. He revealed he reported the incident to RN #2, "10-15 minutes" after the incident was witnessed. CMT #1 revealed he should have reported the incident as soon as it occurred. With the delay in reporting, he revealed it was possible for CNA #1 to have further contact with Resident #10 and other residents in the facility.</p> <p>An interview with CNA #7, on 01/05/12 at 3:30 PM and on 01/06/12 at 1:45 PM, revealed she worked second shift on 12/20/11. At the beginning of the shift, she noticed Resident #10 was sitting in the dining room with CNA #1. The resident was visibly upset. She revealed CMT #1 was in the doorway of the television room, but did not say anything at that time. She called RN #2 to the dining room for assistance with the resident. Upon questioning by RN #2, CMT #1 gave a report of the witnessed incident.</p> <p>An interview with RN #2, on 01/05/12 at 3:55 PM, revealed he was the day shift nurse working on 12/20/11. He revealed CNA #7 called him to the dining room that day because Resident #10 was "really upset." He revealed CMT #1 was in the</p>	F 226	<p>What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur.</p> <p>An Administrative Committee that consist of the Administrator, the Assistant Administrator, the DON, the assigned investigator and a certified investigator will review all statements in any allegation of abuse investigation to ensure there was no delay of reporting and the facility process is followed. This review process will be completed prior to the completion of the final report. The review process will include: The date reviewed, the date and time of the allegation of discovery of abuse, neglect, or exploitation, the date and time incident was reported to the next line supervisor or facility Administrator (List name). (Refer to Attachment E)</p> <p style="text-align: center;">CONTINUED ON PAGE 8</p>	2-21-12	

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F 226	<p>Continued From page 7</p> <p>doorway of the television room and appeared to be "flushed" and "shaky." At that time, CMT #1 reported the alleged abuse to Resident #10 by CNA #1.</p> <p>An interview with the facility's Certified Investigator, on 01/06/12 at 2:25 PM, revealed she investigated the allegation of abuse on 12/20/11. She revealed she was aware CMT #1 did not report the incident as soon as it was witnessed. She stated CMT #1 was not exactly sure how long he waited to report, but CMT #1's best guess at the time of the investigation was five (5) minutes. She revealed CMT #1 was passing medications at the time of the incident and could not leave the medication cart. Per interview, CNA #1 was not "repeatedly hitting" the resident; she had stopped and walked away. She revealed the facility considered CMT #1's timeline of events adequate, so the investigative report did not conclude there was a delay in CMT #1 reporting the incident.</p> <p>An interview with the Director of Nursing, on 01/06/12 at 2:45 PM, revealed CMT #1 was passing medications and witnessed the incident between CNA #1 and Resident #10. She revealed CMT #1 did "to the best of his ability" report the incident immediately. She revealed she expected staff to keep the residents safe, from every aspect.</p> <p>A review of an employee schedule for CMT #1, dated December 2011, revealed he worked in the facility on 12/21/11, 12/22/11, 12/25/11, and 12/26/11. A review of an inservice related to abuse revealed CMT #1 was not inserviced until 12/27/11. Review of the personnel file for CMT #1</p>	F 226	<p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b></p> <p>The allegation of abuse reporting process will be monitored as follows:</p> <p>The Incident Management Committee who meets daily 7 days a week to review all incidents including allegations of abuse to ensure reports of allegations are reported upon discovery of the incidents. (Refer to the Incident Management Assessment and Follow up) (Refer to Attachment B.) The assigned Shift Facility Charge Nurse on the dayshift will be responsible for the review of the Western State Nursing Facility Incident Management Review Process Reporting of Allegation of abuse/neglect/exploitation on weekends and holidays. The Director of Nursing will be responsible for ensuring the 7 day of the week review of the Western State Nursing Facility Incident Management Review Process Reporting of Allegation of abuse/neglect/exploitation is completed (Implemented on 02/14/12).</p> <p>The Administrative Committee will complete the Western State Nursing Facility Reporting allegation of abuse/neglect/exploitation form after each investigation process review to ensure there was no delay of reporting and the facility process was followed. Refer to Attachment E-1 (Implemented on 02/14/12).</p> <p>The Don will ensure the daily Incident Management Committee is followed along with the Administrative Committee Review of allegations of abuse with reporting of the monitoring to the Quality Assurance Committee with action plans developed for any occurrence of non-compliance.</p> <p style="text-align: center;">COMPLETE</p>	2-21-12			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 8 revealed no disciplinary action related to the delay in reporting abuse.	F 226		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food. If direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	483.65 INFECTION CONTROL PREVENT SPREAD, LINENS  What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? <u>The Advanced Practitioner Registered Nurse</u> assessed residents #3, #6 and # 13 with no noted signs and symptoms of infection as Resident #6 had a CBC obtained on 01/06/12 for follow up due to previous infection prior to admission with results within normal limits. Vital signs were taken with in the week of 01/09/12 that remained within normal limits. Resident #3 had a skin assessment completed with no sign or symptoms of infection on 1/10/12. Residents #6 and #17 had skin assessments and overall systems assessments completed the week of 1/8/12. Vital signs were completed with no signs or symptoms of infection. The Infection Control Report revealed no infections for resident #3, #6 and #13 for January.  Educational sessions were given by the Director of Nursing to (LPN) #1, (CNA) #2, #9, and #10 on 02/01/12, and Certified Medication Technician #1 on 2/04/12 and Licensed Practical Nurse #1 on 02/01/12 along with in-services regarding hand washing. Educational sessions included the review of SOP 1M-Handwashing and the requirement to wash hands and change clothes during resident care.  CONTINUED TO PAGE 10	2-15-12

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

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FORM APPROVED  
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F 441	<p>Continued From page 9 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Standard Operating Procedures, it was determined the facility failed to ensure appropriate use of gloves and handwashing during incontinent care for three residents (#3, #6, and #17) in the selected sample of twenty-three residents.</p> <p>The findings include: A review of the facility's Standard Operating Procedure "Handwashing", dated Sept. 2006, revealed "after situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood or body fluids, secretions, or excretions. Gloves should be used in addition to, not as a substitute for handwashing. Gloves should be removed to prevent contamination of hands during removal" and hands washed afterwards. "Gloves should be changed between patients, and may need to be changed during the care of a single patient, for example: when moving from one procedure to another."</p> <p>1. An observation of incontinent care, on 01/05/12 at 10:30 AM, revealed Certified Nurse Aide (CNA) #2 donned gloves and completed incontinent care for Resident #6. CNA #2 then repositioned the resident, touched the resident's clean sheet and reached into the pocket of her</p>	F 441	<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>In order to identify other residents having the potential to be affected by the same deficient practice, the corrective actions taken were as follows:</p> <p>On 02/01/12, the revisions made to the Western State Nursing Facility (Standard Operation Procedure #1M Subject: Hand washing) per the DON will be put into effect. The revisions will read bold in print, "Gloves will be changed between patients, and will be changed during care of a single resident, when moving from one procedure to another." (Refer to Attachment F)</p> <p>On 02/06/12 the Infection Control Nurse will provide in-servicing and verification of understanding of the revised policy (Western State Nursing Facility Standard Operation Procedure #1M Subject: Hand washing) to all direct care Registered Nurses, Licensed Practical Nurses, Certified Medication Technician, Certified Nurse Aides, the MDS Coordinators, Nursing Staffing Directors, Nursing Rehab Coordinator and the Director of Nursing completion date of 02/10/12. (All employees on leave at the time of the in-service will review the revised policy upon first day of return to work). (Refer to Attachment F)</p> <p>Upon the in-servicing for hand washing, the Hand Hygiene Observation Tool will be completed on all of the direct care staff (All RNs, LPNs, CMTs and CNAs) by the Infection Control Nurse by 02/10/2012.</p> <p>Continued on Page 11</p>	2-15-12

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

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F 441	<p>Continued From page 10</p> <p>own shirt while wearing the soiled gloves. CMT #1 assisted CNA #2 with the incontinent care. He donned gloves before providing care, but did not wash his hands after removal of the gloves. He left the resident's room and went to the medicine cart without washing his hands.</p> <p>Interview with CNA #2, on 01/05/12 at 2:05 PM, revealed she should have changed gloves and washed her hands between each procedure with the resident.</p> <p>Interview with CMT #1, on 01/05/12 at 2:20 PM, revealed he should have washed his hands before leaving the resident's room.</p> <p>2. An observation of incontinent care, on 01/05/12 at 10:40 AM, revealed CNA #9 completed incontinent care for Resident #3. She then repositioned the resident and picked up a bottle of cleanser from the floor with her soiled gloves. She cleansed the resident's buttocks, then repositioned the resident in bed, touched the resident's pillow and put the pillow behind the resident's back with her soiled gloves.</p> <p>An interview with CNA #9, on 01/05/12 at 11:15 AM, revealed she should remove her gloves, wash her hands, and don new gloves between different areas of care.</p> <p>3. An observation of incontinent care, on 01/06/12 at 9:15 AM, revealed CNA #10 cleansed Resident #17 after the resident had a bowel movement. She then assisted Licensed Practical Nurse (LPN) #1 reposition the resident in bed while wearing the soiled gloves. LPN #1 provided perineal care for the resident. LPN #1 and CNA</p>	F 441	<p>The Hand Hygiene Observation Tool lists and provides documentation of performance and/or verbalization of knowledge of when and how to perform Hand Hygiene as follows:</p> <p>to be performed:</p> <ul style="list-style-type: none"> <li>• before clean and aseptic procedures;</li> <li>• after contact with blood, body fluids, mucous membranes and non intact skin;</li> <li>• after handling objects such as soiled linen, trash, and equipment;</li> <li>• after removing gloves or other used Personal Protection Equipment;</li> <li>• before resident contact;</li> <li>• after resident contact or when exiting the resident's room;</li> <li>• upon entering resident room</li> <li>• before and after equipment contact;</li> </ul> <p>The Hand Hygiene Observation Tool also lists and provides documentation of performance and/or verbalization of knowledge of appropriate glove use as follows: gloves to be changed between residents and will be changed during the care of a single resident when moving from one procedure to another; gloves will be used when there is a potential for contact with body fluids; gloves will be removed immediately after use. (All employees on leave at the time of observation will be completed upon first day of return to work). (Refer to Attachment -G)</p> <p>What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>On 02/01/12, the Director of Nursing revised the Western State Nursing Facility (Standard Operation Procedure #1MSubject: Hand washing) to read bold in print, "Gloves should be changed between patients, and may need to be changed during care of a single patient, for example; when moving from one procedure to another." (Refer to Attachment -F)</p> <p style="text-align: center;">Continued on Page 12</p>	2-15-12	

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

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F 441	<p>Continued From page 11</p> <p>#10 then applied the resident's brief wearing their soiled gloves. LPN #1 separated soiled linen from trash into two separate bags and then applied the resident's socks while wearing her soiled gloves.</p> <p>An interview with CNA #10, on 01/06/12 at 9:30 AM, revealed she should have changed gloves after providing care to the resident, but was not aware to wash her hands before applying new gloves.</p> <p>An interview with LPN #1, on 01/06/12 at 9:35 AM, revealed she should have washed her hands and changed her gloves after providing perineal care. She revealed if she had been more prepared, she would not have had to separate linen from trash into different bags, but she should have washed her hands before applying the resident's socks.</p> <p>An interview with the Director of Nursing (DON), on 01/06/12 at 2:45 PM, revealed she expected staff to follow the facility's Standard Operating Procedure for handwashing. Per interview, she expected staff to take their gloves off after they are soiled and wash their hands.</p>	F 441	<p>An In-service of the revised policy Western State Nursing Facility (Standard Operation Procedure #1M Subject: Hand washing) will be provided per the Infection Control Nurse beginning on 02/06/12 and completed by 02/10/12. (All employees on leave at the time of the In-service will review the revised policy upon first day of return to work). (Refer to Attachment -F )</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur?</p> <p>The Hand Hygiene/Glove Use Observation Tool will be completed on all direct staff (All RNs, LPNs, CMTs and CNAs) weekly for 4 consecutive weeks beginning the week of 02/13/12, to ensure that the appropriate use of gloves and hand washing are completed during resident care as per facility policy Western State Nursing Facility SOP 1M-Handwashing. A Hand Hygiene/Glove Use Observation will then be completed on all direct care staff quarterly.</p> <p>In-servicing of new employees will also be performed in New Employee Orientation, starting the week of 02/20/12 to ensure knowledge of the handwashing policy is followed. A Hand Hygiene/Glove Use Observation Tool will be completed at the time of in-servicing of new employees to verify performance and/or verbalization of knowledge of proper hand hygiene/glove use. (Refer to Attachment -G).</p> <p>The outcomes of the observations will be reported to the Quality Assurance Committee per the Infection Control Nurse with follow-up action plans developed as needs are identified.</p> <p style="text-align: center;">COMPLETE</p>		

**WESTERN STATE NURSING FACILITY  
GENERAL NURSING FACILITY MANUAL  
HOPKINSVILLE, KENTUCKY  
(Administrative Section)**

**Attachment A**

**STANDARD OPERATING PROCEDURE NO. 1A**

**Effective Date: May 12, 1997**

**Revised: January 30, 1998  
March 10, 1999  
February, 2001  
March 18, 2004  
January 6, 2006  
July 1, 2007  
September 2011**

**Subject: WESTERN STATE NURSING FACILITY  
INCIDENT MANAGEMENT/ABUSE PROTOCOL**



**Reference Documents:**

Procedures on Incident Management Protocol (Department for Mental Health and Mental Retardation Services July 1, 2007). (Appendix A)

**A. STANDARD**

Western State Nursing Facility will strive to ensure continuous improvement of resident care processes and resident outcomes by systematically identifying and analyzing unusual incidents to include the components of effective abuse protection recommended by the Centers for Medicare and Medicaid Services (CMS); the classification of incidents; tracking and trending of incidents; and implementing effective actions to protect from harm those individuals served.

Western State Nursing Facility will follow a proactive, objective, operationalized and integrated system to ensure that all individuals served are free from all forms of abuse, neglect, and exploitation through prevention, protection, screening, identification, reporting/responding, investigating and training. This facility maintains a position of zero tolerance for abuse, neglect, or exploitation for all residents served.

**B. GENERAL DEFINITIONS**

1. **Agent-** Any individual not employed by the facility but working under the auspices of the facility, such as a volunteer, a student, etc....
2. **Certified Investigator-** A person who successfully completes a DMHMRS approved training and has sample investigations reviewed and approved by the Department Incident Management Administrator or designee.

Western State Nursing Facility  
General Nursing Facility Manual  
Standard Operating Procedure No 1A

3. **Department Incident Management Administrator-** The person appointed by the DMHMRS Commissioner responsible for providing functional oversight and management of the facility-based Incident Investigation process and provides functional supervision of the Department Incident Management Coordinator.
4. **Department Incident Management Coordinator-** The person appointed by the Facility Director responsible for facility on-site reviews of Incident Reports.
5. **Facility Incident Management Coordinator-** The staff assigned by the Facility Director responsible for implementing the Incident Management Review Process.
6. **Incitement-** To spur to action or instigate into activity; implies responsibility for initiating another's actions.
7. **Individual-** Refers to the person served in a facility; who resides in a nursing home; who resides in an ICF; who does not reside in an ICF but receives services at the ICF; who receives services in a psychiatric hospital; OR who may be physically away from the facility (nursing home, ICF/MR, or psychiatric hospital) but still on the census of the facility.
8. **Inquiry-** This process entails an examination of the facts reported in a Class 2 Incident to ensure the information is accurate and that the facility has responded appropriately.
9. **Investigation-** this process ensures the facility conducts an objective investigation of all allegations of abuse, neglect, exploitation and Class 3 Incidents, in a timely and thorough manner. This process follows the standard investigative report format approved by the Department Incident Management Administration.
10. **Retaliatory Action-** Any action intended to inflict emotional or physical harm or inconvenience on an employee or individual served that is taken because he or she has reported abuse, neglect, or exploitation. This includes, but is not limited to, harassment, disciplinary measures, discrimination, reprimand, threat, and criticism.

### C. DEFINITIONS CONCERNING ABUSE, NEGLECT, AND EXPLOITATION

1. **Adult Abuse-** Adult abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury or anguish. Abuse also refers to the ill-treatment, violation revilement, malignment, and/or otherwise disregard of an individual, whether purposeful, or due to carelessness, inattentiveness, or omission of the perpetrator. This may be a direct act by an individual or the incitement of another staff member or individual to perform the act. Abuse also may be due to staff neglect or indifference to infliction of injury or intimidation of one resident to another.
2. **Adult Neglect-** A situation in which an adult is unable to perform or obtain for himself the good or services that are necessary to maintain his health or welfare, or the deprivation of services by caretaker, i.e. the failure to provide goods and services necessary to maintain the health and welfare of an adult, which may result in physical harm, mental anguish, or mental illness.
3. **Child Abuse and Neglect-** (KRS600.20) (1) (See Department for Mental Health and Mental Retardation-Incident Management Protocol).
4. **Exploitation-** Obtaining or using an individual's resources, including, but not limited to, funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the individual of those resources. Exploitation includes the misappropriation of an individual's property which includes the deliberate misplacement, mistreatment, or wrongful, temporary, or permanent use of individual's belongings or money without the individual's consent.
5. **Immediately:** After ensuring the safety and well being of the individual (s) served, the Facility Director or Designee shall contact, without further delay, all required state and local government agencies of any reported, suspected, or alleged incident of abuse, neglect, exploitation, OR any Class 3 Incident, according to applicable statutes listed under Section 4.B., authority.
6. **Incident-** An occurrence or event that causes, or may cause, harm to an individual (s) served, staff, visitors, or property.
7. **Injuries of unknown source-**An injury is to be classified as an "injury of unknown source" when **both** of the following conditions are met:
  - a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident.
  - b. The injury is suspicious because the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the frequency of the injury).

8. **Medication Errors-** There are nine (9) categories of medication errors, according to Categories as defined by the National Coordinating Council for Medication Error Reporting and Prevention (NCC-MERP) Error Outcome Category Index:
  - a. Category A: Circumstances or events that have the capacity to cause error; this error requires a medication variance report to the facility Pharmacy and Therapeutics Committee.
  - b. Category B: An error occurred, but the error did not reach the resident; this error requires a medication variance report to the facility Pharmacy and Therapeutics committee.
  - c. Category C: An error occurred that reached the resident, but did not cause resident harm, considered Class 1.
  - d. Category D: An error occurred that reached the resident and required monitoring to confirm that it resulted in no harm to the resident, and/or required intervention to preclude harm, considered Class 1 UNLESS there is a trend, at which point it bumps to Class 3.
  - e. Category E: An error occurred that may have contributed to or resulted in temporary harm to the resident and required intervention, considered Class 3.
  - f. Category F: An error occurred that may have contributed to or resulted in temporary harm to the resident and required initial or prolonged hospitalization, considered Class 3.
  - g. Category G: An error occurred that may have contributed to or resulted in permanent resident harm, considered Class 3.
  - h. Category H: An error occurred that required intervention necessary to sustain life, considered Class 3.
  - i. Category I: An error occurred that may have contributed to or resulted in the resident's death, considered Class 3.
9. **Mental/Psychological Abuse-** Includes, but is not limited to, humiliation, harassment, threats or punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.
10. **Missing Individual:** Absent without authorization regardless of leave status; an individual is considered to be missing if the individual (1) has not been accounted for when expected to be present (2) has left the grounds of the facility without permission.
11. **Para-suicidal Behavior:** Behavior suggesting suicidal thoughts, with no serious attempt present.
12. **Physical Abuse:** Motion or action, by which bodily harm or trauma occurs and includes, but is not limited to, hitting, slapping, pinching, punching, kicking, and burning. Physical abuse also includes controlling behavior through corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment.

13. **Serious Injury-** Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries are harms sustained that require treatment beyond first aid.
14. **Sexual Abuse/Assault-** Sexual contact between staff and an individual or between two individuals and includes any touching of the sexual or other intimate parts of a person done for the purpose of gratifying the sexual desire of either party. Sexual abuse/assault also includes, but is not limited to, staff negligently allowing intimate contact between individuals, sexual harassment, and sexual coercion. (Refer to Western State Nursing Facility-General Nursing Facility Manual, SOP # 9-A, Sexual Abuse/Assault.)
15. **Suicidal Behavior:** Any serious attempt to kill one's self.
16. **Threat-** Any condition or situation which could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of individuals, or in their death.
17. **Verbal Abuse:** Any use of any oral, written, or gestured language that willfully includes disparaging and derogatory terms to individuals or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Verbal abuse also includes pejorative and derogatory terms to describe individuals with disabilities.

#### **D. ABUSE PREVENTION**

1. The facility will make every reasonable effort to maintain an environment free of abuse, neglect, and misappropriation of resident property/funds. This facility maintains a position of zero tolerance for abuse and neglect. (See Attachment A, which is required from every employee annually.
2. The facility will provide information to all residents, families/guardians, and staff on how and whom they may report concerns, incidents, and grievances without fear of retribution and will provide feedback regarding the concerns that have been expressed. This information will be provided on admission and at a minimum of annually thereafter.
3. The facility will identify, correct, and intervene in situations in which abuse, neglect, and/or misappropriation of resident property is more likely to occur.
4. Any identified behaviors that might lead to conflict with staff and other residents will be addressed by the Interdisciplinary Overall Plan of Care Team and will follow through with interventions designed to minimize the risk of conflict. (All residents will be assessed on admission and quarterly thereafter, so to identify behaviors or circumstances that might lead to conflict. All residents

Western State Nursing Facility  
General Nursing Facility Manual  
Standard Operating Procedure No 1A

identified will have specific interventions and goals on their individualized plan of care so to monitor, prevent, and provide optimal resident safety.)

5. Upon employment and annually thereafter, all employees will be in-serviced regarding Resident Rights, Abuse/Neglect, and misappropriation of funds/property.

\*All employees will be given a copy of the Western State Nursing Facility Protocol during New Employee Orientation.

6. The facility will maintain an environment where residents, families/guardians, and visitors are free to report issues regarding abuse/neglect and misappropriation of funds/property to the supervisory staff, the facility administrator, or administrator on call or by calling (270) 889-6025, ext. 294. Monday-Friday 8:00 a.m.- 4:30 p.m. or ext. 395 after hours, weekends, and holidays.
7. The facility will incorporate abuse/neglect, exploitation, and misappropriation of funds/property issues into the Quarterly CQI meeting.
8. Appropriate actions will be taken to investigate and resolve all complaints, grievances, and lost items through the utilization of specific forms provided by the Social Service Department. (Reference SS Manual SOP # 52-53 and Resident Handbook ).
9. All supervisory staff will continuously monitor and identify risk factors for abuse, neglect, exploitation, and/or misappropriation of funds/property, reporting any issues to the department supervisor and facility administrator.

## **E. PROTECTION**

This facility implements a planned, systematic approach of protection of residents that ensures that all individuals served are protected from harm, service interruptions, restrictions, abuse, neglect, and exploitation of all forms (whether from staff, peer to peer, visitors, or other individuals). This is done through programs of prevention, screening, identification, reporting, responding, investigating, and training.

## **F. SCREENING**

Criminal background and Nurse Aide Abuse Registry checks are required before any person is employed at Western State Nursing Facility. In addition, Western State Nursing Facility will conduct a 100% annual background check on current state and contract employees, regardless of work area, at the time of their annual hire date.

### **1. Criminal Background Checks**

KRS 216.533 (1) requires the following background check (s) prior to employment:

- a. An in-state criminal background information check shall be obtained from the Justice Cabinet or Administrative Office of the Courts for each applicant recommended for employment.

- b. An out-of-state criminal background information check (s) shall be obtained for any applicant recommended for employment who has resided or been employed outside of the Commonwealth.

## **2. OIG Exclusion List Checks – Employees/Entities**

Western State Nursing Facility also screens employees and entities through the Federal Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), to exclude individuals and entities that are not eligible to work with healthcare providers due to past illegal acts.

- a. The LEIE Database will be checked for all potential employees before hire to assure that the employee is not listed as excluded. (Bases for exclusion include convictions for program related fraud and resident abuse, licensing board actions and default on health education loans). Any individual listed on the LEIE Database will not be eligible for hire.
- b. The LEIE Database will be checked for contracted entities (those that have access or involvement with medical service information, Medicare or Medicaid billing/reimbursement) before entering into an agreement to assure that the entity is not listed as excluded. Any entity listed as excluded on the LEIE Database will not be eligible to enter into a contractual agreement with Western State Nursing Facility. Renewals of contracts will require a new OIG exclusion search per checking the LEIE Database before the contract is renewed.
- c. The LEIE Database will be periodically checked for determining the participation/exclusion status of current employees and contractors

(Refer to WSNF General Nursing Facility Manual, policy # 47-A – Office of Inspector General Exclusion List Checks For Employees/Entities)

## **3. PERSON WHO MAY NOT BE EMPLOYED**

- a. KRS 216.532 prohibits the employment of any person listed on the Nurse Aide Abuse Registry; and
- b. KRS 216.533 (2) prohibits the facility from knowingly employing any person who has been convicted of a felony offense under:
  - i. KRS Chapter 209;
  - ii. KRS Chapter 218A;
  - iii. KRS Chapter 507.202, 507.030, 507.040;
  - iv. KRS Chapter 509;
  - v. KRS Chapter 510;
  - vi. KRS Chapter 511;
  - vii. KRS Chapter 513;

Western State Nursing Facility  
General Nursing Facility Manual  
Standard Operating Procedure No 1A

- viii. KRS Chapter 514.030;
  - ix. KRS Chapter 530;
  - x. KRS Chapter 531
  - xi. KRS Chapter 508.010, 508.020, 508.030, and 508.032;
  - xii. A criminal statute of the United States or another state similar to paragraphs (a) to (k) of this subsection; or
  - xiii. A violation of the uniform code of military justice or military regulation similar to (a) to (k) of this subsection which has caused the person to be discharged from the Armed Forces of the United States; and
- c. Anyone who has a misdemeanor offense that would indicate the employee would be at risk to abuse, neglect, or exploit an individual served in one of the facilities (e.g. history of assaults or thefts).
- d. Anyone who has a felony offense under any other Kentucky or other state, or federal statute.

#### **4. DUTY TO PROTECT**

The facility must take whatever action is necessary to protect the individuals residing there. For example, if a facility is forced by court order or arbitration rulings to retain or reinstate an employee believed to be abusive, the facility may need to take other measures to ensure beneficiary safety such as:

- a. Assigning the employee to an area where there is no contact with individuals;
- b. Providing increased supervision and additional training for the employee;
- c. For merit employees, confer with the Kentucky Cabinet for Health and Family Services, Office of Human Resource Management and Office of Legal Services regarding appealing the arbitration or court decision, which may include pursuing formal criminal charges.

This is an integration of the following: ICF/MR: State Operations Manual Appendix J – Guidance to Surveyors: Intermediate Care Facilities for Persons With Mental retardation: 42 CFR 483.420 (a) (5)

#### **G. IDENTIFICATION**

The facility staff will actively monitor for and identify events; such as suspicious occurrences, patterns, and trends that may indicate abuse. Any resident event that is reported to any staff by the resident, family/guardian, other staff, or any other person will be considered as suspected abuse if it meets the following criteria:

1. Any indication of possible willful infliction of injury to include unexplained bruising.
2. Unreasonable confinement to a room or other areas of the facility.
3. Any resident or family/guardian complaint of physical harm, pain, or mental anguish resulting from the action of others.

4. Any complaint of deprivation by an individual caregiver of goods and services as needed.
5. Any complaint of the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents or within their hearing distance.
6. Any complaints of sexual harassment, sexual coercion, or sexual assault.
7. Any instance of hitting, slapping, pinching, kicking, or other potentially harmful actions.
8. Any complaint of humiliation, harassment, or threats of punishment or deprivation.
9. Any loss, theft, or inappropriate usage of resident's personal property.

## H. REPORTING/RESPONDING

Western State Nursing Facility will immediately report and respond to any involvement, observation of, or report of an incident or event that indicates a resident injury, harm, abuse, neglect, exploitation, or the potential for.

### 1. EMPLOYEE RESPONSIBILITIES

For any employee who is involved in, observes, or receives a report of an incident or event (hereafter known as "incident" in Section 12), certain responsibilities apply.

- a. **Medical Treatment:** Staff discovering an incident must immediately ensure any necessary first aid is provided and medical services are contacted if additional assistance is needed.
- b. **Reporting Requirements:** It is the responsibility of any staff person to make an immediate verbal report about an incident, regardless of classification, to the immediate supervisor and/or facility administrator or designee as soon as it is discovered. A follow up written report of the incident shall be initiated before the end of the shift of discovery utilizing a standard incident report format.
- c. **Responsibility to Report Abuse, Neglect or Exploitation:**
  - Nursing Service Employees are to report incident immediately to the unit charge nurse and the shift facility charge nurse.
  - The Administrative Staff and Support Services are to report incident immediately to the unit charge nurse and their immediate supervisor.
  - The Director of Nursing and Facility Administrator are to be notified during

Western State Nursing Facility  
General Nursing Facility Manual  
Standard Operating Procedure No 1A

the hours of 8:00 a.m. to 4:30 p.m. Monday through Friday.

- The Administrative OD is to be notified by the nursing supervisor immediately, after 4:30 p.m., weekends, and holidays.

\*Any staff failing to report an incident immediately upon receiving a report, receiving an allegation, or based on a suspicion of abuse, neglect, or exploitation shall be considered in violation of KRS 209, KRS 620, and the facility policy and shall be subject to appropriate disciplinary action, up to and including dismissal.

**d. Responsibility to Report Suspicion of a Crime**

All employees and covered individuals (to include employees, owners operators, managers, agents or contractors) are responsible to timely report any reasonable suspicion of a crime committed against a resident of Western State Nursing Facility (as per the Elder Justice Act under Section 1150B of the Social Security Act)

1. Reports will be made to the State Survey Agency (Office of Inspector General) and to a law enforcement agency of jurisdiction (Kentucky State Police)
  - If the events that cause the reasonable suspicion result in serious bodily injury, the report must be made immediately (but not later than ( 2) hours) of the crime
  - If the events that cause the reasonable suspicion does not result in serious bodily injury, the report must be made no later than (24) hours after forming the suspicion of the crime.
2. Western State Nursing Facility will not retaliate against any employee or covered individual who lawfully reports a reasonable suspicion of a crime in regards to the Elder Justice Act under Section 1150B of the Social Security Act.
3. All covered individuals have the right to file a complaint with the State Survey Agency (Office of Inspector General) if they feel any retaliation has been committed against any employee who reported a suspected crime under the law.

(Refer to WSNF General Nursing Facility Manual Policy # 47A – Elder Justice Act Covered Individual’s Reporting Responsibilities)

- e. Responsibility to Report Other Incidents or Events:** Any staff failing to report an incident immediately upon discovery shall be considered in violation of facility policy and shall be subject to appropriate disciplinary action, up to and including dismissal.

- f. **Responsibility to Cooperate:** Staff are expected to fully cooperate in any internal or external investigation of an incident. Staff are to provide any information pertinent to the incident and any recommendations they may have which may assist in the prevention of future incidents. Failure to cooperate with the investigation process may be considered in violation of facility policy and subject to appropriate disciplinary action, up to and including dismissal.
- g. **Prohibition Against Retaliatory Actions:** Any forms of retaliatory action made toward either an individual served or staff who report incidents, or provide information regarding such incidents in good faith, are strictly prohibited. All forms of retaliatory action against an investigator, either during the course of conducting an investigation or afterwards, are strictly prohibited. Employees found involved in retaliatory actions to any degree are subject to disciplinary action, up to and including dismissal from employment.

## 2. CLASSIFICATION OF INCIDENTS AND PROTOCOL FOR REPORTING

After following KRS 209 and KRS 620 for reporting when a reasonable cause is present to suspect an adult or child has suffered abuse, neglect, or exploitation, the facility will classify the incident.

Incidents are classified according to the potential for harm to individuals and carry protocols for recording and follow-up. Immediate follow-ups for all incidents shall include the cause of incident with intervention for future prevention.

### A. Class 1 Incident

1. Includes Category C medication errors.
2. Includes Category D medication errors, if a trend is not evident.
3. May include, as examples, sprain of unknown origin, trip and fall with no resulting injury, paper cut.
4. Is minor in nature.
5. Does not create serious consequence.
6. Requires a completed Incident report that is retained on file. (Refer to Attachment B-WSNF Resident/Visitor Incident Report).
7. Requires simple fact finding which is documented on the Incident Report form.
8. Is reported on a monthly basis by providing a summary report of Class 1 incidents to the Department Incident Management Administrator; or
9. After an initial assessment of fact-finding is conducted, if there is reasonable cause present to suspect abuse, neglect, or exploitation, the incident should be immediately reported to DCBS, the Department Incident Management Administrator, and OIG AND
10. The incident is reclassified to a Class 3.

### B. Class 2 Incident

Western State Nursing Facility  
General Nursing Facility Manual  
Standard Operating Procedure No 1A

1. Transportation of an individual to an emergency room visit
2. Parasuicidal behavior
3. Threat of harm (Resident to Resident)
4. Has the potential to cause serious injury or harm to the health, safety, or welfare of an individual or individuals.
5. Requires a completed Incident Report that is retained on file. (Refer to Attachment B.)
6. Requires an inquiry to be conducted which is documented on the Incident Report.
7. Does not require either the incident or inquiry to be immediately reported to the Department Incident Management Administrator.
8. Requires the facility to fax/mail the Incident Reports with the inquiry to the Department Incident Management Administrator as the Class 2 Incident Reports are completed on a daily basis.
9. After initial assessment or inquiry is conducted, if there is reasonable cause present to suspect abuse, neglect, or exploitation, the incident shall be immediately reported to DCBS, Department Incident Management Administrator and OIG; AND
10. The incident shall be reclassified to a Class 3.

**C. Class 3 Incident**

1. Includes
  - a. Reported, alleged or suspected abuse, neglect or exploitation;
  - b. Class 1 or 2 incidents reclassified to Class 3;
  - c. Category D medication errors if trend is present;
  - d. Category E through I medication errors;
  - e. Death of any individual on state property;
  - f. Death of any individual served;
  - g. Missing individual (s) from the facility;
  - h. Serious injuries of known cause if:
    1. There is suspicion of abuse, neglect, or exploitation;
    2. The facilities' tracking and trending of similar injuries indicates suspected abuse, neglect, or exploitation; or
    3. If after consulting to the OIG Regional coordinator a determination is made that an investigation is warranted;
  - i. Any injury of unknown cause if:
    1. The injury requires more than first aid;
    2. There is suspicion of abuse, neglect, or exploitation; or
    3. The facilities' tracking and trending of similar injuries indicates suspected abuse, neglect, or exploitation;
  - j. Sexual abuse/assault;
  - k. Injury due to peer-to-peer aggression;
    1. Injury to individuals served due to staff interventions;
  - m. Individual served found out of level of supervision as required by current treatment plan;

- n. Suicidal behavior; or
  - o. Other serious consequences.
2. Is critical in nature OR alleges an immediate threat to the health, safety and welfare of an individual or individuals;
  3. Requires the facility to immediately report the situation to DCBS, the Department Incident Management Administrator, and OIG;
  4. Requires a completed Incident Report to be retained on file; (Refer to Attachment A.)
  5. Requires an investigation to be conducted;
  6. Requires the facility to fax/mail the Incident Reports to the Department Incident Management Administrator as the Class 3 incident reports are completed on a daily basis; and
  7. Requires the facility to fax/mail the Class 3 Investigation Reports to the Department Incident Management Coordinator as the Incident Reports are completed on a daily basis.

### **3. INITIAL IMMEDIATE AND FOLLOW-UP REPORTING TO FACILITY DIRECTOR OR DESIGNEE, DCBS, OIG, AND DEPARTMENT INCIDENT MANAGEMENT ADMINISTRATOR**

As soon as the facility obtains initial information regarding the health, safety and welfare of the individual served and the incident itself, the facility must ensure that all reasonable causes of suspicion that an adult or child has suffered abuse, neglect or exploitation, as well as injuries of unknown source, are reported immediately to the Facility Director or Designee, Department of community Based Services, Office of Inspector General, and the Department Incident Management Administrator.

Reporting will be as follows:

- A. An immediate initial, verbal report is made to the Facility Director or Designee and a Certified Investigator is assigned to initiate an investigation.  
  
**\*If the incident is an event that appears criminal, the facility will report the incident to local law enforcement after consultation with the facility director or designee.**
- B. An initial immediate report is made to DCBS through a telephone call (Contact the local DCBS office during regular working hours. Contact the DCBS Adult Abuse-Child Abuse Hotline at (800) 752-6200 after regular work hours, on holidays or weekends).
- C. After reporting to DCBS, the same initial reporting is sent through electronic mail to the Department Incident Management Administrator.
- D. After contacting DCBS (per phone) and the Department Incident Management Administrator (per electronic mail), an **immediate**, written report is to be made to OIG, DCBS, the Department Incident Management Administrator and Resident

Advocacy (if the individual is a Protection and Advocacy client) through Fax. The report is to be made per the WSNF Report of Unusual Incident form (Refer to Attachment C).

(WSNF maintains Report of Unusual Incident packets which contain fax numbers for required notification of stated agencies and departments. All information and forms needed for the conduction and completion of an investigation are included in the packets which are located in the Forms Room).

- E. If information gathered during the inquiry or investigation differs significantly from the initial report, simultaneously fax any updated reports to DCBS, OIG, Department of Incident Management Administrator and if applicable, Resident Advocacy.

**4. Additional immediate reporting to the Department Incident Management Administrator**

The following events require additional information to be submitted through electronic mail, along with the minimum information stated in Section 8.A.

**A. Death-** If the incident being reported is a death, add the following information:

- a. Initial cause; and
- b. Relevant background information.

(Refer to Western State Nursing Facility-General Nursing Facility Manual, SOP # 45-A, Death and Mortality Review.)

**B. Emergency Room-** If the incident being reported is an emergency room visit, add the following information:

- a. Reason for the visit; and
- b. Outcome of the visit (this information should be emailed as soon as confirmed).

**C. Hospitalization-** If the incident being reported is a hospitalization, add the following information:

- a. Reason for the hospitalization.

**D. Regulatory Agency of Law Enforcement-** Other events to report include:

- 1. Regulatory Agency Visits
- 2. Law Enforcement Visits

If the event being reported is a regulatory agency or law enforcement visit, add the following information:

- 1. Date and time of the visit;
- 2. Agency name;
- 3. Name (s) of visitor; and
- 4. Explanation for visit

**5. ADDITIONAL NOTIFICATION REQUIREMENTS**

Facilities shall pursue the following notifications according to the guidelines provided.

#### **A. Parents, Guardians, Next of Kin, Emergency Contact**

All facilities are required to “notify promptly” regarding any significant incidents, or changes in the individual’s condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence:

1. The individual’s private or state guardian; or
2. The individual’s spouse, if permission is given by the individual; or
3. The individual’s next of kin, if permission is given by the individual; or
4. The individual’s emergency contact, if permission is given by the individual

#### **B. Notify Promptly**

“Notify promptly” is defined as soon as possible unless otherwise agreed to by family/guardian.

1. In all cases, every attempt must be made to reach the family/guardian within twelve hours of discovery.
2. If a message is left on an answering machine, the only information that may be provided is the name and telephone number of the facility caller with a request for the parent/guardian/next of kin/emergency contact to return the telephone call.
3. Written notice shall be sent if the parent/guardian/next of kin/emergency contact is unable to be reached by telephone within the twelve hours of discovery.

### **I. INVESTIGATION**

#### **1. Incident Management Review Process**

Western State Nursing Facility has an Incident Management Review Committee directed by the Incident Management Coordinator where all incidents are reviewed and incident management issues are addressed daily.

The process includes:

#### **A. Western State Nursing Facility Incident Management Coordinator Responsibilities:**

1. Ensure full implementation of the facility’s Incident Management Protocol in accordance with the Department Facility Incident Management Protocol
2. Provide technical assistance to staff members in the completion of the Incident Report form (if when needed).
3. Review all Incident Report forms to ensure they are logical, plausible, and complete.
4. Review all Class 2 and 3 Incident Report forms to ensure they are properly

Western State Nursing Facility  
General Nursing Facility Manual  
Standard Operating Procedure No IA

classified.

5. Provide trend reports and analysis of incident data to staff.
6. Coordinate weekly assessments of all incidents to determine whether incidents were appropriately referred for investigation.
7. Maintain the incident management database.

**B. Incident Management Review Process Responsibilities:**

1. The committee shall consist of direct care staff, social workers, and representatives from Administrative staff members-to ensure effective management, oversight communication, and oversight for effective management.
2. The Incident Management Review committee shall meet daily, irregardless of weekends and holidays.
3. Discussion of all incidents that have occurred within the facility since the previous Incident Management Review meeting.
4. The Incident Management Review committee shall discuss how each incident occurred and whether or not it could have been prevented; and strategies and implementation plans for future prevention.
5. Identifying any additional information needed to determine the cause or circumstances of incidents, with a plan, timeframe, and assigned responsibility to collect the information. The timeframe for follow-up should be based on the severity of the incident. The plan(s) will include action(s) to reduce the number of incidents and make improvements in the facility's procedures.
6. Assisting managers to determine possible cause of incidents, and provide advice and resources. Ensure a system is in place for supervisors to pass the information to direct care staff to prevent such harm in the future.
7. A weekly review of the summaries of the total number of incidents, types of incidents, total number of injuries occurred. Identify any apparent trends or patterns that could facilitate protection from harm or prevention of incidents. Discuss analyses formulated by the Facility Incident Management Coordinator.
8. The Incident Management Review Committee will be responsible for submitting recommendations for resolution of identified problems or trends to staff and will be responsible for assigning responsibility of implementing the resolution to the appropriate staff.
9. The Incident Management Review committee will ensure systematically monitoring of the implementation and outcome of all plans.

**2. INVESTIGATION OF CLASS 3 INCIDENTS**

A. Responsibilities of the Facility Director or Designee

The Facility Director or Designee shall be responsible to:

1. Designate a minimum of one "Certified Investigator" for the facility.
2. Ensure that any individuals receiving services involved in an incident are provided appropriate care and medical treatment and/or measures are taken to ensure the safety of the individual(s) whether it is an individual served, or visitor.
3. Immediately review the incident to determine whether the employee alleged to have participated in abuse, neglect, or exploitation shall be immediately reassigned from direct care client. (Attachment D)
4. Assign an investigator to investigate the incident within two hours of receiving notice of the incident. In making this assignment, the following should be considered:
  - a. Investigations shall be assigned only to those persons who have received appropriate training in conducting investigations.
  - b. Investigations shall be assigned, whenever possible, to someone who has no direct administrative or clinical responsibility or personal associations, or any other potential biases in the organizational unit where the incident occurred.
5. Ensure that proper initial and reclassified incident notifications are completed and transmitted to the Department Incident Management Administrator, DCBS, OIG, and other officials in accordance with state and federal law.
6. All employees alleged to have committed a Class 3 incident will be moved immediately to a non-direct care position for the duration of the incident investigation process. Should there be a determination that the employee should not be on the facility grounds, the facility director will notify the Commissioner's Office of the need for "special leave" under the authority of 101 KAR 2:102, Section 8. The facility director will then submit a written request to the Appointing Authority through the Commissioner's Office. If approved by the Appointing Authority, a request will then be submitted to the Personnel Cabinet Secretary for final approval.
7. Ensure for contract employee, if a determination is made, the contract employee should not be on the facility grounds, internal policies shall be followed.
8. At the conclusion of the facility's incident investigation, determine:
  - a. If the target employee(s) may be returned immediately to their previous work status if the facility investigation does not substantiate the allegation of suspicion of abuse, neglect, or exploitation; (Attachment E)
  - b. If the target employee(s) shall have disciplinary action, up to and including dismissal, if the facility investigation substantiated the allegation of abuse, neglect, or exploitation. The facility will make a request to the Human Resource Office Director to initiate

disciplinary action.

- c. If the target employee(s) may not be returned to their previous work status if the facility investigation determines the allegation of abuse, neglect, or exploitation is inconclusive. The facility should proceed with making a determination on work, status, and not hinge the decision on external reports (e.g. DCBS). If further information is needed, the facility can request a copy of the Continuous Quality Assessment (CQA) from DCBS for further review.
9. Assign an individual(s) to supervise the investigative function, which shall include:
    - a. Assign investigations;
    - b. Participate in the facility incident management review process;
    - c. Provide technical assistance to investigators;
    - d. Identify persons to receive investigation training;
    - e. Monitor the follow-up to any recommendations;
    - f. Serve as the facility point of contact with DMHMRS; and
    - g. Coordinate internal facility peer reviews on investigations;
  10. Notify the Department Incident Management Administrator directly, as soon as possible after discovery, of any important, unforeseen event or situation which occurs (e.g. negative media attention); and
  11. Designate a person(s) to assist with the coordination of investigations made by external agencies. The person shall be responsible for securing all necessary information regarding the incident and assisting as needed in the external investigation process.

#### B. Responsibilities and Authority of the Investigator

To competently carry out assigned duties, the investigator has the following responsibilities and authority:

1. When an investigator is assigned to a case, all other responsibilities are considered secondary to a timely and thorough investigation.
2. The investigator shall have direct access to all staff members and individuals served for the purpose of conducting investigations.
3. The investigator shall have the authority to appear at certain places and times for the purpose of conducting interviews.
4. The investigator shall have the authority to require staff to complete a written statement.
5. The investigator shall have the authority to instruct employees to remain beyond their assigned shift or return to the facility if needed to complete the investigation in an appropriate manner.
6. The investigator shall have access to all relevant documentary evidence concerning the allegation, including access to the records of individuals served.
7. The investigator shall, during the period of the investigation, act at the

direction of the Facility Director or Designee.

#### C. Responsibilities of Facility Supervisors

The Shift Facility Charge Nurse shall take the following actions where appropriate:

1. Secure the scene in an appropriate manner.
2. Keep the potential witnesses at the scene and:
  - a. keep potential witnesses separated when possible if the investigator is immediately on his way to the site.
  - b. If not possible, assign a supervisor to the scene to minimize the potential witnesses from discussing the incident among themselves; and
  - c. Separate potential witnesses as soon as replacement staff coverage is assigned and present.
3. Secure relevant documentary evidence.
4. Upon the investigator's instruction, assist in ways to which will facilitate the investigation.

#### D. Conducting the Investigation

The investigator shall perform the following investigative activities:

1. Initiate the investigation within two (2) hours of assignment by beginning the collection of testimonial evidence;
2. Visit the incident scene to:
  - a. Determine whether medical care has been provided where needed; and
  - b. Determine whether other proper measures have been taken to ensure the safety of the alleged victim;
3. Obtain from the Shift Facility Charge Nurse/Unit Supervisor all physical and documentary evidence or collect it after arriving at the scene if it has not already been collected.
4. Collect all necessary demonstrative evidence including photographs of the scene, etc, and:
  - a. Take photographs of all visible injuries or take photographs to document that no injury is present;
  - b. Secure the scene of the incident to ensure nothing is disturbed if law enforcement authorities are immediately expected, so they can collect the evidence; and
5. Conduct interviews with all potential witnesses and obtain written and signed statements from all potential witnesses.

#### E. The Final Investigative Report

The final investigative report documents the evidence collected and is used to determine whether a report, allegation, or suspicion of abuse, neglect, or exploitation, or other Class 3 incident has been found to be substantiated, unsubstantiated, or inconclusive.

1. After the collection of all relevant evidence, the facility investigator and/or the Incident Management Review Committee must evaluate the report to determine whether there is sufficient evidence to confirm the causes of the allegation:
  - a. The analysis of all relevant evidence must be thoroughly documented in the investigative report in an objective manner;
  - b. The standard of proof to be used is "preponderance of the evidence" which is often expressed as the belief that it is more likely than not that a particular set of facts is true; and
  - c. Based on the available evidence, the investigator, and/or the Incident Management Review Committee may reasonably choose to believe one witness over another;
2. Standard investigative final report format will be utilized. (See Attachment F):
3. The final investigation report shall be given to:
  - a. The Facility Director or Designee for end determination; and
  - b. After end determination, a final copy shall be submitted to the Department Incident Management Coordinator.
4. The investigative reports and documents contained in the investigative file will be confidential and may be disclosed within the facility to those staff with responsibilities for taking disciplinary action or responding to recommendations that require knowledge of its contents:
5. At the close of the investigation, a file will be maintained as follows:
  - a. All investigative information for each. Investigative incident will be maintained in a binder and filed in alphabetical order. (Files will be maintained in the administrator's office;
  - b. A chronological log of all investigations will be maintained;
  - c. There will be an assigned identification number for each incident. (Incident numbers are assigned at the initiation of each investigation and are included on both the initial Report of Unusual Incidents and the Final Investigative Report. Each file will be identified with the assigned identification number.)
6. Information included in each investigative file shall include:
  - a. Initial Report of Unusual Incident;
  - b. Copies of all demonstrative evidence;
  - c. Copies of all testimonial evidence;
  - d. Copies of all documentary evidence;
  - e. Copies of any electronic mail communication;
  - f. Copies of any follow-up action (i.e., counseling sessions, development plans, disciplinary actions, etc.);
  - g. Faxed cover sheets and confirmation of receipt by DCBS, OIG,

Western State Nursing Facility  
General Nursing Facility Manual  
Standard Operating Procedure No 1A

Department of Incident Management of initial and final reports and any updated reports.

h. Copies of any certified mail receipts;

7. All investigative files will be maintained per the facility administrative secretary or designee.

## **J. TRAINING**

All staff at Western State Nursing Facility (Direct Care and Ancillary Support Services) shall be trained regarding incident management and abuse protocol upon employment annually and upon identified need thereafter.

TO BE COMPLETED AND  
TURNED IN TO INC.  
MGMT. COORDINATOR  
BY 8 AM THE NEXT  
WORKING DAY.

WSNF

Attachment B

INCIDENT MANAGEMENT REVIEW AND FOLLOW-UP

Date \_\_\_\_\_ Unit \_\_\_\_\_

Date and Time reported \_\_\_\_\_

Resident Name \_\_\_\_\_ Time and Date of Incident Occurred \_\_\_\_\_

Type of Incident \_\_\_\_\_

Assessment/Description of Incident: \_\_\_\_\_

Date and Time reported to next line supervisor/administrator \_\_\_\_\_

Interventions Put In Place/Follow-up Actions Implemented at Time of Incident: \_\_\_\_\_

Interventions Implemented on Care Plan and Unit Staff Assignment Sheet: \_\_\_ Yes \_\_\_ No

Was Supervision of Resident in Place to Ensure Safety to Self and Others: \_\_\_ Yes \_\_\_ No

(NO requires comment: \_\_\_\_\_)

Assessment and Follow-up Actions Noted in Nursing Notes: \_\_\_ Yes \_\_\_ No

(NO requires comment: \_\_\_\_\_)

Staff Responsible for Nursing Documentation: \_\_\_\_\_

Guardian Notified \_\_\_ Yes (by whom) \_\_\_\_\_ \_\_\_ No (requires comment)

Further Follow-up Action Taken per Incident Management: \_\_\_\_\_

Time Frame for Completion: \_\_\_\_\_

Signature of Incident Management Committee Staff Member \_\_\_\_\_

## ZERO TOLERANCE FOR RESIDENT ABUSE

The Department for Mental Health and Mental Retardation Services is committed to providing a caring and hospitable environment that is both safe and secure for persons residing and working in its facilities. To assure that all staff are reminded of their responsibility to maintain a therapeutic environment, the Department affirms a **ZERO TOLERANCE** for Resident Abuse as defined below:

### **ABUSE OF RESIDENTS**

Acting in a manner that willfully, intentionally, or recklessly causes pain, physical, or emotional injury including but not limited to: slapping, shaking, kicking, choking, hitting, rape or sexual assault; any contact of a sexual nature between a staff person and a resident; any exploitation; or any verbal or other communication to threaten an individual with physical harm or to ridicule, intimidate, humiliate or degrade a resident.

**ZERO TOLERANCE** for resident abuse represents the very best way in which we can achieve our mission and is simply the right thing to do. All staff are expected to acknowledge understanding that such conduct is prohibited and that even a singular violation may result in dismissal. Of course, this does not limit the Department from imposing discipline for other types of infractions where circumstances so warrant.

**Further, staff are reminded that if they have any reasonable cause to suspect that a resident has been abused, neglected, or exploited, they must report that information immediately, pursuant to KRS 209.030. Failure to report will result in a request for major disciplinary action.**

I have received a copy of this document, have read it and understand it.

---

Employee Signature and Date

---

Employee's Printed Name

Effective: November 1, 2003  
Revised: January, 2012

# Western State Nursing Facility

## Employee Monitor Regarding Abuse, Neglect & Exploitation

<b>Employee:</b>	<b>Unit:</b>	<b>Date:</b>
------------------	--------------	--------------

(1) Employee can relate what abuse is (includes any form/type):

Yes  No (comment required) \_\_\_\_\_

\_\_\_\_\_

(2) Employee can relate what to do if they were to see/hear of any abusive behaviors:

Yes  No (comment required) \_\_\_\_\_

\_\_\_\_\_

(3) Employee can relate to immediacy of reporting:

Yes  No (comment required) \_\_\_\_\_

\_\_\_\_\_

(4) Employee can relate who they can report any concerns to:

Yes  No (comment required) \_\_\_\_\_

\_\_\_\_\_

### Licensed Staff Only

(5) If an employee reports to you, or if you witness any form of abuse, neglect, or exploitation what are three things that must be done immediately:

Follow-up required \_\_\_\_\_

\_\_\_\_\_

<b>Inc. Mgmt. Coor. Signature:</b>	
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**Western State Nursing Facility**

**Attachment E**

**INCIDENT MANAGEMENT REVIEW PROCESS OF**

**ALLEGATION OF ABUSE/NEGLECT/EXPLOITATION MONITOR**

Date of Review: \_\_\_\_\_

Date & Time of alleged abuse / neglect / exploitation: \_\_\_\_\_

Date & time staff made aware (if reported by resident): \_\_\_\_\_

Date & time reported to the next line supervisor facility Administrator (List Name) \_\_\_\_\_

List follow-up reporting actions: \_\_\_\_\_

Date & time alleged perpetrator removed from direct care: \_\_\_\_\_

Date & time investigator assigned: \_\_\_\_\_

Was witnessing or receiving report of an allegation of abuse/neglect/exploitation reported upon discovery?     Yes     No

If (No) state follow-up action:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List attending committee members:

_____	_____
_____	_____
_____	_____

Report to be routed to the DON

**WESTERN NURSING FACILITY**

**Attachment F**

**NURSING SERVICE STANDARDS OF OPERATION**

Section: V Infection Control

Date: May 2004 Sept 2005

Revised: Feb 2012

**STANDARD OPERATING PROCEDURE NO. 1 M**

**Subject: Hand Washing**

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**A. STANDARD:**

Hand washing is considered the most important single procedure for preventing infection or the spread of infection in a hospital.

**B. PROCEDURE:**

1. Routine Hand Washing:

a. Indications:

1. When you arrive at work
2. After you go to the toilet
3. Before you leave work
4. Before and after you eat meals
5. Before and after touching wounds, whether surgical, traumatic, or associated with an invasive procedure.
6. After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood or body fluids, secretions, or excretions.
7. After touching inanimate sources that are likely to be contaminated with virulent or epidemiological important microorganisms of special clinical or epidemiologic significance; for example: multiple drug resistant bacteria.
8. Between patient contact
9. Before administering medications. (Use of alcohol gel may be used between patients if sink is not readily accessible.)
10. After administering medications.

2. Procedure:

- a. Remove jewelry.
- b. Wet hands under running water
- c. Keep hands lower than elbows, apply soap.
- d. Use friction to clean all surfaces of lathered hands for 10 to 15 seconds.
- e. Thoroughly rinse hands under running water.
- f. Use clean, dry paper towels to dry the hands.
- g. Use a clean dry paper towel to turn off faucets and discard.

3. Antiseptic Hand Washing:

a. Indications:

1. Prior to performing invasive procedures such as catheterization, wound care, inserting intravenous needles, etc.
2. Prior to caring for a severely immunocompromised patient.

4. Procedure:

- a. Remove jewelry.
- b. Wet hands and forearms, apply antiseptic soap (may use alcohol containing antiseptic hand rubs when hands are already clean, {not visibly soiled with dirt or organic material}) and application should last for at least 20 second.
- c. Wash hands, forearm to just above elbow. Use friction to clean all surfaces for at least 120 seconds. Clean under nails. Thoroughly rinse hands 4-5 seconds under running water, holding hands above the elbows and away from body.
- d. Use paper towels to dry hands.
- e. Use clean, dry paper towel to turn off faucets and discard.

5. Other Hand Care and Protection:

- a. When hand washing facilities are inaccessible and hands are not soiled with dirt or heavily contaminated with blood or other organic material, alcohol based handrubs are recommended for use. In situations where soilage occurs, detergent-containing towelettes should be used to cleanse the hands; alcohol based handrubs can then be used to achieve hand antisepsis.
- b. In the event of interruption of water supply, alternative agents such detergent-containing towelettes and alcohol-based handrubs should be available.
- c. Gloves should be used in addition to, not as a substitute for hand washing.
- d. Gloves should be used for hand contaminating activities. Gloves should be removed to prevent contamination of hands during removal. Hands should be washed when the activity is completed.
- e. **Gloves should be changed between patients, and may need to be changed during the care of a single patient, for example; when moving from one procedure to another.**
- f. Disposable gloves should be used only once and discarded.
- g. Nails should be short enough to allow the individual to thoroughly clean underneath them and not cause glove tears. Artificial nails are not to be worn by direct care staff in patient care areas.
- h. The hands, including the nails and surrounding tissue should be inflammation free.
- i. Lotions may be used to prevent skin dryness associated with hand washing.
- j. When turning off faucets and handling lids of garbage cans, use clean dry paper towels to deep from reinfected hands.

**Reference:**

1. American Journal of Infection Control, August 1995, Volume 23, Number 4. APIC guideline for handwashing and hand antiseptics in health care settings, Elaine L Larson, RN, PhD, FAAN, CIC, 1992, 1993, and 1994 APIC Guidelines Committee.
2. APIC Text of Infection Control and Epidemiology, Copyright 1995, APIC, Inc. APIC Guideline for Hand Washing and Hand Antisepsis in Health-Care Settings; P 28A-11 through 28A-12.
3. Centers for Disease Control; Guidelines for Hand Hygiene in Health Care Settings, MMWR 2002 Vol. 51; no. RR-16.

Hand Hygiene / Glove Use Observation Tool

**Attachment G**

INSTRUCTIONS: Observe. Include a variety of disciplines.

NOTE: Hand Hygiene refers to use of alcohol based hand sanitizer or washing with soap and water for 20 seconds.

Date: \_\_\_\_\_

Completed by: \_\_\_\_\_

Staff Name ---->																	
	Yes	No															
<b>Hand Wash</b>																	
Before clean and aseptic procedures, (medication pass)																	
After contact with blood, body fluids, mucous membranes, non-intact skin																	
After handling objects such as soiled linen, trash, equipment																	
After removing gloves or other used PPE																	
Before patient contact																	
Gloves changed between patients and may need to be changed during the care of a single patient (when moving from one procedure to another)																	
After patient contact or when exiting patient room																	
Upon entering patient room and before equipment contact																	
After equipment contact																	
<b>Glove Use</b>																	
Used when potential for hand contact with body fluids present																	
Gloves removed immediately after use																	

Return completed observation form to Beth Morris

*Acceptable POC re 2/9/12*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185228	(02) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(03) DATE SURVEY COMPLETED  01/06/2012
NAME OF PROVIDER OR SUPPLIER  WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2446 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240		
(04) 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)	(05) COMPLETION DATE	
K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1858</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) story, Type I (332)</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: None.</p> <p>GENERATOR: Type II generator installed in 2002. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 01/06/12. Western State Nursing Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred forty four (144) beds with a census of one hundred twelve (112) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p><i>POC</i></p> <p><i>CMS 2567 received 2/3/12</i></p> <p><i>- Renewed health tag 2/4/12</i></p> <p><i>- POC #1 for health tag NOT accepted</i></p> <p><i>- 2/6/12 - Health tag POC TO HO</i></p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE SIGNATURE

*Jul Sumner*

TITLE

*NHA*

DATE

*2/3/12*

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 74 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185228	(X2) MULTIPLE CONSTRUCTION A: BUILDING 01 - MAIN BUILDING 01 B: WING _____	(X3) DATE SURVEY COMPLETED  01/06/2012
NAME OF PROVIDER OR SUPPLIER  WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 050 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted in accordance with NFPA standards. The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred forty four (144) beds with a census of one hundred twelve (112) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 01/06/12 at 4:15 PM, with the Maintenance Superintendent and the Safety Coordinator revealed the fire drills were not being conducted quarterly at unexpected times under varied conditions. Further observation revealed the facility failed to perform a fire drill in the 2nd quarter on 3rd shift.</p>	K 050	<p>NFPA Life Safety Code Standard</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>On January 30, 2012, appropriate teaching and follow up was done by the facility Assistant Administrator with both the Maintenance Superintendent and the Safety Coordinator in regards to following the NFPA 101 Life Safety Code Standard of holding fire drills at unexpected times, under varying conditions at least quarterly each shift so to ensure the safety of residents, staff and visitors.</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>As all facility residents have the potential to be affected by the same deficient practice, the corrective action taken will be the implementation of a reporting system, (effective February 1, 2012) requiring the Safety Coordinator or the Maintenance Supervisor in his absence, to complete a report after each fire drill each month, listing the date, shift, time, location and conditions of the drill. This report will be turned in to the Assistant Administrator monthly, after the completion of each fire drill, for review and follow up to ensure that fire drills are held monthly at unexpected times under varied conditions at least quarterly on each shift. (Refer to Attachment A - WSNF Monthly Fire Drill Completion Report). (The Safety Coordinator and the Maintenance Supervisor were in-serviced on the implementation of this reporting system on January 30, 2102 per the Assistant Administrator). Continued on Page 6</p>	2-1-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186228	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING: _____	(X3) DATE SURVEY COMPLETED  01/06/2012
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NAME OF PROVIDER OR SUPPLIER  WESTERN STATE NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	<p>Continued From page 2</p> <p>Fire drills were being conducted as follows:</p> <p>First Shift 11-27-11 @ 12:26 PM 08-23-11 @ 10:00 AM 04-28-11 @ 1:37 PM 02-04-11 @ 9:00 AM 01-28-11 @ 11:00 AM</p> <p>Second Shift 12-20-11 @ 3:37 PM 09-29-11 @ 3:00 PM 06-29-11 @ 3:15 PM 05-17-11 @ 3:09 PM 02-23-11 @ 3:06 PM</p> <p>Third Shift 10-31-11 @ 6:33 AM 07-27-11 @ 6:00 AM</p> <p>03-01-11 @ 5:08 AM</p> <p>Interview, on 01/06/12 at 4:15 PM, with the Maintenance Superintendent and the Safety Coordinator revealed they were not aware the fire drills were not being conducted as required, and did not realize they had missed the 2nd quarter fire drill on 3rd shift.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p>	K 050		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 072	<p>NFPA 101 Life Safety Code Standard</p> <p>See Page 4</p>	2-15-12

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NAME OF PROVIDER OR SUPPLIER  WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	<p>Continued From page 3</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of ten (10) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred forty four (144) beds with a census of one hundred twelve (112) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/06/12 between 1:00 PM and 4:00 PM, with the Maintenance Superintendent and the Safety Coordinator revealed linen carts were being stored in the 311, 331, and the 332 Halls.</p> <p>Interview, on 01/06/12 between 1:00 PM and 4:00 PM, with the Maintenance Superintendent and the Safety Coordinator revealed the facility routinely stored linen carts in these halls.</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or</p>	K 072	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>On January 6, 2012, the linen carts were moved by the Maintenance Supervisor from the hallways of Units 311, 331, and 332 to the alcoves on the unit, to ensure the means of egress were free of all obstructions or impediments to full instant use in the case of fire or other emergency. As well, Unit 312 was checked that date by the Maintenance Supervisor with the linen carts found to have been stored appropriately and with no obstruction on the hallway of that unit.</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>In order to identify other residents having the potential to be affected by the same deficient practice, the corrective actions taken are as follow:</p> <p>On January 12, 2012, the Director of Nursing sent an e-mail to all licensed staff making them aware that linen carts cannot be stored on the hallways of the units due to the Life Safety Code Standard.</p> <p>On January 17, 2012, the Director of Nursing sent an e-mail to all licensed staff as a reminder to keep all equipment from the hallways when not in use to ensure resident safety.</p> <p>Continued to page 5 of 6</p>	2-15-12

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NAME OF PROVIDER OR SUPPLIER  WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 4 Impediments to full instant use in the case of fire or other emergency.	K 072	<p>On January 30, 2012, the Assistant Administrator revised the Western State Nursing Facility, Nursing Standard Operating Procedure, Section VII, # 13 (Resident Safety: Unit Rounds) to include "Staff from both the off going and oncoming shifts will make rounds together, checking the hallways (making sure they are free from obstruction and there is full, instant use in case fire or other emergency). As well the policy is revised to state that "Linen carts will be maintained in the alcoves of the unit or in the clean linen room (when not in use) so not to obstruct the hallways. Policy will be implemented February 1, 2012.</p> <p>On January 31, 2012, a memorandum was sent from the Safety Coordinator in regards to NFPA 101 Life Safety Code Standard 7.1.10, informing all facility staff that hallways are to be free of all obstructions or impediments to full instant use in case of fire or other emergency.</p> <p>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p>Effective January 7, 2012, Administrative Rounds made on each unit, each week (per the facility Administrator, Assistant Administrator, Director of Nursing, Director of Social Services, Incident Management Coordinator, the assigned Administrative Nurse for each unit and the Maintenance Supervisor) include hallway checks during rounds to ensure they are free from any obstruction and impediments to full instant use in case of fire or other emergency.</p> <p style="text-align: center;">CONTINUED TO PAGE 8</p>	2-15-12

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NAME OF PROVIDER OR SUPPLIER  WESTERN STATE NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Life Safety Code Continued from Page 2 of 5	K 050	<p>What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur;</p> <p>On January 28, 2012, The facility Assistant Administrator revised The WESTERN STATE NURSING GENERAL NURSING FACILITY MANUAL Policy, # 3-A (Individual Responsibilities in The Event Of A Fire) to include "Fire drills are conducted quarterly on each shift to familiarize facility personnel with the signals and emergency actions required under varied conditions and to evaluate the efficiency, knowledge and response in implementing the facility fire emergency plan." (Refer to policy - Attachment B). The policy will be implemented effective February 1, 2012. The Assistant Administrator will be responsible for ensuring that the policy revisions are followed.</p> <p>Effective February 1, 2012, the Safety Coordinator or Maintenance Supervisor in his absence, will complete a report after each fire drill each month, listing the date, shift, time, location and conditions of the drill. This report will be turned in to the Assistant Administrator monthly, after the completion of each fire drill for review and follow up and to ensure that fire drills are held monthly at unexpected times under varied conditions at least quarterly on each shift. (Refer back to Attachment A - WSNF Monthly Fire Drill Completion Report).</p> <p style="text-align: center;">CONTINUED ON PAGE 7</p>	2-1-12

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NAME OF PROVIDER OR SUPPLIER  WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 050	Life Safety Code Continued from Page 3 of 5	K 050	<p>On January 30, 2012, in-servicing was done per the Assistant Administrator with the facility Maintenance Supervisor and Maintenance Coordinator, in regards to policy changes of Western State Nursing Facility General Nursing Facility Manual-Policy 3-A to ensure their understanding of the Life Safety Code requirements and the in servicing was also done regarding implementation of the Western State Nursing Facility Monthly Fire Drill Completion Report.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur;</p> <p>Effective February 1, 2012, the corrective actions will be monitored per the Assistant Administrator by reviewing the WSNF Monthly Fire Drill Completion Report each month and completing a quarterly monitor to ensure that fire drills are held on each shift during the quarter and at unexpected times under varying conditions. (Refer to Attachment C – Western State Nursing Facility Quarterly Fire Drill Monitor). Results of the monitoring will be reported to the QA Committee and the Safety Risk Management Committee per the Assistant Administrator on a quarterly basis with action plans developed for any issues of noncompliance.</p> <p style="text-align: center;"><b>COMPLETE</b></p>	2-1-12	

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NAME OF PROVIDER OR SUPPLIER  WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240	
(X4) JD PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued from page 5	K 072	<p><b>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur;</b></p> <p>On January 30, 2012 an in-service was held per the Assistant Administrator with the Safety Risk Management Committee in regards to the policy changes of Nursing SOP, Section VII, # 13 (Resident Safety: Unit Rounds). Committee Members consist of facility Administrator, Director of Nursing, Maintenance Supervisor, Incident Management Coordinator, Director of Maintenance, Safety Officer, Director of Social Services, Director of Information Management and Personnel Director.</p> <p>On January 31, 2012, the Incident Management Coordinator initiated in-servicing with all facility staff, in regards to policy changes to Nursing SOP Section VII, # 13 (Resident Safety: Unit Rounds - Refer back to Attachment D). In-service to be completed by 02/15/2012. (All employees on extended leave at the time of the in-servicing will be in-serviced upon return to work). The assigned Administrative Nurse for each Unit will be responsible for ensuring that the revised policies are followed on their individual units. The DON will be responsible to ensure the overall supervision that the revised policy is followed.</p> <p style="text-align: center;"><b>CONTINUED TO PAGE 9</b></p>	2-15-12

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NAME OF PROVIDER OR SUPPLIER  WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2406 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240	
(X4) HD PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued from Page 8	K 072	<p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place.</p> <p>Effective February 1, 2012, the Maintenance Supervisor will monitor each unit (Unit 311, 312, 331, and 332) each week at varied times for a total of four consecutive weeks to ensure that hallways are free of obstruction with full instant use in case of fire or other emergencies. After that time, each unit will be randomly monitored at varied times, a minimum of one time per month for a three month period. Random audits will then continue. Results of the monitoring will be reported to the Quality Assurance Committee and to the Safety Risk Management Committee on a quarterly basis with action plans developed for any issues of concern. (Refer to Attachment E).</p> <p style="text-align: center;"><b>COMPLETE</b></p>	2-15-12