

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

PRINTED: 10/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/11/2013
NAME OF PROVIDER OR SUPPLIER WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240	
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating complaint #KY20780 was conducted on 10/09/13 through 10/11/13 to determine the facility's compliance with Federal requirements. KY 20780 was substantiated with deficiencies cited with the highest scope and severity of a "G".</p> <p>Resident #3 was provided incontinent care while standing in the shower with two (2) Certified Nurse Aides (CNAs) per care plan; however, one (1) CNA left to get a towel, leaving the resident with one CNA and the resident lunged falling to the floor. The resident sustained a fractured right hip, fractured right elbow and swelling and bruising to the penis.</p> <p>Staff failed to transfer Resident #1 to the bed from a care foam chair prior to providing incontinent care. When the staff turned the resident to his/her side, the resident fell off the chair to the floor and sustained a fractured knee and laceration to the left upper forehead. Resident #1 required pain medication two to three times daily to try to control his/her knee pain.</p> <p>Resident #2 was being ambulated with one (1) person assistance without a gait belt when CNA #4 lost control over the resident resulting in an assisted fall to the floor. While Resident #2 was on the floor, he/she raised his/her head off the floor and slammed his/her face on the floor resulting in a black eye to the right eye and a cut above the right brow.</p> <p>Resident #5 was attempting to get to the sink in his/her room to brush his/her teeth and a Broda chair was blocking access to the sink resulting in</p>	F 000		

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

J. L. Sumner

TITLE

NHA

(X6) DATE

11/8/13

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 000	Continued From page 1 the resident attempting to move the chair and sliding to the floor from the wheelchair which resulted in redness to the resident's shins and minor pain.	F 000			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure privacy and dignity were maintained during incontinent care for one (1) of five (5) sampled residents (Resident #1). Certified Nursing Assistants (CNAs) were providing incontinent care for Resident #1 in full view of the resident's roommate. The findings include: Review of the facility's "Nursing Service Vision", (undated), revealed "Nursing through provision of holistic care, will assist the residents in achieving their optimal independence, maximum participation in decision making and positive feelings of self worth and dignity." Interview with Resident #1's roommate, on 10/09/13 at 10:25 AM, revealed Resident #1 was being changed and when staff turned the resident to his/her side, the resident rolled out of the chair onto the floor. When the resident was asked how	F 241	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; One of the two Certified Nursing Assistants (CNAs) failing to provide privacy, no longer works at the facility. The other CNA was issued a disciplinary action on 10/10/13 by the Staffing Director after discovering she failed to provide privacy during care. SOP Section 3, #4, (See Attachment A) "Resident Rights", was reviewed with the CNA. She voiced understanding of the importance of providing privacy with care. How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken; All residents have the potential to be affected by this practice. On 10/18/13 video training and check-offs were initiated for all direct care staff. The video training discussed provision of privacy and was completed by the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Staffing Coordinator, Minimum Data Set (MDS) Coordinator #1, the Clinical Coordinator and the 311 Registered Nurse (RN). A test was administered following the training with a required 80% score to pass (See Attachment B). Also a return demonstration by all direct care staff which included Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Medication Aides (CMA), and Certified Nursing Assistants (CNA) was conducted to ensure privacy is provided during care. Additionally, the DON, ADON, Staffing Director, Clinical Coordinator, MDS Coordinators #1 and #2 Infection control Nurse, the Nurse Practitioner (APRN) and the Incident Management Coordinator were trained and checked-off (See Attachment C). The Care Plans of each resident were updated to include, "provide privacy" (See Attachment D). This was completed on 11/01/13 by MDS Coordinators #1 and #2. The Flow Sheets of all residents (See Attachment E) were also updated to include provision of privacy with all care on 11/01/13 by the MDS Coordinators #1 and #2. SOP Section 3, #4, "Resident Rights" was reviewed with all staff during the in-service (See Attachment A). Any staff that was not present during the in-service will be in-serviced upon return to work. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not reoccur; and,		

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F 241	Continued From page 2 he/she saw what was happened with Resident #1, he/she stated the curtain was not pulled and he/she saw everything. Interview, on 10/10/13 at 11:00 AM, with Certified Nursing Assistant (CNA) #2, who provided care for Resident #1 during the fall, revealed she could not remember if the privacy curtain was pulled or not during incontinent care but if Resident #1's roommate said it wasn't pulled then maybe it wasn't pulled. Interview with CNA #1, on 10/10/13 at 11:15 AM, revealed if she was providing incontinent care to a resident the privacy curtain would always be pulled. She stated Resident #1's roommate does not like to have the curtain pulled and if it was pulled he/she would reach and pull it back so he/she was able to see what was going on with the roommate. The CNA revealed she could not remember if the curtain was pulled during incontinent care for Resident #1. Interview with the Director of Nursing (DON), on 10/11/13 at 4:50 PM, revealed she expected the CNAs to provide privacy to all residents at all times.	F 241	On 10/22/13 an audit was initiated by the DON for all three shifts to monitor privacy provision with resident care. This audit (See Attachment F) was conducted on all three shifts times three days on all residents. The audit was then completed for five residents on each unit each shift times three days. Afterwards three residents every shift will be monitored randomly times two months. After this audit is completed, one resident on every shift each day will be monitored times three months. If at any time the charge nurse notes privacy not provided for resident care, the involved staff member will have disciplinary action conducted by the Charge Nurse of that unit immediately. Once completed these are then turned in to the Director of Nursing (DON). Audits were completed for each visit (See Attachments H and I). Should any issues be noted the monitors will be extended and additional training will be completed with involved staff by the Staffing Coordinator and Clinical Coordinator. Off shift visits were conducted by the DON, ADON, and the Administrative Nurses for each unit. These were conducted on all three shifts times one week. These were completed from 10/22/13 through 10/29/13. There were no issues with privacy identified. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e. what quality assurance will be put into place. The Accident Hazard Monitor audits which included privacy provision will be turned in to the Assigned Administrative nurse for each unit and reviewed by that Administrative Nurse. Any issues with privacy provision will be addressed immediately by the assigned Administrative Nurse for that unit. They will then forward the form to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) who will also check for completion of the monitors and any issues which may have occurred. Should any issues be noted, the administrative nurse for the involved unit will complete training and in-servicing with the staff member responsible for the provision of privacy. This will be initiated immediately upon discovery of the issue of privacy provision. The results of all monitors will be reported to the Quality Assurance Committee by the DON/ADON on a quarterly basis with action plans developed for any issues of non-compliance.	12/6/13
F 282 SS=G	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:	F 282	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Certified Nursing Assistants (CNAs) involved with Resident #2 and Resident #3 both received Disciplinary Action on 09/27/13 and 11/05/13, in regards to not following the care plan. The charge nurse for Resident #5 also received Disciplinary Action on 10/16/13 related to care plan interventions not updated.	

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F 282	<p>Continued From page 3</p> <p>Based on observation, interview, record review and facility's policy and procedure review it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for three (3) of five (5) sampled residents (Resident #2, #3 and #5).</p> <p>Resident #3 was provided incontinent care while standing in the shower with two (2) Certified Nurse Aides (CNAs) per care plan; however, one (1) CNA left to get a towel, leaving the resident with one CNA, and the resident lunged falling to the floor. The resident sustained a fractured right hip, fractured right elbow, and swelling and bruising to the penis.</p> <p>Resident #2 was care planned to receive two (2) person assistance with ambulation to and from all destinations with a gait belt. However, on 09/26/13, Resident #2 was ambulated by one (1) staff with no gait belt which resulted in a fall. Resident #2 sustained a blackened right eye with a laceration above the right brow area.</p> <p>Staff failed to ensure Resident #5's room was kept uncluttered, per care plan, by having an unused "Broda" chair stored in front of the sink. Resident #5 attempted to move the "Broda" chair and he/she slid out of the wheel chair to the floor which resulted in redness to his/her shins and minor pain.</p> <p>The findings include:</p> <p>Review of the facility's Nursing Service Standard of Operation No 3 titled: Assignment/Provision of Resident Care According to the Resident's Comprehensive Plan of Care, last revised 03/2013, revealed the assigned Unit Nurse would</p>	F 282	<p>How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken)</p> <p>All residents in the facility have the potential to be affected by this practice. Policy #7.3 "Assignment Provision of Resident Care According to the Resident's Comprehensive Plan of Care" was revised October 2013, which included changes to the Unit Staff Assignment Sheet (See Attachment G) with interventions as follows: All CNAs and/or CMAs and licensed nurses will monitor and initial at the beginning of shift and every two hours thereafter that the care plan interventions are in place. This was initiated on 10/22/13 with follow up in-servicing beginning on 10/25/13. Any staff that was not present during the in-service will be in-serviced upon return to work.</p> <p>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not reoccur</p> <p>Off shift visits were made by the DON, ADON, Clinical Coordinator, MDS Coordinator #1 and #2 on varying shifts. This was initiated on 09/19/13 and completed on 09/27/13 (See Attachments H and I). No issues were found with care plan provisions. Should a CNA and/or CMA be observed not providing care as per care plan, that staff member will immediately be removed from the floor and disciplinary action up to and/or including termination will be recommended. Reminder signs were placed in each shower room and restrooms to ensure staff has the appropriate supplies needed prior to implementing care (See Attachments J-1 and J-2). This was completed on 11/05/13. The Minimum Data Set (MDS) Coordinators #1 and #2 reviewed all care plans with the flow sheet and the MDS assessment to ensure all interventions were accurate. This was completed by 10/24/13 (See Attachments K). On 10/22/13 an audit was initiated by the DON for all shifts to monitor that care was provided per the resident's care plan (See Attachment P). This audit was conducted on all three shifts by the unit charge nurse times three days on all residents. The audit was then initiated for five residents on each unit each shift times three days. Afterwards three residents every shift will be monitored randomly times two months. After this audit is completed, one resident on each shift each day will be monitored times three months.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e. what quality assurance will be put into place.</p>	12/6/13	

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F 282	<p>Continued From page 4</p> <p>be responsible for the supervision of the provision of resident care according to the Comprehensive Plan of Care. Staff will carry out specific resident care assignments through the utilization of the resident's care plan and unit staff assignment sheet (CNA flow sheet) which designates care plan interventions to be provided.</p> <p>1. Record review revealed the facility admitted Resident #3 on 06/07/11 with diagnoses which included Dementia, Episodic Mood Disorder, Hypertension, Renal Insufficiency, Ulcerative Esophagitis, and Parkinson's Disease.</p> <p>Review of the Quarterly MDS assessment, dated 07/30/13, revealed the facility assessed Resident #3 as needing extensive assistance of two (2) persons for transfers and ambulation.</p> <p>Review of the Comprehensive Care Plan titled "Self-care Deficit", dated 08/06/13, revealed the resident was able to transfer and ambulate with one (1) staff assistance and a gait belt. Further review of the Comprehensive Care Plan revealed two (2) staff should assist the resident if he/she became resistive to care or exhibited combative behaviors. Review of the CNA flow sheet, dated 10/04/13, revealed the resident required ambulation with two (2) person assist using a gait belt as well as to ambulate two-hundred (200) feet with a rolling walker and one person assistance using a gait belt twice a day on the 3-11 shift plus once on the 11-7 shift.</p> <p>Review of the facility's "FINAL INVESTIGATIVE REPORT", dated 10/11/13, revealed the resident had a witnessed fall on 10/04/13 with no apparent injury noted at that time. On 10/06/13, the resident exhibited swelling to his/her right hip and</p>	F 282	<p>The audits are then turned in to the assigned Administrative Nurse for each unit and are reviewed by that Administrative Nurse. Any issues with plan of care provision will be addressed immediately by the Administrative Nurse for that unit. They will then forward the audits to the DON or ADON, who will also check for completion of the monitors and issues which may have occurred. Should an issue be noted, the administrative nurse for the involved unit will complete training and in-servicing with the staff member responsible for the plan of care provision. This will be initiated immediately upon discovery of the issue of plan of care provision. The results of all monitors will be reported to the Quality Assurance Committee by the DON/ADON on a quarterly basis with action plans developed for any issues of non-compliance.</p>	

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F 282	<p>Continued From page 5</p> <p>bruising and swelling to the penis. Prior to 10/06/13, there had been no documented reports of pain or abnormalities. The resident was sent to the hospital on 10/06/13 and was diagnosed with a right hip fracture; and, on 10/08/13 the right elbow appeared to be abnormal and a diagnosis of a right elbow fracture was revealed.</p> <p>Interview with CNA #3, on 10/10/13 at 2:45 PM, revealed he and another CNA were giving Resident #3 a shower. The resident was sitting on a shower chair and when CNA #5 stood him/her up to dry him/her off the resident began to have a bowel movement and CNA #5 asked the other CNA to get her a towel. When CNA #3 turned to get a towel the resident lunged toward the door resulting in CNA #5 losing control over the resident causing both the resident and the CNA to fall. CNA #5 stated she attempted to break the resident's fall with her body and the resident pinned her between the shower wall by falling on her legs and ankle.</p> <p>Interview with MDS Coordinator #1, on 10/11/13 at 1:47 PM, revealed if a resident required extensive two (2) person assist with a gait belt, then that was what should be on the care plan and the CNA flow sheet. Further interview revealed the care plans were supposed to be updated with changes. She stated the nurses that worked the units were supposed to let her know if there was a change in the resident's status.</p> <p>Interview with MDS Coordinator #2, on 10/11/13 at 11:35 PM, revealed if she completed an MDS assessment and the resident was assessed to require extensive assistance with two (2) persons then the care plan should reflect the correct</p>	F 282			

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F 282	<p>Continued From page 6</p> <p>status. She stated if the CNA flow sheet needed to be updated to reflect the resident's status she would do that as needed. She indicated the Comprehensive Care Plan, CNA flow sheet, and MDS assessment should match the resident's status.</p> <p>Interviews with Registered Nurse (RN) #1 and RN #2, on 10/10/13 at 3:25 PM and 3:49 PM and on 10/11/13 at 1:25 PM and 1:33 PM respectively, revealed Resident #3 had fallen and was lowered to the floor. Both RNs stated the resident did not exhibit any signs of pain and when the resident was in pain he/she revealed it by facial grimacing and wincing. RN #2 stated after the resident assisted to get up and dressed, he/she was ambulated out of the shower room to the wheelchair with no concerns noted. The RNs stated it was the responsibility of the nurse on each shift to check the CNA flow record to assure accuracy and sign that it had been reviewed and updated if needed. RN #2 revealed he checked the flow sheet at the beginning and end of the shift for accuracy and if there were any changes he would update them on paper and in the computer. RN #2 stated the Comprehensive Care Plan, the CNA Flow sheet and MDS assessment should match the resident's status.</p> <p>2. Record review revealed the facility admitted Resident #2 on 02/06/79 with diagnoses which included Profound Mental Retardation, Transient Organic Mental Disorder, Seizure Disorder and Bone and Cartilage Disorder.</p> <p>Observation, on 10/09/13 at 11:00 AM, revealed Resident #2 was sitting in a wheel chair in the television lounge with a sheep skin gait belt around his/her waist. The resident had a</p>	F 282			

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F 282	<p>Continued From page 7</p> <p>blackened right eye with a laceration above the right eye.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 08/19/13, revealed the facility assessed the resident's cognition as severely impaired. Further review revealed the facility assessed the resident as being ambulatory with limited, two (2) person assist.</p> <p>Review of the Comprehensive Care Plan titled "Injury, risk for", last revised 08/26/13, and the Certified Nurse Aide (CNA) flow sheet, dated 09/27/13, revealed Resident #2 should be ambulated to and from all destinations with a gait belt and two (2) staff assist.</p> <p>Review of the Nursing Note, dated 09/27/13 at 7:15 PM, revealed Resident #2 was being ambulated by CNA #4 from the dining room and the resident's knees buckled causing the CNA to lose control over the resident, which resulted in a fall. While Resident #2 was struggling to get up after being lowered to the floor, the resident bumped his/her brow ridge above the right eye causing a one quarter (1/4) inch cut to the area. Review of the Facility Resident Transfer form, dated 09/30/13, revealed the resident was sent to the hospital for an x-ray to the right eye to rule out a fracture related to the fall on 09/27/13. Review of the Emergency Department Discharge instructions, dated 09/30/13, revealed a diagnosis of facial contusion and bruise.</p> <p>Interview with CNA #4, on 10/10/13 at 2:30 PM, revealed she was ambulating Resident #2 down the hallway without a gait belt. CNA #4 stated the resident's knees buckled and he/she began to fall and she lowered the resident to the floor. She</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>stated when she was satisfied the resident was completely on the floor she took a step back and the resident lifted his/her head up off the floor and then slammed it back on the floor causing a bump to the head. The CNA revealed she knew the care plan had been written to be specific in addressing that the resident was to have a gait belt and two (2) person assist for ambulation.</p> <p>Interview with the Staffing Director, on 10/11/13 at 11:00 AM, revealed the staff should follow the care plan and the CNA Flow Sheet when providing care to the residents. The Staffing Director stated CNA #4 should have used a gait belt and ambulated the resident with the assistance of another staff member.</p> <p>Interview with the Director of Nursing (DON), on 10/11/13 at 5:00 PM, revealed the CNA should have followed the resident's care plan utilizing a gait belt and having another staff member assist her.</p> <p>3. Record review revealed the facility admitted Resident #5 on 06/22/12 with diagnoses which included Peripheral Vascular Disease, Non-Alzheimer's Dementia, Gout, and Reflux Esophagitis, and Bilateral Below Knee Amputee.</p> <p>Review of a Nursing Note, dated 09/20/13 written at 6:30 PM, revealed Resident #5 experienced a fall on 09/20/13 while attempting to get to the sink in his/her room to brush his/her teeth. The sink was blocked by a Broda chair causing the resident to attempt to move the chair to get to the sink. As a result, he/she slid out of the wheel chair to the floor and complained of pain to his/her shin areas, with redness noted to his/her shins.</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>Observation, on 10/11/13 at 4:40 PM, revealed Resident #5 was sitting up in a wheel chair in his/her room with no concerns noted. Interview with Resident #5, on 10/11/13 at 4:40 PM, revealed he/she was trying to get to the sink to brush his/her teeth and fell on his/her knees because a chair was blocking the sink. He/She stated "it hurt a little bit" and (he/she) has some pain with the incident.</p> <p>Review of the Quarterly MDS assessment, dated 08/27/13, revealed the facility assessed Resident #5 as requiring total assistance of two (2) persons for transfer and was non-ambulatory related to bilateral below the knee amputations.</p> <p>Review of the Comprehensive Care Plan titled, "Impaired Cognition and Impaired Mobility", dated 06/11/13, revealed the resident's room should be kept clutter free. Review of the CNA Flow Sheet, dated 10/11/13, revealed staff should make sure the resident's room was free of clutter and the resident was able to get to the sink to brush his/her teeth.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 10/11/13 at 4:50 PM, revealed the Broda chair belonged to another resident who had moved out of the room approximately two (2) weeks ago or longer. She stated the chair was moved out into the hall after the incident on 09/20/13 at least on her shift and she did not know if it was left out in the hall on the other shifts.</p> <p>Interview with the Director of Nursing (DON), on 10/11/13 at 5:00 PM, revealed the CNAs had been trained on keeping the residents' rooms uncluttered to assist in preventing accidents and</p>	F 282			

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F 282	Continued From page 10	F 282			
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility's policy and procedure it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for four (4) of five (5) sampled residents (Residents #1, #2, #3 and #5).</p> <p>Resident #3 was being provided incontinent care while standing in the shower with two (2) staff and when one (1) staff left to get a towel the resident lunged falling to the floor. The resident sustained a fractured right hip, fractured right elbow and swelling and bruising to the penis.</p> <p>Staff failed to transfer Resident #1 to bed from a care foam chair prior to providing incontinent care. When the staff turned the resident to his/her side the resident fell off the chair to the floor and sustained a fractured knee and laceration to the left upper forehead. Resident #1 required pain medication two to three times a day to control the</p>	F 323	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All resident rooms were observed to ensure they were free of clutter. In addition, the Charge Nurse for each resident received Disciplinary Action related to failure to provide supervision of their assigned unit. All direct care staff (which included CNAs, CMAs, LPNs, RNs) was in-serviced beginning on 10/21/13 regarding "Safe Lift, Transfer, Mobility Assist, Falls Prevention and Resident rights and Ethics" (See Attachments L and M). All staff was tested and must have a score of 80% to pass. Nurses had an additional training on "Accountability and Supervision". They also were required to have an 80% passing score on the test. (See Attachment N) This was completed by the DON, ADON, Staffing Director, the Clinical Coordinator and MDS Coordinator #1.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? All residents who reside in the facility have the potential to be affected. The Clinical Coordinator will conduct rounds twice daily Monday through Friday to monitor for accident hazards. On the weekend the Staff Facility Charge Nurse will conduct those rounds. The Administrative Nurse for each unit will make rounds twice daily Monday through Friday to ensure there are no accident hazards in the rooms on their unit (See Attachment O). The staff on the floor will monitor the rooms on a continuous basis with regards to observing for any accident hazards. Additionally, the Unit Staff Assignment Sheets were revised to include every two hour checks by all licensed nurses and Certified Nursing Assistants (See Attachment G). These will then be reviewed by the Administrative Nurses for each unit to ensure the two hour checks were completed. Any direct care staff who fails to complete the two hour checks will receive disciplinary action.</p> <p>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not reoccur? The DON, ADON, MDS Coordinators #1 and #2 and the Clinical Coordinator conducted off-shift rounds and completed a checklist to ensure care was provided per care plan and to ensure there were no accident hazards in the resident rooms, hallways, shower rooms, dining rooms, and restrooms times 6 days on varying shifts. This was completed from 09/19/13 through 09/27/13 (See Attachments H and I). Any concerns were addressed immediately and corrected. All care plans for each resident were updated to include "Ensure rooms are free of clutter" (See Attachment A).</p>		

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F 323	<p>Continued From page 11 pain to his/her knee.</p> <p>Resident #2 was ambulated by one person and no gait belt instead of two (2) staff with a gait belt per care plan which resulted in the one staff having to lower the resident to the floor. The resident raised his/her head off the floor and slammed his/her face on the floor, which resulted right black eye and a laceration above the right eye.</p> <p>Staff failed to ensure Resident #5's room was kept uncluttered per care plan, by having an unused "Broda" chair stored in front of the sink. Resident #5 attempted to move the Broda chair and he/she slid out of the wheel chair to the floor which resulted in redness to his/her shins and minor pain.</p> <p>The findings include:</p> <p>Review of the Standard Operating Procedure #7A High Risk Situations: Resident High Risk Medical Needs, Falls Risk, last revised 07/2013, revealed the facility will utilize transfer and positioning techniques to promote optimal resident and staff safety. Residents will be assessed at the time of admission regarding areas of potential high risks per the licensed nurse and within twenty-one (21) days per the interdisciplinary overall plan of care team. Reassessment will be completed quarterly thereafter and with any change in status or as otherwise identified with each risk area as follows: residents assessed as high risk for falls will have an individualized plan of care developed and implemented to address specific interventions to prevent falls and provide safety. The licensed nurse will monitor resident fall prevention interventions each shift to ensure</p>	F 323	<p>SOP #7-2E , "Incident Management Assessment" was changed on October 2013 to include, "In the event a resident is found on the floor and has had a fall, the staff are to protect resident's head by placing a pillow under their head and moving any object or furniture to prevent accident hazards" (See Attachment P). SOP #4-7A, "High Risk Situation" was updated to include the same intervention for falls (See Attachment Q). This was initiated on 11/04/13 and in-servicing has begun on the policy changes with all direct care staff conducted by the Clinical Coordinator. Two hour checks by the licensed staff and CNAs was initiated on 10/24/13 to ensure all care is provided per resident's care plan. These checks will be initiated at the beginning of each shift and occur every two hours thereafter until shift change and the next shift will begin the two hour checks after coming on shift (See Attachment G). SOP #4-4H, "Nursing Intervention Health Maintenance Promotion, Urinary Incontinence Management" was updated to include, "Any resident who is incontinent of bowel and/or bladder and requires a lift for transfer will be transferred to the bed for appropriate incontinent care" (See Attachment R). SOP #4-4I "Nursing Interventions-Bowel and Incontinence Management" was updated to include, "Any resident who is incontinent of bowel and requires a mechanical lift for transfer will be transferred to the bed for appropriate incontinent care". (See Attachment S) SOP Section 2, #3 "Nursing Supervision" was reviewed with all staff by the DON and Clinical Coordinator on 10/25/13 (See Attachment T). SOP 4, 4A, "Resident monitoring" was reviewed with all staff by the DON and Clinical Coordinator on 10/25/13 (See Attachment U). The Staff Coordinator added changes to the New Employee Orientation check off that the staff is to ensure the residents who require a mechanical lift for provision of care are placed back to bed to ensure the care being provided is safe and correct (See Attachment C). Visual reminders were placed on the door of all shower rooms and on the wall of the bathroom reminding all direct care staff to ensure they have needed supplies prior to taking residents to the bathroom and/or shower room (See Attachments J-1 and J-2). These were placed on 11/5/13. Policy #V11, SOP 13 was updated on October 2013 to include "Every resident's room free of clutter to prevent accident hazards" (See Attachment V). In-servicing began on 11/05/13 by the Clinical Coordinator/Staffing Coordinator. Every Care Plan and Flow sheet was updated on 10/16/13 by the Clinical Coordinator for any resident who required a lift for transfer. The update was that those residents were to have incontinent care in bed to ensure safety. Monitors were initiated on 09/19/13 to ensure staff members are providing care per the care plan. The Minimum Data Set (MDS) Coordinators #1 and #2 reviewed all care plans with the flow sheet and the MDS to ensure all interventions were accurate and included on the flow sheet and comprehensive care plan (See Attachment O).</p>	
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F 323	<p>Continued From page 12</p> <p>interventions are in place as per the resident's individualized plan of care so to prevent accident hazards of falls.</p> <p>1. Record review revealed the facility admitted Resident #3 on 06/07/11, with diagnoses which included Dementia, Episodic Mood Disorder, Hypertension, Renal Insufficiency, Ulcerative Esophagitis, and Parkinson's Disease.</p> <p>Record review revealed Resident #3 was in the hospital after sustaining a fall on 10/04/13 with latent injuries noted. Further record review revealed the resident was assessed, on 10/06/13, to have sustained a right hip fracture and swelling and bruising to the penis; and, a right elbow fracture which was identified on 10/08/13.</p> <p>Review of the facility's "FINAL INVESTIGATIVE REPORT", dated 10/11/13, revealed the resident had a witnessed fall on 10/04/13 with no apparent injury noted at that time. On 10/06/13, the resident exhibited swelling to his/her right hip and discoloration (bruising and swelling) to the penis. Prior to 10/06/13, there had been no documented reports of pain or abnormalities. The resident was sent to the hospital on 10/06/13, and was diagnosed with a right hip fracture, swelling and bruising to the penis. On 10/08/13, a right elbow fracture was also identified as having occurred from the fall on 10/04/13.</p> <p>Review of the Quarterly MDS assessment, dated 07/30/13, revealed the facility assessed Resident #3 as needing extensive assistance of two (2) persons for transfers and ambulation.</p> <p>Review of the Comprehensive Care Plan titled "Self-care Deficit", dated 08/06/13, revealed the</p>	F 323	<p>A Falls Investigation Room will be set up on 11/13/13 with varied accident hazards throughout the room. All direct care staff will be mandated to tour the room and document accident hazards within the room. This will be conducted on all shifts by the Staff Facility Charge Nurse on each shift until all staff has completed this. A teaching session will be conducted with all staff that did not identify all hazards. This will be completed by 11/27/13.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e. what quality assurance will be put into place.</p> <p>As part of daily rounds, administrative staff will monitor all rooms for clutter Monday through Friday. On the weekend, the Staff Facility Charge will conduct the rounds (See Attachment O). Additionally, audits were initiated on 10/22/13 for all shifts to monitor resident care and providing care per the resident's care plan. This monitor included fall prevention, safe lifts, transfers and mobility assistance. This audit was conducted on all three shifts times three days on all residents. The audit was then initiated for five residents on each unit each shift times three days. Afterwards three residents every shift will be monitored randomly times two months. After this audit is complete, one resident on each shift each day will be monitored times three months. The results of the monitors will be taken to Performance Improvement Meeting (PI).</p>	12/6/13	

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F 323	Continued From page 13 resident was able to transfer and ambulate with one (1) staff assistance and a gait belt. However, review of the CNA flow sheet, dated 10/04/13, revealed the resident required ambulation with two (2) person assistance using a gait belt, as well as to ambulate two-hundred (200) feet with a rolling walker and one person assistance using a gait belt twice a day on the 3-11 shift plus once on the 11-7 shift. Further review of the Comprehensive Care Plan revealed two (2) staff should assist the resident if he/she became resistive to care or exhibited combative behaviors Interview with CNA #3, on 10/10/13 at 2:45 PM, revealed he and another CNA were giving Resident #3 a shower. The resident was sitting on a shower chair and when CNA #5 stood him/her up to dry him/her off the resident began to have a bowel movement and CNA #5 asked the other CNA to get her a towel. When CNA #3 turned to get a towel the resident lunged toward the door resulting in CNA #5 losing control over the resident causing both the resident and the CNA to fall. CNA #5 stated she attempted to break the resident's fall with her body and the resident pinned her between the shower wall by falling on her legs and ankle. Interview with CNA #6, on 10/11/13 at 4:05 PM, revealed she had taken care of Resident #3 and did not notice any bruising or swelling to the resident's hip until she was called into the room to clean the resident and then she noticed swelling to the resident's right hip and swelling and bruising to the penis. She further stated she did not know that the resident had fallen on October 4th and would not have moved him/her if she had known.	F 323			

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F 323	<p>Continued From page 14</p> <p>Interview with Medication Technician #1, on 10/11/13 at 4:10 PM, revealed she had given medication to Resident #3 on this date and did not notice anything unusual about the resident's behavior and did not have to administer him/her any pain medication.</p> <p>Interview with MDS Coordinator #1, on 10/11/13 at 1:47 PM, revealed if a resident required extensive assistance with two (2) persons, and a gait belt, then that was what should be on the care plan and the CNA flow sheet. Further interview revealed the care plans were supposed to be updated with changes. She stated the nurses that worked the units were supposed to let her know if there was a change in the resident's status.</p> <p>Interview with MDS Coordinator #2, on 10/11/13 at 11:35 PM, revealed if she completed an MDS assessment and the resident was assessed to require extensive assistance with two (2) persons then the care plan should reflect the correct status. She stated if the CNA flow sheet needed to be updated to reflect the resident's status she would do that as needed. She indicated the Comprehensive Care Plan, CNA flow sheet, and MDS assessment should match the resident's status.</p> <p>Interviews with Registered Nurse (RN) #1 and RN #2, on 10/10/13 at 3:25 PM and 3:49 PM and on 10/11/13 at 1:25 PM and 1:33 PM respectively, revealed Resident #3 had fallen and was lowered to the floor. Both RNs stated the resident did not exhibit any signs of pain and when the resident was in pain he/she revealed it by facial grimacing and wincing. RN #2 stated after the resident was up and dressed, he/she was ambulated out of the</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>shower room to the wheelchair with no concerns noted. The RNs stated it was the responsibility of the nurse on each shift to check the CNA flow record to assure accuracy and sign that it had been reviewed and updated if needed. RN #2 revealed he checked the flow sheet at the beginning and end of the shift for accuracy and if there was any changes he would update them on paper and in the computer. RN #2 stated the Comprehensive Care Plan, CNA flow sheet and MDS assessment should match the resident's status.</p> <p>2. Record review revealed the facility admitted Resident #1 on 06/12/12 with diagnoses which included Type II Diabetes Mellitus, Hypertension, Multiple Joint Contractures, Depression, Anxiety, Chronic Obstructive Pulmonary Disease, and Post Traumatic Brain Trauma.</p> <p>Observation, on 10/09/13 at 10:30 AM, revealed Resident #1 was sitting in a care foam chair in his/her room with a laceration to the left forehead and complaints of pain to the right knee.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 09/06/13, revealed the facility assessed Resident #1's cognition as cognitively intact and required extensive assistance of two (2) staff for transfer, bed mobility and incontinent care. In addition, the resident was not ambulatory.</p> <p>Review of the Comprehensive Care Plan for "Self-care Deficit", dated 09/09/13, and the CNA Flow Sheet, dated 09/19/13, revealed staff should use a mechanical lift with a blue sling for all transfers. The resident is incontinent of bowel</p>	F 323		

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F 323	<p>Continued From page 16 and bladder, totally dependent for incontinent care, and on a check and change program every two (2) hours and, as needed.</p> <p>Review of the Nurse's Note, dated 09/19/13 at 8:20 AM, revealed the licensed staff was called to Resident #1's room and the resident was found lying on his/her back on the floor with a laceration to the left forehead, redness to both knees and facial grimacing. Further review revealed Resident #1 verbalized pain with movement of the right knee. The Advanced Practitioner Registered Nurse was called and the resident was transferred to the emergency room.</p> <p>Review of the facility's Final Investigation Report, dated 09/26/13, revealed Resident #1 had an assisted fall on 09/19/13 at 8:20 AM. However, further record review revealed the resident rolled out of the chair to the floor while two (2) Certified Nursing Assistants (CNAs) were providing incontinent care to the resident in a care foam chair instead of placing the resident in the bed. This fall resulted in injuries.</p> <p>Review of an x-ray report, dated 09/19/13, revealed Resident #1 had a fracture to the right knee. Review of the Emergency Department Report, dated 09/19/13, revealed the resident presented with a laceration to his/her left forehead as well.</p> <p>Review of the physician's order, dated 09/20/13, revealed Lortab (narcotic for pain) 5/325 milligrams (mg.) five (5) mg. every six (6) hours as needed. A review of Nursing Notes, dated 09/19/13 through 09/23/13, and review of the October Medication Administration Record, revealed Resident #1 was given Lortab two to</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>three time a day in September 2013 and three times a day from 10/01/13 to 010/09/13 for complaints of pain of the right knee.</p> <p>Interview with Resident #1, on 10/09/11 at 10:30 AM, revealed he/she had fallen out of the care foam chair while having his/her adult brief changed. He/She stated he/she was not sure how the CNAs let him/her fall because one was on each side of the chair. Further interview on 10/10/13 at 11:30 AM revealed Resident #1 preferred to be transferred to the bed with the Hoyer (mechanical) lift for incontinent care and felt safer in the bed.</p> <p>Interview with CNA #1, on 10/10/13 at 11:15 AM and CNA #2 on 10/10/13 at 11:30 AM, revealed they were involved in caring for the resident when the fall occurred. Both CNAs stated the two (2) of them were changing the resident's brief when CNA #2 rolled the resident too far causing him/her to roll out of the chair. CNA #1 stated the resident had requested to be left in the care foam chair to be changed due to the Hoyer lift hurting his/her legs. CNA #1 and #2 stated they had been trained to transfer a resident with a Hoyer lift back to the bed from a chair before providing incontinent care.</p> <p>Interview with Resident #1's roommate, on 10/09/13 at 10:25 AM, revealed the CNAs were going to change Resident #1 and when they turned him/her on his/her side he/she fell. She stated the CNAs did not pull the curtain so she saw everything that happened. ===Interview with Resident #1's roommate, on 10/09/13 at 10:25 AM, revealed Resident #1 was being changed and when staff turned the resident to his/her side, the resident rolled out of the chair onto the floor.</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>When the resident was asked how he/she saw what was happened with Resident #1, he/she stated the curtain was not pulled and he/she saw everything.</p> <p>Interview with the Staffing Director on, 10/11/13 at 11:00 AM, revealed during orientation and training the first thing she trained staff was to follow the care plan for a resident. She stated the facility had skills check lists for all employees and it was re-emphasized that a mechanical lift required two (2) person assist and if a care plan stated a resident required two persons assistance for ambulation or standing then the staff should follow it. She further revealed she provided training regarding providing incontinent care in the bed and never in any kind of a chair.</p> <p>Interview with the Director of Nursing (DON), on 10/11/13 at 5:00 PM, revealed the CNAs had been trained on transferring residents as well as how and where to provide incontinent care. The training included transferring a resident to bed from a chair to provide incontinent care. She further stated that all staff had been inserviced on safe transfers and ambulation.</p> <p>3. Record review revealed the facility admitted Resident #2 on 02/06/79 with diagnoses which included Profound Mental Retardation, Transient Organic Mental Disorder, Seizure disorder, Bone and Cartilage Disorder.</p> <p>Observation of the resident, on 10/09/13 at 11:00 AM, revealed Resident #2 sitting in a wheel chair in the television lounge with a sheep skin gait belt around his/her waist. Further observation revealed the resident's right eye was black with a cut above the right eye that resulted from a fall on</p>	F 323		
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F 323	<p>Continued From page 19 09/27/13.</p> <p>Review of Nursing Notes, dated 09/27/13 revealed Resident #2 was being ambulated in the hallway with one (1) person assist and no gait belt when the resident's knees buckled resulting in CNA #4 assisting the resident to the floor. While Resident #2 was struggling to get up after being lowered to the floor, he/she bumped his/her brow ridge above his/her right eye causing a 1/4 inch cut to the area. Review of the facility's Resident Transfer Form, dated 09/30/13, revealed the resident was sent to the hospital for an x-ray to the right eye to rule out a fracture related to the fall on 09/27/13. Review of the Emergency Department Discharge instructions, dated 09/30/13, revealed a diagnosis of facial contusion and bruise.</p> <p>Review of the Quarterly MDS assessment, dated 08/19/13, revealed the resident required limited, two (2) person assist for ambulation.</p> <p>Review of the Comprehensive Care Plan titled "Injury, risk for", last revised 08/26/13 and the Certified Nursing Assistant (CNA) flow sheet, dated 09/27/13, related to ambulation revealed the resident was to be ambulated to and from all destinations with a gait belt and two (2) staff assistance.</p> <p>Interview with CNA #4, on 10/10/13 at 2:30 PM, revealed she was ambulating Resident #2 down the hallway without a gait belt. She stated the resident's knees buckled and he/she began to fall and she lowered the resident to the floor. She further revealed when she was satisfied the resident was completely on the floor she took a step back and the resident lifted his/her head up</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>off the floor and then slammed it back on the floor causing a bump to his/her head. Further review revealed she knew the care plan was specific in addressing the resident was to have a gait belt and two (2) person assistance for ambulation. She stated she was ambulating the resident alone and without a gait belt because staffing was one less than normal and she did not want to take the time to find a gait belt and another person to assist her in ambulating the resident.</p> <p>Interview with the Staffing Director, on 10/11/13 at 11:00 AM, revealed during orientation and training the first thing she trained staff on was to follow the care plan for a resident. She stated they had skills check off lists for all employees and it was re-emphasized if a care plan stated a resident required two (2) person assistance for ambulation or standing then the staff should follow it.</p> <p>Interview with the Director of Nursing (DON), on 10/11/13 at 5:00 PM, revealed the CNAs had been trained on transferring residents as well as using a gait belt for all residents who required assist with ambulation and transfers.</p> <p>4. Record review revealed the facility admitted Resident #5 on 06/22/12 with diagnoses which included Peripheral Vascular Disease, Non-Alzheimer's Dementia, Gout, and Reflux Esophagitis, and Bilateral Below Knee Amputee.</p> <p>Review of a Nursing Note, dated 09/20/13 written at 6:30 PM, revealed Resident #5 experienced a fall on 09/20/13 while attempting to get to the sink in his/her room to brush his/her teeth. The sink was blocked by a Broda chair causing the resident to attempt to move the chair to get to the sink. As a result, he/she slid out of the wheel</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>chair to the floor and complained of pain to his/her shin areas with redness noted to the shins.</p> <p>Observation, on 10/11/13 at 4:40 PM, revealed Resident #5 was sitting up in a wheel chair in his/her room with no concerns noted.</p> <p>Interview with Resident #5, on 10/11/13 at 4:40 PM, revealed he/she was trying to get to the sink to brush his/her teeth and fell on his/her knees because a chair was blocking the sink. He/She stated "it hurt a little bit and he/she has some pain with the incident."</p> <p>Review of the Quarterly MDS assessment, dated 08/27/13, revealed the facility assessed Resident #5 to require total assistance of two (2) persons for transfer and was non-ambulatory related to bilateral below the knee amputations.</p> <p>Review of the Comprehensive Care Plan titled, "Impaired Cognition and Impaired Mobility", dated 06/11/13, revealed staff should provide extensive assistance with personal hygiene, oral care by staff, and the resident's room should be kept clutter free. Review of the CNA Flow Sheet, dated 10/11/13, revealed the resident was to be assisted with bathing, dressing, and grooming as well as make sure the resident's room was free of clutter and the resident was able to get to the sink to brush his/her teeth.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 10/11/13 at 4:50 PM, revealed the Broda chair belonged to another resident who had been moved out of the room approximately two (2) weeks ago or longer. She stated it was moved out into the hall after the incident on 09/20/13 at</p>	F 323			

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F 323	Continued From page 22 least on her shift and she did not know if it was left out in the hall on the other shifts. Interview with the Director of Nursing (DON), on 10/11/13 at 5:00 PM, revealed the CNAs had been trained on keeping the residents' rooms uncluttered to assist in preventing accidents. She agreed the Broda chair should not have been blocking the sink.	F 323			