F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Intakes: TN0033080

Based on medical record review, observation and interview, it was determined the facility failed to follow the physician's order for 1 of 5 sampled residents reviewed.

The findings included:


Observations on the 300 hall on 2/19/14 at 10:00 AM, revealed Resident #5 in a wheelchair, being pushed down the hall wearing a Velcro self-release belt, with no pressure sensitive alarm in place as ordered.

A laboratory director or provider/supplier representative's signature: [Signature]

Title: [Title]

Date: 3/5/14

The above findings are true and correct. The改正 was made on 3/5/14.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 1</td>
<td>Observation in Resident #5's room on 2/19/14 at 3:05 PM, revealed Resident #5 lying in bed, with his w/c at the foot of the bed with a Velcro self release belt laying in the w/c, with no pressure sensitive alarm in place as ordered. Observations on the 300 hall on 2/19/14 at 4:00 PM, revealed Resident #5 sitting in a w/c, wearing a Velcro self release belt, with no pressure sensitive alarm in place as ordered. During an interview in the conference room on 2/19/14 at 5:40 PM, the Director of Nursing stated, &quot;...When he came back on the admission order the PSA was ordered [Pressure Sensitive Alarm]... He is supposed to have the PSA and not the self release.&quot;</td>
<td>F 309</td>
<td>Indicate what measure facility will take or systems it will alter to ensure problem does not recur. Continue monitoring by DON, charge nurses, supervisors, and medical records staff to maintain compliance of following physicians orders. The Director of Staff Development (DSD) will continue to in-service staff found to be non-compliant. Time Frame for Completion is reasonable.</td>
<td>2/20/14</td>
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