

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

PRINTED: 05/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2011
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P.O. BOX 189 GLASGOW, KY 42141		
(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 000	INITIAL COMMENTS	F 000		
F 221 SS=E	<p>A standard health survey was conducted on April 26-28, 2011. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policies, it was determined the facility failed to ensure four (4) of seventeen (17) sampled residents (Resident #2, #7, #13, #14) were free from physical restraints. Residents #2 and #14 were observed to utilize a lap buddy. Resident #7 utilized a pelvic device and Resident #13 utilized a merry walker while out of bed; however, there was no evidence the devices were utilized to treat a medical symptom. Resident #14's lap buddy was implemented on May 4, 2010; however, there was no evidence the facility had obtained a physician's order prior to the use of the lap buddy and no evidence a restraint assessment had been completed for the use of the lap buddy until May 22, 2010. In addition, there was no evidence the facility had informed the responsible party of the risks/benefits related to the use of the lap buddy for Resident #2.</p> <p>The findings include:</p>	F 221	<p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The safety devices/restraints for residents #2, 7, 13, and 14 have been reviewed by the Director of Nursing on 05/20/11 to determine that the assessment and physician orders reflect the indicated use, and that the responsible parties have been informed of the risks and benefits.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>One additional resident is currently utilizing a restrictive safety device and was assessed for least restrictive fall risk interventions and device use with review/revision of the device assessments, orders, care plan, and risk/benefit review with the responsible parties to address the indicated interventions on 5/20/11.</p> <p>If a new admission has a physician order for a restraint, the RN supervisor will assess the resident utilizing the Comprehensive Device Assessment within 24 hours of admission and quarterly thereafter.</p> <p>All residents with a physician order for restraints will be assessed quarterly as a component of the MDS assessment or if a significant change in condition is identified by the Quarterly Care Committee.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p>	06/03/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Rebecca Jandy Facility Director 5/26/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions). Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

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F 221	<p>Continued From page 1</p> <p>A review of the facility's Restraint policy/procedure (dated August 25, 2010) revealed a trial of least restrictive measures would be documented prior to utilizing a restraint device, unless the physical restraint was necessary to provide life-saving treatment. The policy noted a pre-restraint assessment was required to be completed by the licensed nurse at the time a restraint was ordered by the physician and evaluated/updated every three (3) months. In addition, the policy noted a physician's order was required to include the specific type of restraint, the reason for the restraint, and the specified timeframe for the use of the restraint. The policy further noted a consent for the restraint was required to be obtained from the Resident and/or legal guardian and the risks, benefits, and alternatives for the restraint would be discussed and documented in the Resident's medical record. The policy also noted the restraint assessment would be reviewed for restraint reduction quarterly by the multidisciplinary team.</p> <p>1. Resident #2 was observed on April 26, 2011, at 4:40 p.m. and at 5:50 p.m. to be sitting in a wheelchair in the facility hallway with a lap buddy in place on the wheelchair. On April 27, 2011, Resident #2 was observed at 1:30 p.m. to be in the wheelchair with the lap buddy in use. The resident was unable to remove the lap buddy upon request on April 27, 2011, at 1:30 p.m. Interview with the resident on April 27, 2011, at 1:30 p.m. revealed the lap buddy kept the resident from getting out of the wheelchair and described the lap buddy as "a nuisance". Again on April 28, 2011, at 9:15 a.m., the resident was observed in a wheelchair with a lap buddy in place.</p>	F 221	<p>The nursing policy Restraints was revised on 5/09/11 to include "Documented evidence to support that the restraint/device is medically justified" and "Documented evidence of resident or legal representative approval of the restraint/device".</p> <p>The restraints assessment was revised on 05/09/11 to include "Medical Symptoms for Device Consideration, Current Device Orders (specify when and what)" and date "Risk/Benefits discussed with Resident/Responsible Party" and date "Consent for Device obtained from Resident/Responsible Party".</p> <p><u>When a physician orders a physical restraint for a resident to treat the resident's medical symptoms, the Acknowledgement of Physical Restraint form is reviewed with the Resident or Legal Representative. The form lists the type of restraint, medical symptom for the usage of a restraint, risks and benefits, and a signature line by the resident or responsible party. The resident or responsible party can either sign to accept or refuse the physical restraint. The responsible party cannot give permission to use restraints when the restraint is not necessary to treat the resident's medical symptom.</u></p> <p>All facility nursing staff will receive in-service education on the use of resident least restrictive safety device interventions including but not limited to: obtaining physician orders for the device, addressing the medical symptoms for device use on the assessment, and reviewing the risks/benefits with the responsible parties as provided by Staff Development Coordinator by 05/31/11.</p> <p>Newly hired nursing staff (state or contract) will be in-serviced on the Restraints policy and Comprehensive Device Assessment during new employee orientation.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p>		

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F 221	<p>Continued From page 2</p> <p>A review of the medical record revealed Resident #2 was admitted to the facility on October 14, 2010, with diagnoses to include Dementia with behavioral disturbances, Hypertension, Osteoarthritis, Coronary Artery Disease, and Degenerative Joint Disease. A review of a significant change Minimum Data Set (MDS) assessment completed on March 22, 2011, revealed the facility assessed Resident #2 to require extensive assistance of two staff for bed mobility, transfers, ambulation and toileting. In addition, the resident was assessed to have no impairments with range of motion and did not require the use of a restraint.</p> <p>The facility's fall risk assessment form indicated a score of eight (8) or greater revealed the resident was at high risk for falls. A review of the fall risk assessment completed on March 28, 2011, revealed Resident #2 was assessed to have a score of twelve (12) and was at risk for falls.</p> <p>A review of the fall history for Resident #2 revealed the resident fell April 15, 2011, when the resident attempted to self-transfer from the wheelchair to the resident's walker. A review of the post fall investigation revealed the intervention to prevent further falls was to apply a lap buddy to the resident's wheelchair. Further record review revealed a physician's order was obtained on April 15, 2011 for the use of the lap buddy. However, there was no evidence the facility had identified a specific medical symptom to support the use of the lap buddy.</p> <p>Review of the Pre-Restraint/Bed rail assessment revealed on April 15, 2011, the Pre-Restraint/Bed</p>	F 221	<p>The Restraints Assessment Review Tool CQI indicator will be utilized monthly for all residents utilizing a restraint device for the monitoring of device/physical restraint use under the supervision of the Director of Nursing.</p> <p>The Restraints Assessment Review Tool includes the following: the medical symptom demonstrating device need, comprehensive device assessment date, physician order date, guardian notification date, care plan and nurse aide assignment sheet review date. The Director of Nursing will share findings of the <u>Restraints Assessment Review Tools completed in the prior month for residents with a physical restraint</u> and <u>whether</u> corrective actions <u>were indicated for specific residents</u> at the monthly CQI/QA Committee meeting. <u>The Committee will track the number of residents' restrained, medical symptoms supporting the device, date of physician's order for the restraint, and type of restraints being utilized monthly to ensure all residents are maintaining their highest level of practicable well-being.</u></p>		

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F 221	<p>Continued From page 3</p> <p>rail assessment was updated and the lap buddy/restraint was added due to the resident sustaining a fall during an attempt to self-transfer on April 15, 2011. However, the assessment failed to identify a medical symptom to justify the use of the lap buddy for Resident #2.</p> <p>Furthermore, the facility failed to evaluate how the use of the lap buddy would assist the resident to attain/maintain the resident's highest practicable level of physical and psychosocial well-being. The last page of the Pre-Restraint assessment contained information regarding the risk/benefits of the restraint device and a consent form to be signed by the resident or responsible party (R/P). However, this page of the assessment had not been completed and had not been signed by the resident's R/P.</p> <p>Interviews conducted with Certified Nurse Aides (CNA #3 and #4) on April 27, 2011, at 2:00 p.m. and at 3:15 p.m. revealed staff utilized a lap buddy for Resident #2 to prevent the resident from getting up out of the wheelchair. The CNAs stated the lap buddy was considered to be a restraint for Resident #2. CNA #3 and #4 stated the resident was not able to remove the lap buddy independently.</p> <p>An interview conducted with RN #2 on April 27, 2011, at 1:40 p.m. revealed the RN was responsible for completing the Pre-Restraint assessment when a restraint device was ordered by the physician. However, RN #2 stated he did not believe he was working on April 15, 2011 when the lap buddy was implemented for Resident #2.</p> <p>An interview conducted with Resident #2's R/P on</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>April 27, 2011, at 3:00 p.m., revealed the R/P lap buddy had been initiated to prevent Resident #2 from falling out of the wheelchair and the lap buddy benefited the resident. The R/P stated she had been notified when the lap buddy had been implemented. However, according to the R/P, she had not been informed of the risk/benefits related to the use of the lap buddy.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #5 on April 28, 2011, at 2:20 p.m., revealed the LPN wrote the telephone physician's order for the use of the lap buddy on April 15, 2011. LPN #5 stated the registered nurse (RN) was responsible to complete the restraint assessment. LPN #5 further stated the lap buddy prevented Resident #2 from getting out of the wheelchair and no other restraint devices had been attempted for the resident.</p> <p>2. Resident #14 was observed on April 27, 2011, at 11:35 a.m., to be in a wheelchair in the hallway. The resident was observed to be sitting toward the edge of the wheelchair and was using his/her feet to propel the wheelchair. A lap buddy was observed to be in place on the resident's wheelchair. Resident #14 was not interviewable due to cognitive status.</p> <p>A review of the medical record revealed Resident #14 was admitted to the facility on July 24, 2007 with diagnoses of Dementia with behavioral disturbances, Paranoid Schizophrenia, Osteoarthritis, Chronic Renal Failure, and Alzheimer's Disease. A review of a significant change MDS assessment completed on February 1, 2011 revealed the facility assessed Resident #14 to have short/ long term memory deficits with</p>	F 221		

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F 221	<p>Continued From page 5</p> <p>moderately impaired decision making skills, required total assistance of two (2) staff persons for transfers, bed mobility, and was non-ambulatory. In addition, Resident #14 was assessed to utilize a trunk restraint (lap buddy) daily.</p> <p>Further review of the medical record revealed a lap buddy had been implemented for Resident #14 in 2008 due to the resident's fall history. A review of the progress notes revealed attempts to reduce/remove the lap buddy had been attempted and on April 20, 2010, the lap buddy was discontinued. Documentation in the progress notes revealed Resident #14 sustained a fall on May 4, 2010 and the lap buddy was reapplied to the resident's wheelchair. However, there was no evidence the facility had obtained a physician's order for the use of the lap buddy. In addition, there was no evidence a restraint assessment had been conducted for the use of the lap buddy until May 22, 2010.</p> <p>A review of the annual restraint evaluation completed on February 5, 2011, revealed the lap buddy was used for Resident #14 due to the resident scooting to the edge of the wheelchair seat and had the potential of sliding out of the chair. The assessment indicated the resident did not follow cues/commands and did not attempt to self-transfer. The assessment further noted recommendations to continue the use of the lap buddy.</p> <p>A review of the April 2011 physician's orders revealed a body alarm, clip alarm and a floor alarm were to be utilized to prevent the risk for falls for Resident #14. However, there was no</p>	F 221			

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F 221	<p>Continued From page 6</p> <p>evidence the physician had ordered the lap buddy to be used for Resident #14.</p> <p>An interview conducted with RNs #1 and #3 on April 28, 2011, at 6:10 p.m. revealed a physician's order was required prior to implementation of a restraint device. The RNs stated a pre-restraint and quarterly restraint evaluation was required to be completed by the RNs. RN #1 and #3 stated the lap buddy was used to prevent Resident #14 from getting out of the wheelchair unassisted and stated the resident could not remove the lap buddy independently. The RNs stated there was no evidence a physician's order had been obtained when the lap buddy was re-applied on May 4, 2010 and no evidence attempts had been made toward restraint reduction for Resident #14.</p> <p>3. Resident #13 was observed on April 28, 2011, at 3:00 p.m., in a merry walker in the hallway and to move down the hallway using his/her feet. Resident #13 was not interviewable due to his/her cognitive status.</p> <p>A review of the April 2011 physician's orders revealed the physician had not ordered a merry walker to be utilized for Resident #13.</p> <p>A review of the medical record revealed Resident #13 was admitted to the facility on March 31, 2009 with diagnoses of Mental Retardation, Seizure Disorder, Depression, and Muscular Atrophy. A review of the annual MDS assessment completed on February 1, 2011 revealed the facility assessed Resident #13 to have short/long term memory deficits with</p>	F 221			

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F 221	<p>Continued From page 7</p> <p>severely impaired decision making skills, and requires assistance of one (1) staff person for transfers. In addition, staff noted Resident #13 utilized a chair that prevented rising on a daily basis.</p> <p>Further review of the medical record revealed staff documented on the pre-restraint assessment for Resident #13 dated February 5, 2011, the specific reason for the restraint was "Resident had prior use of merry walker with crossbar at transferring facility, and he/she had been admitted to the facility in March 2009, with orders for use of the merry walker." In addition, there was no documentation that staff had assessed a medical symptom for the use of a merry walker for Resident #13.</p> <p>An interview conducted with the DON on April 28, 2011, at 6:20 p.m., revealed a physician's order was required prior to implementation of a restraint device. The DON stated that Resident #13 had always had the merry walker and a physician's order should be present in the medical record. However, the DON reviewed the medical record for Resident #13 and acknowledged that she was unable to find documentation of an order for the use of the restraint for the resident.</p> <p>An interview with LPN #3 conducted on April 28, 2011, at 7:00 p.m., revealed Resident #13 was unable to release his/her self from the merry walker.</p> <p>4. Resident #7 was observed at 5:15 p.m. on April 26, 2011, to be sitting in a broda (reclined geri) chair with a pelvic restraint in place. Resident #7 was unable to remove the pelvic</p>	F 221			

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F 221	<p>Continued From page 8</p> <p>restraint upon command. Resident #7 was not interviewable.</p> <p>A review of the medical record revealed Resident #7 was admitted to the facility on July 27, 2004, with diagnoses to include Huntington's chorea, Dementia, Osteoarthritis, Organic Affective Syndrome, Depression, and Mild Mental Retardation. A review of the annual comprehensive Minimum Data Set (MDS) completed on March 21, 2011 revealed the facility assessed Resident #7 to require the assistance of two (2) staff persons for bed mobility, transfers and toileting. Resident #7 was assessed to have no limitations in range of motion, severely impaired decision making skills, and required the use of a chair to prevent rising.</p> <p>Review of the medical record revealed an order had been obtained for the broda chair on March 10, 2010. However, there was no evidence the facility had determined the medical symptom to require the use of the broda chair and the pelvic restraint.</p> <p>A Pre-Restraint/Bed rail Assessment updated on March 14, 2011 revealed the broda chair enabled Resident #7 to have a secured upright posture in a sitting position, and to provide support to the upper and lower extremities. In addition, Resident #7 utilized the use of a pelvic restraint to prevent injury to the resident related to involuntary movements.</p> <p>A review of the comprehensive care plan updated on March 21, 2011, revealed Resident #7 was at high risk for falls, and required the use of a broda chair with a pelvic restraint. Resident #7 was assessed to have a score of fifteen (15) on the</p>	F 221			

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F 221	Continued From page 9 fall risk assessment (score of eight (8) or greater at high risk for falls). An interview was conducted with LPN #6 at 3:30p.m., on April 28, 2011. The LPN stated the broda chair enabled resident #7 to be out of bed. The LPN further stated resident #7 had constant involuntary movement, and the pelvic restraint prevented resident #7 from flinging self from the broda chair. An interview on April 28, 2011, at 8:50 p.m. with the Minimum Data Set (MDS) nurse revealed she reviewed the flow records related to restraints to ensure the restraints were released every two (2) hours. The MDS nurse revealed she only reviewed documents required to complete the MDS assessment such as the type of restraint required or if the restraint was still effective. The MDS nurse stated she did not review the physician's orders to ensure staff had obtained and written an order for the restraint.	F 221			
F 225 SS = E	483.13(c)(1)(ii)-(iii), (c)(2)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authority.	F 225	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. An investigation into the skin tears/bruising experienced by residents #2, 4, 6, 9, 10 and 14 has been completed, with findings reviewed with the physicians and responsible parties. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit will be completed by the Director of Nursing of the last 2 weeks of skin assessments for all current residents to determine that all skin tears/bruises identified to be of unknown origin have been investigated and reported to the State Agencies as indicated. A report listing all initial injuries of unknown origin was compiled from the internal database	06/03/11	

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F 225	<p>Continued From page 10</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must present further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and a review of the facility's policy/incident reports/incident tracking logs, it was determined the facility failed to thoroughly investigate and report injuries of unknown origin (bruises, skin tears and abrasions) to the required state agencies for six (6) of seventeen (17) sampled Residents (Residents #2, #4, #6, #9, #10 and #14).</p> <p>The findings include:</p>	F 225	<p>for the last two weeks to determine if they were investigated for probable cause and/or reported to state agencies.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>The facility policy Incident Management was revised 5/11/11 to include the updated Incident Report Form. The Incident Report Form was revised to include a box reminding nursing staff to interview the resident, assess the environment and interview staff whenever an injury of unknown origin is initially reported. <u>In the event the injury cannot be explained by interviewing the resident assessing the environment and interviewing the staff, an investigation will be conducted and reported to the state agencies.</u></p> <p>The nursing staff will receive in-service education on the documentation, investigation and reporting of skin tears/bruises determined to be injuries of unknown origin as provided by the Staff Development Coordinator by 05/31/11.</p> <p>The licensed nursing staff will receive education on the nursing policy Weekly Skin Integrity Assessment by the Staff Development Coordinator by 05/31/11.</p> <p>Newly hired licensed staff (state and contract) will be in-serviced on the Incident Report Form and Weekly Skin Integrity Assessment during new employee orientation.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>An incident report is completed by the licensed nurse when a resident experiences an injury of unknown origin. The incident report is completed on the shift of occurrence and the form provides space for interviewing the resident, assessing the environment, interviewing the staff to determine probable cause and implementation of immediate interventions.</p>		

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F 225	<p>Continued From page 11</p> <p>Review of the facility's abuse policy subtitled Safe Environment dated July 13, 2009, revealed the facility would conduct an objective investigation of all allegations of abuse, neglect, exploitation and Class 3 incidents, in a timely and thorough manner. Further review of the policy revealed the facility would classify incidents according to the potential for harm to individuals into three (3) categories. Each category revealed if there was reasonable cause present to suspect abuse, neglect or exploitation, the incident should be reported immediately to the appropriate authorities. Review of the three (3) categories revealed incidents were classified according to the potential for harm to individuals and had established protocols for recording and follow-up. The policy directed staff that immediate follow-up for all incidents should include the cause of the incident with interventions for future prevention.</p> <p>Review of Class 3 incidents listed on the policy included: injury of unknown cause if the injury required more than first aid, was suspicious of abuse, neglect or exploitation or if the facility's tracking and trending of similar injuries indicated suspected abuse, neglect or exploitation.</p> <p>1. Review of the medical record revealed Resident #9 was admitted to the facility on December 5, 1995, with diagnoses of Seizure Disorder, Parkinson's Disease and Alzheimer's. Review of a significant change in MDS Assessment dated as completed on April 11, 2011, revealed the facility assessed Resident #9 as being severely impaired in daily decision making, and required extensive to total assistance from two (2) staff members for any</p>	F 225	<p>The Incident Management Committee (consisting of the Facility Director, Facility Superintendent Associate, Director of Nursing, Risk Manager, Social Service Director, Administrator on Call, and/or day shift RN) reviews all resident incidents from the previous 24 hours including incidents involving injuries of unknown origin Monday-Friday and the day shift RN reviews the incidents on Saturday-Sunday. The Risk Manager is a member of the Incident Management Committee and is responsible for ensuring injuries of unknown origin (skin tears/bruises) have been investigated, documented and reported in accordance with regulatory requirements.</p> <p>All resident incidents are entered into an internal facility database for analytical review of cause and interventions. The Risk Manager will compile a weekly synopsis of all resident incidents and forward the report to the incident management committee members by Friday. The Facility Director will ensure all injuries of unknown origin will be reported to the state agencies. <u>The incident management committee will review all investigations before submitting to the state agencies to ensure recommended follow-up actions are implemented.</u></p> <p>The Risk Manager will present the total number <u>and type</u> of injuries with unknown origin to the monthly CQI/QA Committee meeting. <u>The Risk Manager will share the number of investigations forwarded to the state agencies and a synopsis of the investigatory findings to the monthly CQI Committee.</u> The Facility Superintendent Associate is responsible for reviewing all reports shared at the CQI/QA Committee meeting.</p>		

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F 225	<p>Continued From page 12</p> <p>activity of daily living.</p> <p>Review of the incident reports and incident log for Resident #9 revealed on December 29, 2010, the Resident sustained a skin tear (1 centimeter by 0.5 centimeter) to the right inner hand below the index finger. On March 6, 2011, during the provision of morning care, staff noted Resident # had an abrasion (1 centimeter by 1 centimeter) to the right knee.</p> <p>In addition, on March 17, 2011, Resident #9 was assessed to have two (2) abrasions (1 centimeter by 1 centimeter and 1 centimeter by 0.3 centimeter) on the right lower leg. The incident report dated March 17, 2011, also indicated the resident had redness of the right lower extremity.</p> <p>The facility failed to investigate the injuries to Resident #9 to determine a possible cause of the injuries and failed to report the injuries of unknown origin to the appropriate state agencies.</p> <p>Observations on April 26, 2011, at 1:40 p.m., 4:00 p.m. and on April 27, 2011 at 1:35 p.m. revealed Resident #9 was in a wheelchair in the hallway of the facility and was slowly moving about in the hallway by using the handrails and pushing with his/her feet. Continued observation revealed Resident #9 had tremors of the left upper extremity, had geri-sleeves in place on both upper extremities and was wearing a protective helmet.</p> <p>An attempt was made on April 27, 2011 at 2:50 p.m. to conduct a skin assessment of Resident #9, however, the resident became very agitated,</p>	F 225			

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F 225	<p>Continued From page 13</p> <p>cursed and instructed staff to "get away".</p> <p>Interview on April 27, 2011, at 3:00 p.m. with Registered Nurse (RN) #1/floor supervisor revealed staff were to assess resident for injuries after a report of any incident, complete a report of the incident, begin "alert" charting for seventy-two (72) hours, notify the resident's guardian of the incident and if the resident's injury was "serious", staff were to notify the resident's physician. RN #1 also stated if a resident sustained "minor" injury, the resident's physician was notified by placing the incident report on a clipboard that the physician reviewed each day. RN #1 stated incident reports were forwarded to Risk Management for review and the Risk Management would determine if an investigation was needed.</p> <p>2. A review of the medical record for Resident #2 revealed the resident was admitted to the facility on October 14, 2010 with diagnoses to include Dementia with behavioral disturbances, Hypertension, Osteoarthritis, Coronary Artery Disease, and Degenerative Joint Disease. A review of the significant change MDS assessment conducted on March 22, 2011, revealed Resident #2 was assessed to require extensive assistance of two (2) staff persons for bed mobility, transfers, ambulation, and toileting.</p> <p>Resident #2 was observed to be sitting in a wheelchair with geri-sleeves on both upper extremities, and knee Hi Thrombo Embolic Deterrent, (TED) hose (used to decrease the occurrence of blood clots of the legs) on both lower extremities on April 26, 2011, at 4:40 p.m., on April 27, 2011, at 8:50 a.m. and on April 28,</p>	F 225			

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F 225	<p>Continued From page 14</p> <p>2011, at 9:15 a.m. A skin assessment conducted with facility staff on April 28, 2011, at 3:45 p.m. revealed no alterations in the resident's skin condition.</p> <p>A review of the incident report dated October 20, 2010 revealed facility staff identified a skin tear to Resident #2's right forearm. The report noted treatment was provided to the skin tear and an intervention was implemented for staff to assist the resident to navigate difficult areas, such as doorways. On December 23, 2010, an "old" skin tear was noted to be "reopened" and steri-strips were applied. Further review of the incident reports revealed a skin tear was discovered on January 24, 2011 on the resident's left shin area when the CNA went into Resident #2's room. However, there was no evidence these three (3) incidents had been thoroughly investigated to identify a possible cause for the injury or to evaluate for possible abuse. In addition, there was no evidence the facility had reported these injuries of unknown source to the appropriate state agencies.</p> <p>An interview conducted with RN #2 on April 27, 2011, at 1:40 p.m. revealed staff were required to complete an incident report when a skin tear was identified. RN #2 stated the Risk Manager would determine if an investigation would be conducted of an incident after a review of the incident report. RN #2 also stated he was not sure if a skin tear sustained by a resident would be investigated. The RN stated he was one of the facility's three (3) investigators, and he had not conducted any investigations in the past one (1) or two (2) years.</p>	F 225			

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F 225	<p>Continued From page 15</p> <p>3. Resident #10 was admitted to the facility on December 10, 2002. The Resident's diagnoses included Dementia with Behavioral Disturbances, Severe Peripheral Vascular Disease (PVD), Renal Insufficiency, Vision Loss, Agitation Psychosis, and Depression. A review of the significant change MDS assessment conducted on February 8, 2011 revealed the facility assessed Resident #10 had moderate impairment with cognition, required total assistance of staff for bed mobility, transfers, toileting, personal hygiene, and was non-ambulatory.</p> <p>Resident #10 was observed on April 26, 2011, at 5:00 p.m. to be sitting in a wheelchair in the facility dining room. The Resident was dressed in personal clothing with geri-sleeves to both upper extremities and a dressing on the right foot/ankle. On April 27, 2011, at 8:55 a.m. and at 1:30 p.m., Resident #10 was observed again to be up in a wheelchair with geri-sleeves to both upper extremities. Resident #10 was not interviewable due to cognitive impairment. A skin assessment revealed a closed ulcer on the Resident's right outer foot. No other areas of redness or skin breakdown was noted.</p> <p>A review of a incident report revealed a skin tear was noted to Resident #10's left elbow when direct care staff was transferring the Resident to the bed on December 22, 2010. The report noted the area was cleaned and a band-aid was applied. On January 15, 2011, a skin tear was found on the Resident's left hand that measured .5 cm. x .5 cm.</p>	F 225			

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F 225	<p>Continued From page 16</p> <p>There was no further information noted on the incident report. Further review of the incident reports revealed skin tears were again noted to Resident #10 on January 21, 2011. The incident report noted a skin tear (measuring 1.5 cm x 5 cm) was discovered on the resident's right upper forearm and a skin tear (measuring 2 cm x 2 cm) was noted on the resident's left upper forearm. However, there was no evidence the three (3) incidents had been thoroughly investigated to determine a possible cause or to evaluate the injuries for possible abuse of the resident. In addition, there was no evidence the facility had reported the three (3) incidents of unknown injury to the state agencies.</p> <p>An interview conducted with RN #2 on April 27, 2011, at 1:40 p.m., revealed the Risk Manager was responsible to determine if incidents met the criteria for investigation. RN #2 also stated he was not sure if an investigation would be conducted for a skin tear. The RN stated he was one (1) of the facility's three (3) investigators, and he had not conducted any investigations in the past one (1) to two (2) years.</p> <p>An interview with the Risk Manager (RM) on April 28, 2011, at 1:35 p.m. revealed there was no evidence the facility had conducted an investigation into the three (3) incidents of skin tears for Resident #10. In addition, the RM stated these incidents had not been reported to the state agencies.</p> <p>4. Resident #14 was admitted to the facility on July 24, 2007. The Resident's diagnoses included Dementia with behavioral disturbances, Paranoid Schizophrenia, Osteoarthritis, Chronic</p>	F 225			

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F 225	<p>Continued From page 18</p> <p>Renal Failure, and Alzheimer's Disease. A review of the significant change MDS assessment completed on February 1, 2011 revealed the facility assessed Resident #14 had short/long term memory deficits with moderately impaired decision making skills, required total assistance of two (2) staff persons for transfers, bed mobility and was non-ambulatory.</p> <p>Resident #14 was observed on April 27, 2011, at 11:35 a.m. to be in a wheelchair in the hallway. The Resident was observed to be sitting toward the edge of the wheelchair and was using his/her feet to propel the wheelchair. Resident #14 was not interviewable due to cognitive status.</p> <p>A review of the incident report dated January 4, 2011 revealed Resident #14 was assessed to have bruising to the top of both hands, redness to the perineal area, a bruise to the right upper leg, and a skin tear to the right lower leg. However, there was no evidence the facility had conducted an investigation to determine a possible cause of these injuries. On February 5, 2011, nursing staff assessed Resident #14 to have a red area (measuring 2 cm x 2 cm) on the Resident's right knee with a 1 cm x 1 cm "yellow scabbed" area to the center when the direct care staff went into the Resident's room. There was no evidence the facility had conducted an investigation into this incident. In addition, there was no evidence these incidents of injury of unknown origin had been reported to the state agencies.</p> <p>An interview conducted with RN #2 on April 27, 2011, at 1:40 p.m., revealed the Risk Manager determined if an investigation would be conducted into an incident. RN #2 also stated he</p>	F 225		

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F 225	<p>Continued From page 18</p> <p>was not sure if an investigation would be conducted for a skin tear. The RN stated he was one of the facility's three (3) investigators, and he had not conducted any investigations in the past one (1) to two (2) years.</p> <p>An interview with the Risk Manager (RM) on April 28, 2011, at 1:35 p.m., confirmed there was no evidence the facility had conducted an investigation or reported these incidents involving Resident #14 to the state agencies.</p> <p>15. A review of the medical record for Resident #6 revealed the Resident had been admitted to the facility on April 10, 2008, with diagnoses to include Schizophrenia, Chronic Obstructive Pulmonary Disease, and Diabetes Mellitis. A review of the quarterly Minimal Data Set (MDS) for Resident #6 dated April 12, 2011, revealed the facility had assessed the Resident to be moderately cognitively impaired, and to require the total dependence of two (2) persons to transfer the Resident. The MDS further revealed the Resident used a wheelchair for mobility.</p> <p>A review of the incident reports for Resident #6 revealed the Resident had sustained bruising to the right index finger which was observed by the family on August 22, 2010, at 3:25 p.m. The incident reports further revealed on October 16, 2010, at 5:10 a.m., Resident #6 had been observed by nursing staff to have discoloration to the Resident's right knee, measuring 0.2 centimeters by 2.0 centimeters. There was no documentation that the facility had investigated the injuries in an attempt to determine a cause of the injuries, or had reported the injuries of</p>	F 225			

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F 225	<p>Continued From page 19</p> <p>unknown origin to the appropriate state agencies.</p> <p>Observation of Resident #6 on April 26, 2011, at 6:30 p.m., April 27, 2011, at 8:55 a.m., 9:30 a.m., 1:30 p.m., 2:30 p.m. and April 28, 2011 at 9:00 a.m., revealed the Resident to be up in the wheelchair and able to propel his/herself. An attempt to perform a skin assessment on April 28, 2011, at 9:30 a.m., was unsuccessful. The Resident refused and stated, "no, go away".</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #6 on April 27, 2011, at 3:30 p.m., revealed the nurse was to complete an incident report of any injury to Residents. The LPN further revealed the nurse was to place the completed report on a clipboard for the physician to review. The LPN further stated the physician was in the facility on a daily basis. The LPN also revealed Administration obtain the incident reports every day, to discuss them in the morning meeting.</p> <p>An interview conducted with the facility's Director of Nursing (DON) on April 28, 2011, at 7:20 p.m., revealed he/she was unaware of how Resident #6 sustained the bruises on August 22, 2010, and October 16, 2010. The DON further revealed she had only felt major incidents such as broken bones, bruises with fingerprints, needed to be investigated, or reported to the state agencies.</p> <p>6. Review of the medical record revealed Resident #4 was admitted to the facility on September 16, 2011, with diagnoses of Dementia with behavioral disturbances, Hypertension, Type two (2) diabetes, Chronic Kidney Disease and History of Cardiovascular Accident.</p> <p>Review of a significant change MDS assessment</p>	F 225		

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F 225	<p>Continued From page 21</p> <p>completed on February 7, 2011, revealed the facility assessed Resident #4 was severely impaired in daily decision making, and required extensive assistance with all activities of daily living.</p> <p>A skin assessment observation conducted on April 28, 2011 at 10:50 a.m. with LPN #3, and CNA #1, revealed Resident #4 had a bruise to lower right inner leg, that was brown in color, and was approximately two (2) centimeters round. Further observation revealed a bruise to top of the resident's left thumb, that was purple in color and approximately one (1) centimeter round. There was no documentation provided that the bruises had been thoroughly investigated or reported to the appropriate state agency.</p> <p>An interview with the Risk Manager (RM) on April 28, 2011, at 10:15 a.m., revealed the Administrator, Social Workers, Director of Nursing (DON), MDS Nurse, and the RM reviewed incident reports daily.</p> <p>Further interview with the Risk Manager (RM) on April 28, 2011, at 1:35 p.m., related to the investigation of skin tears/abrasions/injuries of unknown origin for Residents #2, #4, #6, #9, #10 and #14, revealed all incident reports were reviewed daily during the Incident Management Meeting to determine if the incident report met the criteria to be investigated. The RM stated the Administrator, Assistant Administrator, Social Services Director (SSD), Director of Nurses (DON), MDS Nurse, and the RM attended the daily Incident Management Meetings. The RM stated incidents were reviewed for possible</p>	F 225			

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F 225	<p>Continued From page 21</p> <p>causes and, if a cause could not be determined, the incident would be marked "unknown". The RM also stated she was responsible to report incidents to the appropriate state agencies. The RM further stated the skin tears sustained by Residents #2, #4, #6, #9, #10 and #14, had not been investigated and had not been reported to the state agencies.</p> <p>An interview with LPN #3 on April 28, 201, at 10:55 a.m., during skin assessment of Resident #4, revealed that she was unaware Resident #4 had bruises present. LPN #3 stated staff were to notify the charge nurse if a Resident was observed to have bruises, and the bruises would be documented.</p> <p>An interview conducted with RN #2 on April 28, 2011, at 11:15 a.m. revealed that if staff were to complete an incident report if bruising was identified on a resident, RN #2 stated an attempt would be made to determine how the bruise occurred. However, the RN was unaware of who was to be notified of bruises of unknown origin.</p> <p>The facility Administrator (ADM) stated in an interview conducted on April 28, 2011, at 6:35 p.m. incident reports were reviewed daily during the Incident Management Meeting. The ADM stated an investigation was only conducted if the incident met the facility's criteria (Class I, Class II, and Class III) for investigation. The ADM stated injuries of unknown source were not reported to the stated agencies unless a "major" injury had occurred.</p> <p>An interview conducted with the facility's Director</p>	F 225			

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F 225	Continued From page 22 of Nursing (DON) on April 28, 2011, at 7:20 p.m. revealed she was unaware bruises of unknown original would need to be investigated, or reported to the state agencies.	F 225	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide a sanitary, orderly, and comfortable interior. One door with chipped paint, one loose hallway baseboard, cracked tile in two (2) hallways, one (1) Resident wheelchair with worn and torn arms, and one (1) Resident geri-chair with worn and torn armrests were observed on the environmental tour on April 28, 2011. The findings include: The facility was asked for a policy related to maintenance repairs and none was provided. During the environmental tour of the facility on April 28, 2011, at 4:15 p.m., the following items were observed to be in need of repair: -Solarium door on the Second Floor of the facility was observed to have chipped paint. -The baseboard was observed to be loose in the	F 253	The Solarium door on the second floor was repainted on 5/20/11. The baseboard in the hallway between rooms #301 and 302 was repaired on 05/13/11. The tile in the hallway between room #402 and the linen room, and in front of the Fourth Floor nurses station was replaced on 5/20/11. The wheelchair and geri-chair arm rests were repaired/replaced on 4/29/11. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An inspection was conducted by the Director of Environmental Services and the Director of Maintenance of all resident wheelchairs/geri chairs, rooms and common areas to identify necessary repairs on 5/20/11. All areas have been prioritized and scheduled for completion. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Maintenance staff received in-service education on the importance to <u>inspect the 2nd floor residential unit wheelchairs/geri chairs, rooms and common areas by the 7th day of the month, 3rd floor residential unit wheelchairs/geri chairs, rooms and common areas by the 15th day of the month, and the 4th residential unit wheelchairs/geri chairs, rooms and common areas by the 21st day of the month</u> to identify and address all necessary repairs as provided by Director of Environmental Services. The facility policy Resident Environment was revised on 5/18/11 to include "equipment noted to be torn or in disrepair, complete a work order".	06/03/11

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F 253	Continued From page 23 hallway between Resident rooms 301 and 302. -The tile in the hallway between Resident room 402 and the linen room was observed to be cracked. -The tile in the hallway in front of the Fourth Floor nurses station was observed to be cracked. -A wheelchair being used by Resident #9 was observed to have worn and torn armrests. -A geri-chair being used by Resident #18 was observed to have worn and torn armrests. An interview conducted with the Maintenance Supervisor (MS) for the facility on April 28, 2011, at 4:55 p.m., revealed the facility utilized a work order system. The MS stated any staff member could obtain a work order at the nurses station to inform the Maintenance Department of anything that needed to be repaired. The MS stated he checked each nurses station three times a day for work requests, and also conducted a daily walk through on each nursing unit. The MS further revealed he made an environmental round on one floor every week.	F 253	<u>The facility utilizes an internal electronic work order system. All staff is encouraged to enter a work order when an item is broken or requires repair. The maintenance staff prints the work orders daily and logs completion date.</u> All nursing and maintenance staff will be in-serviced on the facility policy Resident Environment by Staff Development Coordinator by 05/31/11. <u>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</u> The General Environment CQI indicator for the monitoring of the facility general environment will be <u>completed by the last day of the month</u> by the Director of Environmental Services. <u>A summary of the audit and implemented corrective actions will be shared at the monthly CQI/QA Committee meeting. Discrepancies identified during the audit will be tracked and trended until the issue(s) is resolved.</u>	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to provide services according to professional standards for one (1) unsampled resident (Resident #19). Resident #19 received liquid/ crushed medications per gastrostomy tube	F 281	<u>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</u> Resident #19 is provided crushed and liquid medications with thorough tapping of the crushing container to determine all particles/pieces are administered, and rinsing of the medicine cup in accordance with medication pass standards of practice. The interdisciplinary team reviewed her care plans on 5/17/11 and stated no adverse effects were noted per review of nurses' notes and vital signs records. <u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</u>	06/03/11

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F 281	<p>Continued From page 24</p> <p>(G/T); however, the nurse failed to ensure the resident received the correct dosage as prescribed by the physician.</p> <p>The findings include:</p> <p>A review of the Medication Administration policy/procedure (review date March 2, 2011) revealed the responsibilities of the nurse administering medications included administering the correct dose of medication to residents. The policy/procedure did not include guidance/direction for ensuring how all the medication would be removed from either the plastic sleeve or plastic cup to ensure the resident received the correct dosage of medication.</p> <p>A review of the medical record revealed Resident #19 had physician orders to receive Amlodipine 5 milligrams (mg) twice a day, Calcium with Vitamin D 600 mg/400 twice a day, Metoclopramide HCL 10 mg. daily Thermotabs Salt Substitute one (1) tablet twice a day, Vitamin D 1000 units (two tablets) daily, Centrum Vitamin 15 cubic centimeters (cc) daily, Valproic Acid 750 mg. (15 cc) daily. The medications were ordered to be administered per gastrostomy tube (G/T).</p> <p>A medication administration observation conducted on April 27, 2011, at 9:15 a.m., revealed Licensed Practical Nurse (LPN) #3 obtained the tablet/capsule medications for Resident #19 and crushed these medications together in a plastic sleeve with a pill crusher. LPN #3 was then observed to pour the crushed medications from the plastic sleeve into a paper cup. The nurse was observed to tap the sides of</p>	F 281	<p>All residents with crushed and liquid medications have the potential to be affected. Medication pass observations will be completed on all licensed staff and CMTs by 05/31/11, to determine that crushed and liquid medications are administered in accordance with medication pass standards of practice, which includes thorough tapping/inspection of the crushing container to determine all particles/pieces are dispensed and rinsing/administration of the medication from the medicine cup.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>The nursing policy Medication Administration General Rules was revised on 5/06/11 to include "Rinse plastic soufflé cup of any residual medication with water." In addition, the policy states, "Ensure all contents are emptied from paper soufflé cup/crushing pouch of Silent Night Crusher".</p> <p>The nursing policy Medication Administration was revised on 5/06/11 to include "Rinse any remaining liquid from the plastic soufflé cup". <u>The plastic soufflé cup holds 30cc of liquid. The licensed staff are able to utilize 30cc of water to rinse any remaining liquid/medications from the soufflé cup.</u></p> <p>Licensed nursing staff and CMTs will be in-serviced on the two revised medication policies and usage of the Silent Knight Pillcrusher by 05/31/11.</p> <p>The Medication Performance Checklist for Selected Medications & Techniques was revised on 05/19/11 to include "#8 (Rinse liquid medication, tap sides and corners of the pouch to remove any trapped particles.)".</p> <p>Licensed nursing staff and CMTs will receive in-service education on the administration of crushed and liquid meds in accordance with medication pass standards of practice including but not limited to: thoroughly tapping and</p>	

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F 281	<p>Continued From page 25</p> <p>the plastic sleeve to remove the medications; however several particles/pieces of a white substance was still present in the plastic sleeve. The nurse then poured the two (2) liquid medications into separate plastic cups and took all the medications into Resident #19's room.</p> <p>The nurse was then observed to check/verify placement of the G/T, mixed the crushed medications with water, and poured the medications into an asepto syringe to administer the medications per G/T to Resident #19. The nurse was then observed to pour the liquid medications in the asepto syringe. However, a small amount of the liquid medications still remained in each of the plastic medication cups. Observation revealed the nurse failed to ensure Resident #19 received the prescribed dosage of medication.</p> <p>An interview conducted with LPN #3 on April 27, 2011, at 10:00 a.m., revealed the facility had implemented the use of the plastic sleeves and "Silent Crusher" for crushing medications approximately two (2) months ago. LPN #3 stated she had been directed to tap the sides of the plastic sleeve to remove all the medications. LPN #3 also stated she had not been directed to rinse the plastic medication cups to ensure all the medications had been removed from the medication cups.</p> <p>An interview conducted with the Director of Nursing (DON) on April 28, 2011, at 10:20 a.m., revealed the nurses were responsible to ensure the residents received the correct dosage of medication as prescribed by the resident's physician. The DON stated the nurse should tap</p>	F 281	<p>inspecting the crushing container to determine that all particles/pieces of the crushed med are administered, and rinsing/administration of the med from the medicine cup, as provided by pharmacy representative on 05/25/11.</p> <p>Newly hired licensed staff and CMTs (state and contract) will be in-serviced on the nursing policy Medication Administration and Silent Knight Pillcrusher during new employee orientation.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p><u>The Medication Performance Checklist for Selected Medications and Techniques will be utilized on seven licensed staff members and/or CMTs as a monitoring tool for medication pass observation monthly under the supervision of the Director of Nursing. The Director of Nursing will share deviations from professional standards of quality identified during the medication administration observations with the CQI/QA Committee meeting. Discrepancies and corrective action steps will be tracked monthly until the issue is resolved.</u></p>		

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F 281	Continued From page 26 the sides of the plastic sleeve to remove all the medications and to rinse the plastic medication cups to ensure all the medications was administered. The DON stated no inservice/education had been provided to the nurses for the use of the "Silent Crusher" for crushing medications. The DON observed the powder substance that remained in the plastic sleeves after the medications for Resident #19 had been crushed. The DON revealed that some of the medications had been left in the plastic sleeve.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide services to one (1) of seventeen (17) sampled residents in accordance with the resident's written plan of care. Review of the written plan of care for Resident #4 revealed staff were to ensure Resident #4 had an abdominal binder on at all times, had skin sleeves on the upper extremities at all times, and had Thrombo Embolic Deterrent (TED) hose (elastic stocking to prevent blood clots) applied every morning. In addition, the footboard of the resident's bed was to be covered with sheepskin, and Resident #4 was to be up in geri-chair at the nurses station when awake for comfort and supervision.	F 282	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #4 has been assessed for abdominal binder, skin sleeve, TED hose, foot board padding use and geri-chair placement on 5/20/11 with the care plan and nurse aide assignment sheet being reviewed and updated. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents requiring the use of abdominal binders, skin sleeves, TED hose and padded foot boards have the potential to be affected. These residents have been assessed by a RN Supervisor to determine ongoing need for these interventions, and the C.N.A assignment sheets and care plans will be updated by 05/31/11 to reflect the indicated interventions. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All facility nursing staff will receive in-service education as provided by the Staff Development Coordinator on the provision of abdominal binders, skin sleeves, TED hose and padded foot board interventions in accordance with each resident's care plan by 05/31/11.	06/03/11

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F 282	<p>Continued From page 27</p> <p>However, observations on April 26, 2011, and April 27, 2011, revealed the facility staff had not implemented the interventions as planned for the resident.</p> <p>The findings include:</p> <p>A review of Resident #4's record on April 26, 2011, revealed the resident was admitted to the facility on September 16, 2008. The resident's diagnoses included Chronic Obstructive Pulmonary Disease, History of Cardiovascular Accident, Dementia with behavior disturbance, Type two (2), Depression and Gastrostomy Tube Placement. Review of Resident #4's significant change Minimal Data Set (MDS) assessment dated February 7, 2011, revealed the resident required extensive assistance for bed mobility and transfers.</p> <p>A review of Resident #4's plan of care revealed the plan was update don February 7, 2011, and revealed the resident was at risk for falls/injury, alteration in skin integrity, and alteration in nutrition, interventions included an abdominal binder, skin sleeves, and TED hose on at all times. In addition, the resident's footboard was to be covered with sheepskin at all times. Also, based on a review of the plan of care, the resident was to be assisted up on a geri-chair at the nurses station when awake for comfort and supervision.</p> <p>A review on April 27, 2011, at 4:10 p.m., of the CNA's daily assignment sheet revealed Resident #4 was to have TED hose on in the morning and off in the evening, and an abdominal binder and skin sleeves on at all times. The assignment</p>	F 282	<p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>The RN supervisors will conduct monthly rounds to ensure the resident's care coincides with the nurse aide assignment sheet and plan of care. The RN supervisors will document findings of at least 35 residents per month on the Care Plan/Assignment Sheet/Resident Assessment CQI tool. Specifically, <u>the RN supervisors</u> will be monitoring the provision of abdominal binders, skin sleeves, TED hose and padded foot board interventions in accordance with the care plan <u>by the last day of the month</u> under the supervision of the Director of Nursing. <u>An internal database will track the date the residents are reviewed and if changes were indicated in their plan of care.</u> The Director of Nursing will review the findings of <u>the 35 resident audits, and whether the care plan and/or nurse aide assignment sheet required any revisions during the monthly CQI/QA Committee meeting.</u></p>	

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F 282	<p>Continued From page 28</p> <p>sheet revealed a sheepskin pad was to be on the footboard of the bed to protect the resident's skin due to the resident's restless movement of legs. In addition, the assignment sheet revealed the resident was to be assisted up to a geri chair every shift for two hours.</p> <p>Observations conducted on April 26, 2011, at 4:00 p.m. revealed Resident #4 was lying in the bed. Based on observation, the TED hose, abdominal binder, or skin sleeves were noted not to be applied. Further observation revealed the footboard of Resident #4's bed did not have a sheepskin covering.</p> <p>Continued observation conducted on April 27, 2011 at 12:00 p.m., 1:30 p.m., 3:05 p.m., 5:00 p.m. revealed no evidence of an abdominal binder or skin sleeves in use for Resident #4. In addition, observation revealed the footboard of Resident #4's bed did not have a sheepskin covering. Resident #4 was not observed to be up in geri chair on this date.</p> <p>Interview conducted on April 27, 2011, with CNA #2 at 4:15 p.m., revealed resident's care needs were indicated on the daily assignment sheets. CNA #2 stated night shift CNAs were responsible to lay skin sleeves out for residents and stated "it's been awhile since sheepskin has been on Resident #4's bed." CNA #2 was unaware as to why the abdominal binder or skin sleeves were not in place for the resident, as noted on the daily assignment sheet. CNA #2 further revealed she was aware Resident #4 required both the abdominal binder and the skin sleeves.</p> <p>Interview conducted on April 28, 2011, at 9:00</p>	F 282			

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F 282	Continued From page 29 a.m. with CNA #1 revealed the daily assignment sheet was used to inform staff of the resident' care needs. The CNA stated if the items were not in use as planned, staff were to implement the measures and notify the Charge Nurse. The CNA further revealed she was unaware the items had not been applied to Resident #4, and had not notified the Charge Nurse. Interview with Unit Manager, RN #2, conducted on April 27, 2011 at 4:20 p.m. revealed he assessed residents every two (2) hours to ensure resident care needs were met. RN #2 stated "honestly I don't know the resident doesn't have an abdominal binder, skin sleeves or why the footboard is not covered with sheepskin." Interview with the DON, conducted on April 28, 2011, at 10:15 a.m., revealed that she relied on the LPNs and RNs to ensure resident care needs were met, and to update the care plans as needed.	F 282		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility	F 323	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. An inspection was completed by MDS Coordinator, with resident permission, of the bedside stand of resident #20 on 05/18/11. All items with warning labels indicating potential resident risk were removed to be stored in a locked access area. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with bedside hygiene products have the potential to be affected. An inspection with resident permission, was completed by a RN Supervisor on 05/23/11 of all bedside stands. All products with warning labels indicating potential resident risk were removed, <u>placed in a basin and stored in the individual resident's locked personal closet. Alert and oriented residents will be issued a key to their closet so they can secure items when needed.</u>	06/03/11

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F 323	<p>Continued From page 30</p> <p>failed to ensure the residents' environment remained as free from accident hazards as possible. Observation during the environmental tour revealed the facility failed to ensure chemical substances were secured/locked and not accessible to residents. A review of the labels on the containers revealed the chemicals were to be kept out of reach.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Personal Care Supplies, dated April 27, 2010, revealed personal care items were to be kept in the disposable wash basin in the resident's individual closet. The policy further revealed the personal care items were to be taken to the bathroom when care was provided to a resident and returned to the closet when care was completed.</p> <p>Observation during the environmental tour on April 28, 2011, at 09:05 a.m., revealed two (2) bottles of GermX (hand sanitizer), one (1) bottle of Sween Baza Cleanse and Protect (skin care product), one box of Polident Denture Tablets, and one (1) bottle of Cepacol Antibiotic Mouthwash were setting on the nightstand in resident room #205A. The labels on the containers had a cautionary statement to keep the products out of the reach.</p> <p>A review of the Material Data Safety Sheets (MSDS) from the manufacturers of the products revealed: -Germ X could cause irritation of the respiratory tract if inhaled, could cause nausea, vomiting, or diarrhea if ingested, or could cause irritation to the eyes.</p>	F 323	<p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Nursing policy Personal Care Supplies was revised on 5/18/11 to include "personal care items are not to be left on bedside tables due to safety of wandering residents for possible ingestion". Hand sanitizer and skin care products were added as personal care items to be stored in the resident closet.</p> <p>Facility nursing staff will receive in-service education as provided by the Staff Development Coordinator by 05/31/11 on the need to monitor for and remove from the bedside stand any products with warning labels indicating the potential for resident risk.</p> <p><u>Newly hired nursing staff (state and contract) will be in-serviced on the facility policy Personal Care Supplies during new employee orientation.</u></p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>Resident bedside stands will be inspected <u>by the last day of the month</u> by RN Supervisors under the supervision of the Director of Nursing as part of the compliance rounds to determine that all products with warning labels indicating the potential for resident risk are stored in the <u>resident's locked closet</u>. The RN supervisors will document findings of at least 35 residents per month on the Care Plan/Assignment Sheet/Resident Assessment CQI tool. <u>The Director of Nursing will tabulate the findings of the inspection , report on the number of residents reviewed, whether items were securely locked and the necessity to implement any corrective action steps with the CQI/OA Committee. An internal database will track the residents reviewed and if any hazardous items were not securely locked.</u></p>	

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NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P. O. BOX 189 GLASGOW, KY 42141		
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F 323	Continued From page 31 -Sween Baza Cleanse and Protect revealed contact of the product with the eyes, and ingestion of the product should be avoided. The MSDS also revealed if the product was ingested, a physician should be consulted. The label on the box of Polident Denture Tablets and the bottle of Cepacol Antibiotic Mouthwash revealed the Poison Control Center was to be contacted if the product was ingested. An interview conducted with Licensed Practical Nurse (LPN) #6 on April 28, 2011, at 3:25 p.m., revealed the facility had eight (8) residents on the Second Floor of the facility who could potentially wander into other residents' rooms and come into contact with the products. An interview conducted with the facility's Administrator on April 28, 2011, at 5:00 p.m., revealed the personal care items should not have been placed on the resident's nightstand. The Administrator further stated the items should have been placed in the wash basin in the resident's closet. The Administrator stated the nurses were responsible for ensuring chemicals were stored in the resident's closet. The Administrator stated the nurse was expected to monitor to ensure chemicals are not left out and in reach of any residents, when the nurse made rounds every two (2) hours.	F 323			
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at the proper	F 364	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. Food items are served at proper temperatures in accordance with dietary standards of practice and prepared according to the specified recipe. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	06/03/11	

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F 364	<p>Continued From page 32</p> <p>temperature.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide foods that were palatable and at a preferable temperature during the lunch and evening meal on April 26, 2011.</p> <p>The findings include:</p> <p>A review of the Point of Service Temperature policy/procedure (dated August 27, 2010) revealed the point of tray delivery temperatures would be at the minimum temperatures when served to the residents. The policy noted the minimum temperatures for the following food items should be delivered to the residents at: meat items (greater than 115-125 degrees), vegetables (greater than 115-125 degrees), creamed soup (greater than 130 degrees), and milk less than 45 degrees.</p> <p>A review of the Tray Line and Meal Service policy (dated August 25, 2010) revealed a test tray for food temperatures and palatability would be conducted/recorded weekly. The policy noted the test trays would be rotated between breakfast, lunch, and dinner meals and between the regular, ground, and puree consistence of foods.</p> <p>Observation of the noon meal service on April 26, 2011, revealed the first food cart was delivered to the third floor main dining room from the kitchen</p>	F 364	<p>All residents receiving meal trays have the potential to be affected. The meal service schedules and procedures have been reviewed/revised by the Registered Dietitian and Dietary Manager to determine that adequate time is allowed between cart delivery, and that cold items are kept in cold storage prior to serving. <u>The initial cart will be sent to 4th floor, second cart to 3rd floor, third cart to 2nd floor, fourth cart to 4th floor, fifth cart to 3rd floor, and sixth cart to 2nd floor. The change in cart times will allow nursing staff approximately 15-20 minutes to distribute the first cart before receiving the second cart of meal trays.</u></p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Facility policy Resident Food Services was revised on 5/18/11. Milk and juice will be stored in the kitchenette refrigerator for the second and fourth floor residential units prior to meal service and milk and juice will be placed in an ice chest on the third floor residential unit prior to meal service. Tea and water with ice in the glasses will be served on the meal tray.</p> <p>Facility dietary and nursing staff will receive in-service education on the revised meal service schedules and procedures, and the need to serve food items at temperatures in accordance with dietary standards of practice, as provided by the Staff Development Coordinator by 05/31/11.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>The Dietary Manager or <u>Food Prep Center Coordinator</u> will test a meal tray weekly to ensure food items are served at the appropriate temperature. The Registered Dietitian will test a meal tray once a month to ensure items are the appropriate temperature at point of service. <u>The results of the weekly and monthly test trays</u></p>	

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F 364	<p>Continued From page 33</p> <p>in a closed, unheated cart at 1:05 p.m. The last tray was removed from the food cart at 1:55 p.m. (50 minutes after the cart was delivered). A palatability test was conducted with facility staff revealed the pureed meat was 114 degrees Fahrenheit and tasted warm, the pureed carrots was 104 degrees Fahrenheit and tasted slightly warm, with no seasoning, and the baked beans was 90 degrees Fahrenheit and tasted slightly warm.</p> <p>Further observation of the noon meal service on April 26, 2011, revealed the second foot cart arrived on the third floor for the second dining room at 1:11 p.m. The last tray was removed from the food cart at 1:45 p.m. (34 minutes after the cart was delivered) and another palatability test was conducted. The food palatability test conducted with facility staff revealed the carrots were 102 degrees Fahrenheit and tasted slightly warm and bland, the baked beans were 96 degrees Fahrenheit and tasted slightly warm, and the hamburger patty was 100 degrees Fahrenheit and tasted cool with no seasoning.</p> <p>Observations of the evening meal service on April 26, 2011, revealed the first closed tray cart was delivered to the third floor from the kitchen at 5:00 p.m. the last tray was removed at 5:38 p.m. (38 minutes after the cart was delivered) and a palatability test was conducted of the food items. The pureed turkey was 110 degrees Fahrenheit and slightly warm, the cream of broccoli soup was 90 degrees Fahrenheit and tasted cool, and the nectar thickened milk was 60 degrees Fahrenheit and tasted cool.</p> <p>An interview was conducted with CNA #4 on</p>	F 364	<p>will be shared at the monthly CQI/QA Committee Meeting. <u>If the test tray temperatures are below the minimum guidelines, a process improvement team will be established consisting of nursing and dietary personnel to review policies and procedures, meal pass times and dining room seating arrangements. Recommendations from the process improvement team will be forwarded to the CQI/QA Committee.</u></p>	

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F 364	Continued From page 34 April 26, 2011, at 1:00 p.m. CNA #4 stated if a tray sat for forty (40) minutes before being delivered to a resident, she would re-order the resident a tray. An interview with the Dietary Manager (DM) on April 28, 2011 at 8:50 a.m., revealed weekly test trays had not been conducted per facility policy. The DM stated the Registered Dietitian (RD) was supposed to conduct a monthly test tray; however, the DM stated the RD had missed several months due to the required furlough days. The DM stated the test tray conducted in December 2010, revealed foods were not served at the appropriate food temperatures. However, the DM stated the next test tray conducted in February 2011 revealed the foods temperatures were appropriate and no corrective plan of action had been implemented. An interview conducted with the DON on April 28, 2011, at 7:30 p.m., revealed meal service should be completed within 15-20 minutes.	F 364		
F 367 SS = D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, it was determined the facility failed to provide a therapeutic dietary supplement for one (1) of seventeen (17) samples residents. Resident #10 had a physician's order for Glucerna to be provided three (3) times a day	F 367	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. The physician discontinued the Glucerna order for Resident #10 on 05/03/11 due to desired weight gain. The interdisciplinary team reviewed and revised his plan of care on 05/17/11. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with dietary supplements have the potential to be affected. An audit of all dietary orders and tray cards was completed by the Dietary Manager on 05/20/11 to determine that supplements are addressed accurately. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	06/03/11

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F 367	<p>Continued From page 35</p> <p>with each meal. However, staff failed to provide Glucerna for Resident #10 during the evening meal on April 26, 2011.</p> <p>The findings include:</p> <p>A review of the April 2011 physician's orders revealed Resident #10 had a diet order for a No Concentrated Sweets, mechanical soft diet with one (1) can of Glucerna to be provided three (3) times a day with each meal. Resident #10 was observed on April 26, 2011, at 6:20 p.m. to be eating in the main dining room on the third floor. A review of the resident's tray card revealed the resident was to have a mechanical soft, no concentrated sweet diet with Glucerna at each meal. Observation of the resident's meal tray revealed no evidence the Glucerna had been provided for Resident #10 as ordered by the resident's physician.</p> <p>An interview conducted with CNA #1 on April 28, 2011, at 9:15 a.m., revealed she was not sure if Resident #10 was required to receive a supplement on each tray. CNA #1 stated the supplements were added to the resident's tray by the dietary department. However, the CNA stated she was required to check the resident's tray card to ensure the resident received the appropriate supplements.</p> <p>An interview conducted at 11:05 a.m., on April 28, 2011 with the Dietary Manager (DM) revealed each dietary staff person who served foods on the tray line was required to check the resident's tray card to ensure the diet was served as ordered. The DM stated Resident #10 did not receive the Glucerna as ordered due to an</p>	F 367	<p>The nursing policy Supervision of Resident Nutrition was revised on 5/18/11 to include prior to serving the food tray, the nurse aide must check the diet card to assure that the correct food tray, "supplements, fluids, and consistency of meal" is being served to the resident.</p> <p>An electronic web-based tray card system was ordered from Gordon Food Service on 5/08/11 and will be implemented <u>by 06/02/11</u>. A paper tray card will be printed for each resident for each meal. All dietary staff will receive training on the new tray card system <u>by 06/01/11</u>. <u>When a physician orders a dietary supplement to be served with meals, the Dietary Manager or Food Prep Center Coordinator will enter the information into the electronic tray card system. The dietary supplement will be printed on the paper tray card for the specific resident.</u></p> <p>Dietary and nursing staff will receive in-service education on the <u>importance to provide dietary supplements with meals in accordance with physician orders as provided by Staff Development Coordinator by 06/01/11.</u></p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>The Dietary Manager or <u>Food Prep Center Coordinator</u> will test a food tray weekly to ensure food items are served according to the resident diet order. The Registered Dietitian will test a food tray monthly to ensure food items are served according to the resident diet order. The Dietary Manager will audit all supplement orders against the tray cards <u>by the last day of the month</u> to ensure the residents are receiving <u>dietary supplements with meals as ordered by the physician. A summary of the test tray results and audit of the supplement orders with meals</u> will be shared at the monthly CQI/QA Committee meeting. <u>If discrepancies are noted, a process improvement team consisting of nursing and dietary will review the tray card system and physician orders.</u></p>	

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F 367	Continued From page 36 "oversight" by the dietary staff.	F 367		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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 action related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Licensed nursing staff performs accu-check testing utilizing glucometer cleaning/disinfection techniques and hand washing/sanitizing procedures in accordance with facility policy and infection control standards of practice.</p> <p>The shift Nursing Supervisor received retraining on facility policy for cleaning/disinfecting glucometers and handwashing on 04/27/11.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents requiring accu-check testing have the potential to be affected. Accu-check testing procedure observations will be completed on all licensed nursing staff by the Staff Development Coordinator by 05/31/11 to determine that glucometer cleaning/disinfection techniques and hand washing/sanitizing procedures are utilized in accordance with facility policy and infection control standards of practice.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>The nursing policy Optimum EZ Blood Glucose Monitor was revised on 5/04/11 to include "Wash hands or use hand sanitizer in accordance with facility policy".</p> <p>The facility handwashing policy was revised on 5/09/11 to include instructions on using "<u>Alcohol Based Hand Sanitizer</u> – Follow these rules when decontaminating your hands with an alcohol hand sanitizer" when soap and water are not available.</p>	06/03/11

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

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F 441	<p>Continued From page 37</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and policy review, it was determined the facility failed to provide a safe, sanitary environment to help prevent the development and transmission of disease and infections for two (2) sampled residents out of seventeen (17), (Residents #11 and #12). During observation of a blood glucose check being performed by the shift Nursing Supervisor (NSV), the NSV failed to perform handwashing after performing the check, and failed to clean the glucometer between residents as instructed by the manufacturer's guidelines.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Optimum Blood Glucose Monitor, dated February 3, 2010, revealed the meter should be cleansed after each use with Gluco Chlor wipes.</p> <p>A review of the facility's policy titled Handwashing, dated February 3, 2010, revealed all personnel were required to wash their hands before and after each resident contact. The policy further revealed a waterless hand sanitizer may be used when soap and water was not available.</p> <p>Observation revealed the NSV conducted a blood glucose check on Resident #11 on April 26, 2011, at 5:55 p.m. Further observation revealed the NSV failed to wash/sanitize her hands after performing the check. The NSV then cleansed</p>	F 441	<p>In-service education will be provided for the licensed nursing staff on accu-check testing including but not limited to glucometer cleaning/disinfecting and hand washing/sanitizing in accordance with facility policy and infection control standards of practice, as provided by the Staff Development Coordinator by 05/31/11.</p> <p>Newly hired licensed nursing staff (state and contract) will be in-serviced on the Optimum EZ Blood Glucose Monitor policy and Handwashing policy during new employee orientation.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>The Medication Performance Checklist for Selected Medications and Techniques will be completed on seven licensed staff for the monitoring of accu-check testing in accordance with infection control standards of practice under the supervision of the Director of Nursing. <u>The Director of Nursing will identify which staff members were observed and whether the individuals adhered to facility policy and procedures with handwashing and cleaning/disinfecting of glucometers and present the information to the monthly CQI/QA Committee. Individuals identified as not following policies and procedures will receive immediate retraining with the Staff Development Coordinator.</u></p>		

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F 441	<p>Continued From page 38</p> <p>the glucometer with a Tena Wipe. The NSV the proceeded to attempt to perform a blood glucose check on Resident #12 without cleansing the glucometer with the wipe recommended by the manufacturer. However, the NSV was asked to step out into the hallway by the surveyor.</p> <p>An interview conducted with the NSV on April 26, 2011, at 6:00 p.m. revealed she always cleansed the glucometer with Tena Wipes. The NSV thought she knew what to use to clean the glucometer, but she had picked up the wrong wipes. The NSV then looked through the drawers and pulled out a Gluco Chlor wipe. The NSV then stated "I think this was what I was supposed to use." The NSV further stated she normally cleansed her hands with the Tena wipes, and only used the Alcare Hand Sanitizer after every two (2) residents.</p> <p>Interviews were conducted with LPN #1, LPN #2, LPN #5, LPN #8, RN #5, RN #6 on April 26, 2011, between 6:15 p.m. to 6:30 p.m., and revealed all were knowledgeable of the appropriate method for cleansing the glucometer with the Gluco Chlor wipes. Further interview with staff revealed staff were knowledgeable about the facility's policy and procedure for cleaning the glucometer. All medication carts were observed on April 26, 2011 at 6:30 p.m. and the medication carts contained Gluco Chlor wipes readily available for use.</p> <p>An interview conducted with the Infection Control Nurse for the facility on April 26, 2011, at 6:45 p.m. revealed staff were expected to cleanse the glucometer with Gluco Chlor wipes which were what the manufacturer had recommended for the</p>	F 441		

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F 441	Continued From page 39 glucometer the facility was using. The Infection Control Nurse further stated the NSV had attended an inservice on October 28, 2010, on how to properly clean the glucometer. The Infection Control Nurse further revealed Tena wipes were not considered an acceptable form of hand sanitizing and stated the NSV had attended an inservice on handwashing on December 8, 2010. The Infection Control Nurse further revealed all employees must attend the handwashing in-service annually.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM -- ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure one (1) out of seventeen (17) sampled residents, Resident #3, was equipped with a proper call light to alert staff when the resident required assistance. The findings include: A review of the facility's policy titled Resident Call System, which contained no date, revealed all residents would be assessed by a licensed nurse for cognitive and physical ability necessary to operate a call light on admission and every ninety (90) days thereafter. The policy further revealed if	F 463	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 has been assessed for call light use and provided with a call bell as an alternative call system intervention based on assessment findings on 4/28/11. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. Current residents have been assessed for call light use utilizing the Nurse Call System Assessment by 5/21/11. Alternative call light interventions (such as bells or touch pads) have been implemented for residents if call light use has been determined inappropriate or unsafe. New admissions will be assessed for a call light within 24 hours of their admission to the facility and quarterly thereafter. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The nursing policy Resident Call System was revised on 5/12/11 to include an updated Nurse Call System Assessment tool. The Nurse Call System Assessment Tool includes alternatives to the call light such as the Padcall Pneumatic Call Cord and Hand Bell.	06/03/11

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NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P. O. BOX 189 GLASGOW, KY 42141		
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F 463	<p>Continued From page 40</p> <p>it was determined the bedside call system cord presented a safety hazard, the care plan would address an alternate means for responding to the resident's requests and needs.</p> <p>A review of the medical record for Resident #3, revealed on the admission Minimal Data Set (MDS) assessment dated September 8, 2010, the resident was assessed to be independent with decision making. However, on the Nurse Call System Assessment dated August 30, 2010, the resident had been assessed to not have a nurse pull cord related to the resident having a history of suicidal ideations.</p> <p>Observation of the Resident #3 on April 26, 2011, at 4:00 p.m., 5:00 p.m., 6:00 p.m.; April 27, 2011, at 8:50 a.m., 9:25 a.m., 10:25 a.m., 2:00 p.m., 3:00 p.m., 4:00 p.m., and April 28, 2011 at 8:45 a.m., revealed the resident was in his/her room with no call light or any other method of alerting staff to the resident's requests or needs.</p> <p>An interview conducted with Resident #3 on April 27, 2011, at 2:00 p.m. revealed the resident started he/she had to go to the nurses station if he/she required assistance from the nursing staff, or had to yell out to alert the staff. The resident responded to his/her requests in a timely manner. The resident further stated he/she has not had a call bell since she was admitted to the facility.</p> <p>An interview conducted with the facility's Director of Nursing (DON) on April 28, 2011, at 9:10 a.m., revealed Resident #3 had a history of suicidal ideations. The DON stated according to the Nurse Call System Assessment dated August</p>	F 463	<p>Licensed and non-licensed nursing staff will receive in-service education on the call light alternatives including but not limited to: specific alternative being implemented for residents; the need to identify residents requiring call light alternatives; the need to respond to the call light alternatives timely, as provided by the Staff Development Coordinator by 05/31/11.</p> <p>Newly hired nursing staff (state and contract) will be in-serviced on the Resident Call System policy during new employee orientation.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>Call light use will be assessed quarterly for each resident as part of the MDS assessment process by a RN Supervisor, to determine that the appropriate resident communication system is in place. <u>An internal facility database tracks which residents have a call light and the type of call light being utilized. The Director of Nursing will share the number of residents not utilizing a call light and the reason why a call light is not at their bedside at the monthly CQI/QA Committee meeting.</u></p> <p>RN Supervisors will conduct monthly rounds to ensure residents assessed for a call light have the device at their bedside. The RN supervisors will document findings of at least 35 residents per month on the Care Plan/Assignment Sheet/Resident Assessment CQI tool. <u>The Director of Nursing will summarize the findings of the RN Supervisor rounds and share the information with the monthly CQI/QA Committee meeting.</u></p>	

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F 463	Continued From page 41	F 463		
F 520 SS=E	<p>30, 2010, Resident #3 should have been given a bell to ring to alert staff, instead of a corded call light. The DON was unsure why Resident #3 did not have a bell.</p> <p>483.75(o)(1)QAA COMMITTEE-MEMBERS/MEET QUARTELRY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of facility policies, it was determined the facility failed to ensure the quality assessment and</p>	F 520	<p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The safety devices/restraints for residents #2, 7, 13, and 14 have been reviewed by the Director of Nursing to determine that the assessment and physician orders reflect the indicated use on 5/20/11.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>Only one additional resident is currently utilizing a restrictive safety device and has been assessed for least restrictive fall risk interventions and device use with review/revision of the device assessments, orders and care plan to address the indicated interventions on 5/20/11.</p> <p>If a new admission has a physician order for a restraint, the RN supervisor will assess the resident utilizing the Comprehensive Device Assessment within 24 hours of admission and quarterly thereafter.</p> <p>All residents with a physician order for restraints will be assessed quarterly as a component of the MDS assessment or if a significant change in condition is identified by the Quarterly Care Committee.</p> <p><u>The interdisciplinary CQI/OA committee meets the second Wednesday of every month to review and discuss issues affecting all departments. Team members consist of the Medical Director, Facility Director, Facility Superintendent Associate, Director of Nursing, Risk Manager, Dietary Manager, Registered Dietitian, pharmacy representative, Social Services Director, Activity Director,</u></p>	06/03/11

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F 520	<p>Continued From page 42</p> <p>assurance committee was effective in identifying and correct quality deficiencies related to restraint use for residents. Residents #2, #7, #13, and #14 were observed to utilize a lap buddy, pelvic restraint, or a merry walker; however, there was no evidence the facility followed established policy/procedures to ensure residents remained free from physical restraints. In addition, there was no evidence the facility identified the residents' R/P were not being informed regarding the possible risks/benefits associated with restraint use. (Refer To F221).</p> <p>The findings include:</p> <p>A review of the Continuous Quality Improvement (QI) policy (reviewed on October 15, 2008) revealed the facility would maintain a quality improvement program to identify and address quality of life issues to provide the highest possible level of care for the facility residents. The policy further noted the QI committee was responsible to identify quality deficiencies, to develop plans of action to correct the quality deficiencies, and to monitor the effect of these corrections. The policy also noted the committee would obtain and utilize input from the residents, families, guardians, and the inter-disciplinary team to design or revise programs within the facility.</p> <p>A review of the facility Restraint policy/procedure (dated August 25, 2010) revealed a physician's order was required to be obtained prior to the use of a restraint device and would include the specific type of restraint, the reason for the restraint, and the specified timeframe for the use of the restraint. The policy noted a pre-restraint assessment was required to be completed by the</p>	F 520	<p><u>Medical Records, Staff Development Coordinator, MDS Coordinator, Nursing Staff, Personnel Supervisor, Maintenance Supervisor, Housekeeping Supervisor, Laundry Supervisor, and Fiscal Officer.</u></p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Facility nursing staff will receive in-service education on the use of resident least restrictive safety device interventions including but not limited to: obtaining physician orders for the device and addressing the medical symptoms for device use on the assessment, as provided by the Staff Development Coordinator by 05/27/11.</p> <p>The Quality Improvement Organization for Kentucky (Health Care Excel) was contacted 5/20/11 by the Administrator for information on restraints.</p> <p><u>All staff is encouraged to share concerns with the CQI/QA committee. The facility implemented an Opportunity Statement form in 1999 for staff members to identify an internal process that needs improvement, a timeframe to achieve the improvements, what improvements can be made, why improvement is needed and suggested team members. The Opportunity Statement form is located on the facility electronic shared drive and can be accessed by all team members. Once the form is completed by a staff member, the Risk Manager will schedule a meeting of the suggested team members to review the Opportunity Statement and discuss the process.</u></p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>The Restraints Assessment Review Tool for the monitoring of device/physical restraint use will be utilized monthly for all residents with a physician order for restraint under the supervision of the Director of Nursing. The Director of Nursing</p>	

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F 520	<p>Continued From page 43</p> <p>licensed nurse at the time a restraint was ordered and evaluated/updated every three (3) months. In addition, the policy noted a consent for the restraint was required to be obtained from the resident and/or legal guardian and the risks, benefits, and alternatives for the restraint would be discussed and documented in the resident's medical record.</p> <p>Resident #2, #7, #10 and #14 were observed to utilize a lap buddy, pelvic restraint, or a merry walker during the survey conducted on April 26-28, 2011. However, there was no evidence the devices were utilized to treat a medical symptom. Resident #14's lap buddy was implemented on May 4, 2010; however there was no evidence the facility had obtained a physician's order prior to the use of the lap buddy and no evidence a restraint assessment had been completed prior to the use of the lap buddy until May 22, 2010. In addition, there was no evidence the facility had informed the responsible party of the risks/benefits related to the use of the lap buddy for Resident #2.</p> <p>An interview conducted with the Director of Nursing (DON) on April 28, 2011, at 7:30 p.m., revealed the facility did not have an audit and/or tool to review/evaluate the use of restraints for Residents. The DON stated the Minimum Data Set (MDS) nurse monitored the amount of time the resident utilized the restraint daily and reported this information to the QI committee. The DON further stated no staff was specifically responsible to monitor/evaluate the use of restraints to ensure restraints were necessary for residents and to ensure the established restraint policy/procedures were being followed.</p>	F 520	<p>will share the findings of the audit at the monthly CQI/QA Committee meeting.</p> <p>The Restraints Assessment Review Tool includes the following: the medical symptom demonstrating device need, comprehensive device assessment date, physician order date, guardian notification date, care plan and nurse aide assignment sheet review date. The Director of Nursing <u>will share a synopsis of the restraint audits and any corrective actions implemented</u> at the monthly CQI/QA Committee meeting.</p> <p>The Facility Superintendent Associate is responsible for ensuring the Director of Nursing discusses the Restraints Assessment Review CQI Tool results and corrective action steps are discussed at the monthly CQI/QA Committee meeting.</p> <p><u>The Risk Manager oversees the process improvement teams within the facility and maintains all meeting minutes. Systematic changes recommended in a process improvement meeting are to be discussed and adopted at the monthly Quality Trends Analysis Group meeting. The monthly Quality Indicator Reports generated from the Minimum Data Set are reviewed in the Quality Trend Analysis Group to identify any areas of concerns and corrective action. Compliance audits implemented as a result of a process improvement team project are reviewed at the monthly CQI/QA Committee for review and discussion. The Facility Superintendent Associate is the chairperson of the CQI/QA Committee and responsible for reviewing and signing the CQI/QA Meeting minutes for inclusion of all mandated facility reporting of identified system concerns.</u></p>		

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F 520	<p>Continued From page 44</p> <p>An interview conducted with the Superintendent Associate (SA) and the Risk Manager (RM) on April 28, 2011, at 7:45 p.m., revealed the SA and the RM shared the responsibility as the QI coordinator. Both the SA and the RM stated they did not have anything to do with the restraint program and no one was specifically assigned to monitor/evaluate restraint use in the facility. The SA and RM also stated the MDS nurse was responsible for tracking the amount of time each Resident spent in the restraint in an attempt to reduce the use of the restraint; however, the facility did not have an audit and/or monitor in place to evaluate the restraint program and to ensure Residents remained free from restraints.</p> <p>An interview on April 28, 2011, at 8:50p.m., with the Minimum Data Set (MDS) nurse revealed she reviewed the flow records related to restraints to ensure the restraints were released every two (2) hours. The MDS nurse revealed she only reviewed documents required to complete the MDS assessment such as the type of restraint required or if the restraint was still effective. The MDS nurse stated she did not review the physician's orders to ensure staff had obtained a written an order for the restraint.</p>	F 520			

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K 018	<p>Continued From page 1</p> <p>Doors found deficient were located throughout two smoke compartments. The deficient practices could affect staff, residents and visitors. The facility had the capacity for 160 beds.</p> <p>The findings include:</p> <p>Observation on April 28, 2011, starting at approximately 12:45 p.m., during a tour of the facility, revealed multiple corridor doors had unapproved metal kick-down type door stops, screwed close to the bottom door edge, which would nullify intent and render the doors not capable of resisting the passage of smoke. This type of unapproved device would be an impediment to closing the doors and keeping them closed.</p> <p>An interview with the facility Maintenance Supervisor revealed the facility was not aware this type of device was not approved at these locations, potentially interfering with the material installation designed to contain and resist the passage of smoke into other spaces.</p> <p>The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on April 28, 2011.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.6.3.1 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 in. (4.4-cm) thick, solid-banded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Exception No. 2: In smoke compartments</p>	K 018	<p>The General Environment CQI indicator for the monitoring of the facility general environment will be utilized monthly under the supervision of the Director of Environmental Services. The General Environment CQI tool includes the criteria "No impediment (door stops) to closing corridor doors". Findings of the audit as well as corrective actions will be shared at the monthly CQI/QA Committee meeting.</p>	

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NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P. O. BOX 189 GLASGOW, KY 42111		
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K 018	Continued From page 2 protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018		
K 025 SS = B	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3 Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This condition affected the staff, residents and visitors. The facility had the capacity for 100 beds. The findings include: On April 28, 2011, at approximately 1:30 p.m., the smoke barrier wall above the protective ceiling over the fire doors at the 200 and 300 level halls by the kitchenettes (room 326) were observed as not going all the way up past the ceiling tiles to	K 025	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. A smoke barrier wall was installed above the protective ceiling over the fire doors at the 200 and 300 level halls by the kitchenettes (room 326) on 5/19/11. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An inspection of fire doors in resident areas was conducted by the Maintenance Supervisor to ensure a smoke barrier wall goes above the ceiling tile to the ceiling above on 5/20/11. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Maintenance staff has received in-service education on the importance of smoke barriers going past ceiling tiles to the ceiling above as provided by the Director of Environmental Services on 05/18/11. Indicate how the facility plans to monitor its performance to ensure the solutions are sustained. The General Environment CQI Indicator for the monitoring of the facility general environment will be utilized monthly under the supervision of the Director of Environmental Services. The General Environment CQI tool includes criteria "smoke barrier above ceiling over fire doors". Findings of the audit as well as corrective actions will be shared at the monthly CQI/QA Committee meeting.	

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K 023	Continued From page 3 the ceiling above. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on April 28, 2011. Actual NFPA Standard reads: Smoke barriers shall be continuous from an outside wall to an outside wall. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces per NFPA 101, 8.3.2. When pipes, conduits, cables, wires, air ducts and similar building service equipment pass through smoke barriers, the space between the penetrating item and the smoke barrier shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or protected by an approved device that is designed for the specific purpose per NFPA 101, 8.3.6.1	K 023			
K 144 89 = F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to maintain weekly inspection logs for the emergency generator. The	K 144	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. A weekly emergency generator log was implemented on 5/19/11. The monthly emergency generator log was revised on 5/19/11 to include a column for the start time and end time of the monthly load test, date of the load test and initials of the staff member overseeing the test. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Environmental Services Supervisor will review and initial the weekly emergency generator log by the 5 th of the following month to ensure the generator was inspected weekly by maintenance staff and exercised under load for a minimum of 30 minutes monthly.		

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NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 189 STATE AVENUE P. O. BOX 189 GLASGOW, KY 42141		
(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 144	<p>Continued From page 4</p> <p>emergency generator would affect all smoke compartments, all residents, staff, and visitors. The facility had the capacity for 100 beds.</p> <p>The findings include:</p> <p>Record review on April 28, 2011 at approximately 3:00 p.m. revealed that the facility was not keeping a suitable weekly log of inspections of the emergency generator.</p> <p>An interview the facility Maintenance Director revealed the facility had no knowledge of this requirement.</p> <p>Observations were confirmed by the facility Maintenance Director during the survey and at the exit interview with the Administrator on April 28, 2011.</p> <p>Actual NFPA standard reads: Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly for a minimum of 30 minutes. NFPA 110 section 6.4.1 and 6.4.2.</p>	K 144	<p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Maintenance staff has received in-service education on the requirement of inspecting the emergency generator weekly and documenting on the log as provided by the Director of Environmental Services on 05/18/11.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>The General Environment CQI Indicator for the monitoring of the facility general environment will be utilized monthly under the supervision of the Director of Environmental Services. The General Environment CQI tool includes criteria that the "emergency generator is inspected weekly and initiated by the Environmental Services Supervisor monthly". Findings of the audit as well as corrective actions will be shared at the monthly CQI/QA Committee meeting.</p>		