

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

PRINTED: 12/06/2010
FORM APPROVED
CMS NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	RECEIVED DEC 21 2010	(X3) DATE SURVEY COMPLETED 11/18/2010
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NAME OF PROVIDER OR SUPPLIER WILLIAMSON ARH	STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH EAST BRANCH
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	PLAN OF CORRECTION F282	
F 282 SS=D	<p>A standard health survey was conducted on November 16-18, 2010. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to ensure services were provided in accordance with each resident's written Comprehensive Plan of Care for three (3) of ten (10) sampled residents (residents #1, #2, and #4). According to the plans of care for residents #1, #2, and #4, two (2) upper side rails were to be elevated; however, observations of residents #1, #2, and #4 during the survey conducted on November 16-18, 2010, revealed four (4) side rails to be elevated.</p> <p>The findings include:</p> <p>1. Review of resident #1's medical record revealed diagnoses which included Malignant Neoplasm of the Rectum, Anxiety, COPD, CAD, Malaise and Fatigue, CHF, and Stage I Decubitus Ulcer of the Coccyx.</p> <p>Review of the Comprehensive Plan of Care with a revision date of October 2010 revealed resident #1 was to have non-restricted side rails.</p>	F 282	<p>I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. Resident #1: A side rail reassessment was completed on 11/30/10 by the SNF Clinical Nurse Manager. (See Attachment # 1). Resident #1 still requested use of upper side rails. Staff educated regarding side rail use on 11-30-10 by the SNF Clinical Nurse Manger. (See Attachment # 2.) Also refer to Skilled Nursing Departmental Unit minutes dated 11/19/10 conducted by SNF Clinical Nurse Manager documenting staff education relating to side rail use. (See Attachment #3). Care Plan for Resident #1 updated on 11/30/10 by the SNF Clinical Nurse by the SNF Clinical Nurse Manger (See Attachment #4)</p> <p>b. Resident #2: A side rail reassessment was completed on 11/30/10 by the SNF Clinical Nurse Manger (See Attachment #5). The staff was educated on side rail use on 11/30/10 by the SNF Clinical Nurse Manger (See Attachment #2). Also, please refer to Skilled Nursing Departmental unit meeting minutes</p>	12-1-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Karen Reed, NHA</i>	TITLE <i>Administrative</i>	(X6) DATE <i>12-21-10</i>
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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 282	<p>Continued From page 1</p> <p>Documentation included resident #1 had been educated on risks/benefits of side rails, and resident #1 chose to keep the side rails up. The goal stated the resident would have no decrease in Range of Motion (ROM) or Injury.</p> <p>Observation of resident #1 on November 16, 2010 at 2:15 p.m., 3:20 p.m., and 4:35 p.m., and on November 17, 2010, at 9:10 a.m. and 10:20 a.m., revealed the resident was in bed with four side rails elevated.</p> <p>Review of the Side Rail Decision Tree dated June 25, 2010, revealed the side rails were to be utilized as an enabler only, and resident #1 requested the use of the side rails. Furthermore, according to the documentation, resident #1 only required the upper side rails to be elevated to assist with bed mobility.</p> <p>An interview with Certified Nursing Assistant (CNA) #2 on November 17, 2010, at 2:40 p.m., revealed CNA #2 had worked at the facility for 15 years and was aware of the residents who tried to get out of bed and those who did not. CNA #2 revealed during his/her shift resident #1's bed rails were always elevated on all four sides. CNA #2 revealed he/she was not made aware until November 17, 2010, that all four rails were not to be elevated for resident #1.</p> <p>An interview conducted with the Clinical Nurse Manager (CNM) on November 17, 2010, at 10:50 a.m. and 3:50 p.m., revealed resident #1 should only have the upper side rails elevated for use as an enabler to assist the resident with bed mobility, transfers, and per the resident's request. The CNM revealed resident #1 did not attempt to get out of bed on his/her own.</p>	F 282	<p>dated 11/19/10 conducted by the SNF Clinical Nurse Manger documenting education of staff on side rail use. (See Attachment #3). Care Plan was updated for Resident #2 on 11/30/10 by the SNF Clinical Nurse Manger (See Attachment #6)</p> <p>c. Resident #4: A side rail reassessment was completed on 11/30/10 by the SNF Clinical Nurse Manger (See Attachment #7). Also, please refer to Skilled Nursing Departmental unit meeting minutes dated 11/19/10 conducted by the SNF Clinical Nurse Manger documenting education of staff on side rail use. (See Attachment #3). Care Plan was updated for Resident #4 on 11/30/10 by the SNF Clinical Nurse Manger (See Attachment #8)</p> <p>II. Address how the facility will identify other residents having the potential to be affected by the same practices.</p> <p>a. All residents had the potential to be affected by the same practice. There were 22 residents on 11/30/10. Three of the twenty-two are listed above. The other nineteen had side rail reassessments completed on 11/30/10 by the SNF Clinical Nurse Manger. The Care Plans were updated as applicable by the SNF Clinical Nurse</p>	

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F 282	<p>Continued From page 2</p> <p>2. Review of resident #2's medical record revealed diagnoses that included Dementia, Abscess of Right Knee with Methicillin Resistant Staphylococcus Aureus (MRSA), Anxiety, Congestive Heart Failure, Hypertension, Chronic Obstructive Pulmonary Disease, and Anemia.</p> <p>Review of the Side Rail Assessment for resident #2, dated and signed by the legal guardian on September 15, 2010, revealed both upper side rails were to be elevated. Review of the Side Rail Decision Tree dated September 25, 2010, revealed the side rail was utilized as an enabler, and that resident #2 only required the upper side rails to be elevated.</p> <p>Observation of resident #2 on November 16, 2010, at 2:00 p.m., 3:00 p.m., 4:55 p.m., and 5:30 p.m., and on November 17, 2010, at 9:00 a.m., revealed both upper and lower side rails to be elevated.</p> <p>An interview with CNA # 1 on November 17, 2010, at 11:30 a.m., revealed the CNA had elevated all four side rails for resident #2. The CNA did not know until November 17, 2010, that all four rails were not to be elevated for the resident.</p> <p>An interview with the Clinical Nurse Manager (CNM) on November 17, 2010, at 10:00 a.m., revealed resident #2 should only have the upper side rails elevated as the side rails were not a restraint, but were utilized as an enabler for the resident.</p> <p>3. Review of resident #4's medical record</p>	F 282	<p>Manger (See Attachments #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27)</p> <p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. A Side Rail Communication Tool was developed (See Attachment #2) to alert all staff (Nursing and Rehab) by highlighting the side rails that should be up, e.g. upper, lower, or both. The tool was implemented on 12/01/10. Refer to Attachment #2 to show documentation that staff members were educated by the SNF Clinical Nurse Manager on 11/30/10 on the new tool. Refer to Attachment # 28 for in-service of Rehab staff by Rehab Director on use of tool.</p> <p>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>a. A Performance Improvement Monitor has been implemented effective 12/01/10. (See Attachment # 29). The SNF Clinical Nurse Manager will assess for appropriate side rail position based upon care plan needs weekly and summarize the data monthly. The data will be compiled and reported quarterly</p>	

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F 282	<p>Continued From page 3</p> <p>revealed diagnoses which included Osteoarthritis Multiple Sites, Left Knee Deformity, Anxiety, Depression, Hallucinations, and Lymphoma.</p> <p>Review of the Comprehensive Plan of Care with a revision date of October 2010 revealed resident #4 was to have non-restricted side rails. Documentation included resident #4 had been educated on risks/benefits of side rails, and resident #4 chose to keep the side rails up. The goal stated the resident would have no decrease in Range of Motion (ROM) or Injury.</p> <p>Observation of resident #4 on November 16, 2010, at 2:38 p.m., 3:25 p.m., and 4:45 p.m., and on November 17, 2010, at 9:17 a.m. and 10:25 a.m., revealed the resident was in the bed with four side rails elevated.</p> <p>Review of the Side Rail Decision Tree dated October 10, 2010, revealed the side rails were to be utilized as an enabler only, and resident #4 requested the use of the side rails. Furthermore, resident #4 only required the upper side rails to be elevated to assist with bed mobility.</p> <p>An interview with CNA #2 on November 17, 2010, at 2:40 p.m., revealed CNA #2 had worked at the facility for 15 years and was aware of the residents who tried to get out of bed and those who did not. CNA #2 stated resident #4 attempted to get out of bed on several occasions. CNA #2 revealed during his/her shift resident #4's bed rails were always elevated on all four sides. CNA #2 revealed he/she was not made aware until November 17, 2010, that all four rails were not to be elevated for resident #4.</p> <p>An interview conducted with the Clinical Nurse</p>	F 282	to the Skilled Nursing Facility Performance Improvement Committee.

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F 282	Continued From page 4 Manager (CNM) on November 17, 2010, at 10:50 a.m. and 3:50 p.m., revealed resident #4 should only have the upper side rails elevated for use as an enabler to assist the resident with bed mobility, transfers, and per the resident's request.	F 282	F 323 I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
F 323 SS=E	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, interviews, and record reviews, it was determined the facility 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 a disinfectant spray and Povidone-Iodine Solutions (Betadine) were secured/locked and not accessible to residents. The findings include: Observation during the environmental tour on November 17, 2010, at 9:10 a.m., and on November 18, 2010, at 1:00 p.m., revealed a partially used spray bottle of Oxivir Tb (a disinfectant/sanitizer) positioned on a handrail in the women's shower room. Further observation on November 17, 2010, at	F 323	a. The Oxivir was removed from the women's shower room and locked up in Housekeeping Closet on 11/18/10/ b. Staff members were re-educated on not keeping Oxivir out in an unlocked area on 11/19/10 by the SNF Clinical Nurse Manager. (See Attachment #3). Staff instructed to lock cleaner in Clean Utility Room between baths and never leave in the Women's shower room. c. The bottle of Providone-Iodine Solution was removed from the resident #3 room on 11/17/10. The Providone-Iodine in room 129 was removed on 11/18/10/ II. Address how the facility will identify other residents having the potential to be affected by the same practices. a. All other residents had the potential to have had some type of ointment, solution, or cleanser left in their rooms. All resident rooms and	12-1-10

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F 323	<p>Continued From page 5</p> <p>2:15 p.m., revealed a partially used 4-ounce bottle of Povidone-Iodine Solution (a topical microbicide antiseptic) on resident #3's bedside table.</p> <p>Observation on November 18, 2010, at 9:30 a.m., revealed an unused 4-ounce bottle of Povidone-Iodine Solution on the bedside table in resident room 129, bed 1.</p> <p>Review of the facility's Census and Conditions, dated November 16, 2010, revealed 11 residents had been diagnosed with dementia.</p> <p>Interview on November 17, 2010, at 10:00 a.m., with the housekeeper revealed residents should not have access to any chemicals. The housekeeper stated all cleaning supplies were required to be locked on the housekeeper's cleaning cart and the CNAs would inform the housekeeper when the shower chairs or tubs needed cleaned/disinfected. The housekeeper was unaware of the disinfectant/sanitizer being stored in the women's shower room.</p> <p>Interview on November 17, 2010, at 12:15 p.m., with the Administrator revealed nurses were responsible for keeping Povidone-Iodine solution locked in the treatment carts and the housekeepers were responsible for storing the disinfectant/cleaning supplies in their locked cleaning carts. The Administrator stated the solutions should never be left unsecured/unlocked.</p> <p>Interview on November 17, 2010, at 2:50 p.m., with CNA #1 revealed CNAs clean/disinfect shower chairs or tubs after each use and store the spray disinfectant in the shower room. CNA #1 stated the disinfectant was given to the</p>	F 323	<p>shower areas were checked by the NHA on 11/18/10. No other medications/ointments/solutions/cleaners were found.</p> <p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. Staff members were re-educated on 11/30/10 by the SNF Clinical Nurse Manager (See Attachment #3, page 2) not to leave any medication, ointment, solution, or chemical in any unlocked area.</p> <p>b. Monitoring of resident rooms and shower areas will be completed by management (Clinical Nurse Manager and/or NHA) weekly ensure no medication, ointment, solution, or chemical is left in a non designated area. Data will be compiled monthly.</p> <p>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>a. A Performance Improvement Monitor has been developed and effective 12/01/10 to monitor compliance. (See Attachment #30). Observation checks of resident rooms and other inappropriate areas and will be performed weekly by the SNF Clinical Nurse manager, data compiled monthly and reported quarterly to the Skilled Nursing Facility Performance Improvement Committee.</p>		

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F 323	Continued From page 6 housekeeper to lock up once all the resident showers were completed for the day. According to CNA #1, the nurses were responsible for the Povidone-Iodine and keeping the solution locked in the treatment cart. Review of the Material Safety Data Sheet (MSDS) revealed Povidone Iodine may cause skin sensitization and may cause eye irritation. Overexposure from breathing aerosols and/or iodine vapors may cause irritation to the respiratory tract, bronchitis, and absorption through the lungs. High concentrations of iodine in the blood from inhalation or ingestion may cause thyroid disorder (hyperthyroidism), renal disturbances, acidosis, and electrolyte disturbances such as increased iodine levels and severe hyponatremia. Conditions that may be aggravated by exposure to povidone iodine: asthma, chronic bronchitis, and thyroid disorders. Review of the MSDS for Oxivir Tb revealed the emergency measures for eye or skin contact were to rinse with plenty of water.	F 323	F 364 I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Skilled Nursing staff members were educated on 11/19/10 by the SNF Clinical Nurse Manager (See Attachment #3, page 2) regarding keeping Food Cart Doors closed while passing trays II. Address how the facility will identify other residents having the potential to be affected by the same practices. a. All resident trays have the potential to cool down too fast if cart doors are left open during meal tray pass. b. Staff members educated on 11/19/10 by the SNF Clinical Nurse Manager (attachment #3, page 2) to keep cart doors closed during meal tray pass. c. On 11/19/10, the SNF Clinical Nurse Manager implemented weekly checks during meal tray pass to ensure the meal cart doors are closed when trays are not being passed. (See Attachment #31).	12-1-10
F 364 SS=E	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 temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure each resident received food that was	F 364		

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F 364	<p>Continued From page 7</p> <p>palatable and at the proper temperatures during the evening meal on November 11, 2010.</p> <p>The findings include:</p> <p>Observation of the evening meal on November 16, 2010, at 5:00 p.m., revealed two CNAs delivered trays to residents. Observations revealed the CNAs left the meal cart door open during the meal service. The last tray was taken as a test tray at 5:27 p.m., to check for proper temperatures and palatability with the Registered Dietitian (RD). The RD took the temperatures for the test tray with the kitchen thermometer and the temperatures were as follows: Pureed stuffed pepper - 100 degrees Fahrenheit (F), pureed carrots - 100 degrees F, mashed potatoes - 102 degrees F, cream soup - 110 degrees F, blended pineapples and cottage cheese - 56 degrees F, and milk - 42 degrees F. The test tray was checked for palatability by the RD and surveyors and the food was noted to be warm to taste.</p> <p>An interview with the RD on November 16, 2010, at 5:45 p.m., revealed the doors to the meal carts should not be left open during the meal service as the temperature of the meal trays would decrease too rapidly. The RD stated 120 degrees F should be the point of service temperature for hot foods. The RD was unsure how long trays should remain undelivered before new trays were obtained. The RD stated the test tray was not at the correct temperatures.</p> <p>A review of the Appalachian Regional Healthcare (ARH) meal observation check sheet (undated) revealed the following food temperature guidelines: entrees - 140 degrees F, potatoes - 140 degrees F, vegetables - 140 degrees F, cold</p>	F 364	<p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. The SNF Clinical Nurse Manager will perform weekly checks during meal tray pass to ensure the meal cart doors are closed when trays are not being passed.</p> <p>b. Temperatures of food will be monitored weekly by the Dietary Manager to check for appropriate temperature of foods served. (See Attachment # 33)</p> <p>c. The Meals Observation Check list to conduct test tray temperatures was updated on 11/25/10 (See Attachment #33) to reflect the Federal Food Code adopted by Kentucky in 2005. At the time of the survey, the form was using holding temperatures for the kitchen and this needed to be updated to reflect the current food code.</p> <p>d. The Dietary department implemented temperature checks on trays delivered to SNF on 11/25/10. (See Attachment # 34).</p> <p>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>a. A Performance Improvement monitor was developed and</p>	

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F 364 F 371 SS=D	Continued From page 8 beverages - 50 degrees F, and cold desserts - 50 degrees F. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to serve food under sanitary conditions. Observation of the tray line service on November 16, 2010, revealed a dietary staff person changed gloves without washing his/her hands while preparing trays. During the evening meal service on November 16, 2010, a CNA was observed to change gloves without washing hands between residents. In addition, coffee was observed to be delivered thirty-two (32) to fifty (50) feet uncovered down the hallway. The findings include: 1. Observation of the tray line service on November 16, 2010, at 4:45 p.m., revealed a dietary staff member changed gloves while preparing trays for residents. Observation revealed he/she did not wash his/her hands.	F 364 F 371	implemented effective 12/1/10 for weekly checks of meal cart doors being kept closed during meal deliver by the SNF Clinical Nurse Manager. Data will be compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment # 35) b. A Performance Improvement monitor was developed and implemented effective 12/1/10 by the Dietary Department. Temperature checks will be conducted weekly for the meal trays at delivery time in the Skilled Nursing Facility by the Dietary Manager Data will be tallied monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment #32). F-371 I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. On 11/17/10, the Dietary Manager spoke with the employee involved and re-educated her on hand washing. In addition, she re-educated the other employees working that day. (See Attachment #36) II. Address how the facility will identify other residents having the potential to be affected by the same practices.	12-3-10

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F 371	Continued From page 9 An interview with the dietary staff member on November 16, 2010, at 4:45 p.m., revealed the staff member was to wash his/her hands after every glove change, and hands should have been washed after the glove change during the tray line service. An interview with the Registered Dietitian (RD) revealed all staff was required to wash their hands after glove changes, before reapplying new gloves. 2. Observation of the evening meal service on November 16, 2010, at 5:15 p.m., revealed coffee to be delivered uncovered down the hallway from 32 to 50 feet. An interview with CNA #1 revealed no food items should be delivered to resident rooms farther than right outside the doorway uncovered. According to the CNA, the coffee should have been left on the delivery cart until outside of the resident room to be delivered. An interview with the Clinical Nurse Manager (CNM) on November 16, 2010, at 5:45 p.m., revealed the CNAs were not supposed to deliver uncovered food items down the hallway.	F 371	a. All other Dietary employees had the potential not to wash hands when changing gloves. On 12/1/10 and 12/03/10, all Dietary employees were re-educated by an Infection Control Nurse regarding CDC guidelines for hand washing. (See attachment #37) III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. a. The Dietary management staff will observe employees in that department on a weekly basis to assure compliance in hand washing.		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. a. A Performance Improvement monitor was developed and implemented effective 12/1/10. The Dietary Manager will perform weekly observations of various Dietary employees to monitor for proper hand washing by CDC guidelines. Data will be compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment # 38) I. Address what corrective action will be accomplished for those residents		

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F 371	Continued From page 9 An interview with the dietary staff member on November 16, 2010, at 4:45 p.m., revealed the staff member was to wash his/her hands after every glove change, and hands should have been washed after the glove change during the tray line service. An interview with the Registered Dietitian (RD) revealed all staff was required to wash their hands after glove changes, before reapplying new gloves. 2. Observation of the evening meal service on November 16, 2010, at 5:15 p.m., revealed coffee to be delivered uncovered down the hallway from 32 to 50 feet. An interview with CNA #1 revealed no food items should be delivered to resident rooms farther than right outside the doorway uncovered. According to the CNA, the coffee should have been left on the delivery cart until outside of the resident room to be delivered. An interview with the Clinical Nurse Manager (CNM) on November 16, 2010, at 5:45 p.m., revealed the CNAs were not supposed to deliver uncovered food items down the hallway.	F 371	found to have been affected by the deficient practice. a. Effective 11/19/10, a coffee urn is being placed on each Skilled Nursing food delivery cart by Dietary. II. Address how the facility will identify other residents having the potential to be affected by the same practices. a. All other residents had the potential to have coffee carried uncovered to their rooms by using only one coffee urn even though there were two food delivery carts. b. Effective 11/19/10, a coffee urn is being placed on each Skilled Nursing food delivery cart by Dietary. III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. a. Each food delivery cart delivering food trays to the Skilled Nursing facility will have a separate coffee urn on it.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.	

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F 371	Continued From page 9 An interview with the dietary staff member on November 16, 2010, at 4:45 p.m., revealed the staff member was to wash his/her hands after every glove change, and hands should have been washed after the glove change during the tray line service. An interview with the Registered Dietitian (RD) revealed all staff was required to wash their hands after glove changes, before reapplying new gloves. 2. Observation of the evening meal service on November 16, 2010, at 5:15 p.m., revealed coffee to be delivered uncovered down the hallway from 32 to 50 feet. An interview with CNA #1 revealed no food items should be delivered to resident rooms farther than right outside the doorway uncovered. According to the CNA, the coffee should have been left on the delivery cart until outside of the resident room to be delivered. An interview with the Clinical Nurse Manager (CNM) on November 16, 2010, at 5:45 p.m., revealed the CNAs were not supposed to deliver uncovered food items down the hallway. A review of the hand washing policy dated January 20, 2005, revealed the facility required staff to wash hands after each glove change.	F 371	a. A Performance Improvement monitor was developed and implemented effective 12/1/10. The Dietary Manager will monitor weekly the food delivery carts delivered to the Skilled Nursing Facility to assure a separate coffee urn is being placed on each cart. The data will be compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment # 39)	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	F 431 L. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. On 11/16/10, the Nursing Home Administrator spoke with RN #3 to re-educate her on the need to lock the medication carts when the cart is either not in use or not within her sight II. Address how the facility will identify other residents having the	12-1-10

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F 431	<p>Continued From page 10</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to label, date, and store all drugs and biologicals in accordance with currently accepted professional principles. Observation on November 16, 2010, of an evening medication pass revealed staff failed to ensure the medication cart was</p>	F 431	<p>potential to be affected by the same practices.</p> <p>a. All other residents RN #3 administered medications to would have the potential of the medication cart being left unlocked.</p> <p>b. RN #3 was re-educated on 11/16/10 by the SNF Clinical Nurse Manager. She states she knew she was suppose to lock the cart, but became nervous during the survey. She voiced understanding of the proper process to follow.</p> <p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. On 11/19/10, a Skilled Nursing Departmental meeting was conducted by the SNF Clinical Nurse Manager and all staff (LPN & RN) were instructed on locking the medications carts. (See Attachment # 3)</p> <p>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>a. A Performance Improvement monitor was developed and implemented effective 12/01/10. The SNF Clinical Nurse Manager will</p>		

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F 431	Continued From page 11 locked/secured at all times. The findings include: Observation of medication pass on November 16, 2010, at 4:45-5:10 p.m., revealed RN #3 administered medications to three residents. RN #3 prepared three medications for an unsampled resident in room 151, bed 2. RN #3 entered the resident's room, performed a finger stick glucose test, and administered the oral medications to the resident; however, RN #3 failed to ensure the medication cart/drawers were locked. Further observation revealed RN #3 prepared one medication for an unsampled resident in room 153, bed 2. RN #3 entered the resident's room, administered the oral medication, but failed to lock/secure the medication cart. During the medication administration, the resident's roommate requested a medication for diarrhea. RN #3 returned to the medication cart, obtained the requested medication, and re-entered room 153 to administer the medication to the resident in bed 1. RN #3 failed to lock the medication cart. Interview on November 17, 2010, at 10:35 a.m., with RN #3 revealed the RN was knowledgeable of the requirement to keep the medication carts locked at all times. RN #3 stated the RN was nervous and just failed to ensure the medication cart was locked. Review of the facility's policy and procedure related to medication administration with a revision date of November 2008 revealed staff was to lock the medication cart when not in use.	F 431	monitor the medication cart weekly to ensure they are locked 100% of time when medication nurse does not have in sight. Data will be compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee (See Attachment # 40)	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F 441 I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. On 11/16/10, the Nursing Home Administrator spoke to RN # 3 and to the nurse aides to re-educate on	12-1-10

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F 441	Continued From page 12 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	proper hand washing procedures based upon CDC guidelines. II. Address how the facility will identify other residents having the potential to be affected by the same practices. a. All other residents had the potential for staff members not following proper hand washing procedures. b. An in-service was held on 11/19/10 by the SNF Clinical Nurse Managers for all Skilled Nursing staff on Hand washing techniques. (See Attachment #3) III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. a. Monitoring of staff members on a weekly basis by the SNF Clinical Nurse Manager to ensure the staff are following CDC proper hand washing guidelines. IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.	

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F 441	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure staff washed their hands after each direct resident contact for which hand washing was indicated by accepted professional practice. Observation during medication pass, and during the evening meal pass on November 16, 2010, revealed staff failed to wash/sanitize hands between resident contact and after removing gloves.</p> <p>The findings include:</p> <p>Observation of medication pass on November 16, 2010, at 4:45 p.m., revealed RN #3 entered resident room 151, donned gloves, performed a finger stick glucose test for the unsampled resident in bed 2, removed the gloves, and then returned to the medication cart and prepared and administered three oral medications to the resident. RN #3 returned to the medication cart and prepared one medication for an unsampled resident in room 153, bed 2. RN #3 entered the resident's room and administered the oral medication; however, RN #3 failed to wash/sanitize hands between resident contact and after removing gloves. RN #3 returned to the medication cart, obtained a requested as-needed (prn) medication and re-entered room 153 to administer the medication to the resident in bed 1. RN #3 returned to the medication cart and failed to wash/sanitize hands after resident contact.</p> <p>Observation of the evening meal service on November 16, 2010, at 5:15 p.m., revealed a CNA applying gloves, taking a meal tray into a resident's room, and taking off the gloves without</p>	F 441	<p>a. A Performance Improvement monitor was developed and implemented effective 12/1/10. The SNF Clinical Nurse manager will monitor staff members in the Skilled Nursing Facility washing hands or using sanitizer weekly. The data will be compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee (See Attachment # 41)</p>	

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F 441	Continued From page 14 washing hands before reapplying another pair of gloves. An interview with CNA #1 revealed the CNA knew that hands were required to be washed after each glove change. Interview on November 17, 2010, at 10:35 a.m., with RN #3 revealed the RN was knowledgeable of the requirement to wash/sanitize hands between resident contact and after removing gloves. RN #3 stated the RN was nervous. An interview with CNA #1 revealed no food items should be delivered to resident rooms farther than right outside the doorway uncovered. A review of the hand washing policy dated January 20, 2005, revealed the facility required staff to wash hands after each glove change. Review of the facility's policy and procedure related to medication administration with a revision date of November 2006 revealed staff was required to wash hands prior to and after medication administration.	F 441	I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. The emergency activation pull cord was repaired on 11/18/10. II. Address how the facility will identify other residents having the potential to be affected by the same practices. a. All other resident rooms had the potential of missing activation pull cords. On 11/18/10, every resident room was checked by the Nursing Home Administrator for missing pull cords. There were no other rooms missing pull cords. III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. a. Skilled Nursing management staff will monitor all the resident rooms on a weekly basis for Environment of Care concerns. (See Attachment # 42)	12-1-10
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 and interview, it was determined the facility failed to maintain	F 463		

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F 463	Continued From page 15 accessible/fully functional call light systems in residents' bathrooms. The findings include: Observations during the environmental tour on November 17, 2010, revealed in resident room 149, the emergency activation pull cord in the bathroom was missing. Interview on November 18, 2010, at 1:00 p.m., with the Maintenance Supervisor (MS) revealed staff was to notify the Maintenance Department of items in need of repair by completing a work order on the computer or by calling the Department. The MS stated the MS was unaware of the missing activation cord.	F 463	IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. a. A Performance Improvement monitor was developed and implemented 12/01/10 to monitor the Environment of Care to include pull cords in all applicable areas. The data will be collected weekly by the SNF Management Staff, compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment #43)	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Formica was chipped in five (5) resident rooms, cabinet doors were off track in three (3) resident rooms, drywall was chipped and marred, mineral deposits were observed on the sink faucets, tile was missing in the shower room and in one (1) resident's bathroom.	F 465	F 465 I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Formica chipped: On 12/8/10, the Appalachian Regional Hospital system Director of Projects and system Director of Maintenance completed a walk-thru of the Skilled Nursing Facility to determine the best method to repair the Formica that was chipped. II. Address how the facility will identify other residents having the potential to be affected by the same practices.	12-20-10

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F 465	<p>Continued From page 16</p> <p>The findings include:</p> <p>During the environmental tour of the facility on November 17-18, 2010, the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> -The formica was chipped on the closet door in resident rooms 122, 129, 132, 136, and 151, and at the nurses' station facing the hallway. -Cabinet doors were off and propped against the wall in resident rooms 122, 129, and 136. -The metal track for the sliding cabinet door was soiled/dirty in resident rooms 129 and 151. -An armrest was missing from the wheelchair in resident room 122. -Mineral deposits were observed on the faucet in resident rooms 122, 148, and 156. -The bathtub faucet covering was missing which exposed a straight line water pipe in the bathroom of resident room 156. Additionally, the hot water pressure was drastically reduced in the bathroom sink. -The pull string to activate the overbed light was missing in resident rooms 129 and 132. -Wall tiles were missing in the women's shower room and in the bathroom of resident room 148. -The drywall was chipped at the head of bed 1 in resident room 149 and the drywall had black/marred areas on the drywall in resident rooms 148 and 149. <p>Interview on November 18, 2010, at 1:00 p.m., with the Maintenance Supervisor (MS) revealed staff was to notify the Maintenance Department of items in need of repair by completing a work order on the computer or by calling the Department. The MS stated repairs were recently made in the lobby and hallways; however, the MS was not aware of the identified areas needing</p>	F 465	<p>a. A detailed environment of care survey was completed on 12/02/10. In addition to resident room 122, 129, 132, 136, and 151, and the nursing station that were cited at the time of the survey, resident rooms 130, 131, 133, 135, 146, 147, 148, 149, 150, 152, 153, 154, 155, 156, also have Formica chipped or missing. On 12/8/10, the Appalachian Regional Hospital system Director of Projects and system Director of Maintenance completed a walk-thru of the Skilled Nursing Facility to determine the best method to repair the Formica that was chipped.</p> <p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. Skilled Nursing management staff will monitor all the resident rooms on a weekly basis for Environment of Care concerns. (See Attachment # 42)</p> <p>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>a. A Performance Improvement monitor was developed and implemented 12/01/10 to monitor the Environment of Care to include Formica in all applicable areas. The data will be</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER WILLIAMSON ARH			STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503	
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F 465	<p>Continued From page 16</p> <p>The findings include:</p> <p>During the environmental tour of the facility on November 17-18, 2010, the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> -The formica was chipped on the closet door in resident rooms 122, 129, 132, 136, and 151, and at the nurses' station facing the hallway. -Cabinet doors were off and propped against the wall in resident rooms 122, 129, and 136. -The metal track for the sliding cabinet door was soiled/dirty in resident rooms 129 and 151. -An armrest was missing from the wheelchair in resident room 122. -Mineral deposits were observed on the faucet in resident rooms 122, 148, and 156. -The bathtub faucet covering was missing which exposed a straight line water pipe in the bathroom of resident room 156. Additionally, the hot water pressure was drastically reduced in the bathroom sink. -The pull string to activate the overbed light was missing in resident rooms 129 and 132. -Wall tiles were missing in the woman's shower room and in the bathroom of resident room 148. -The drywall was chipped at the head of bed 1 in resident room 149 and the drywall had black/marred areas on the drywall in resident rooms 148 and 149. <p>Interview on November 18, 2010, at 1:00 p.m., with the Maintenance Supervisor (MS) revealed staff was to notify the Maintenance Department of items in need of repair by completing a work order on the computer or by calling the Department. The MS stated repairs were recently made in the lobby and hallways; however, the MS was not aware of the identified areas needing</p>	F 465	<p>collected weekly by the SNF Management Staff, complied monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment #43)</p> <p>I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. The cabinet doors were repaired on 11/19/10.</p> <p>II. Address how the facility will identify other residents having the potential to be affected by the same practices.</p> <p>a. On 12/02/10, an environment of care survey was conducted by the Nursing Home Administrator to include the cabinet doors in each resident room. There were no other doors off.</p> <p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. Skilled Nursing management staff will monitor all the resident rooms on weekly basis for Environment of</p>	1/1

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F 465	Continued From page 16 The findings include: During the environmental tour of the facility on November 17-18, 2010, the following items were observed to be in need of repair: -The formica was chipped on the closet door in resident rooms 122, 129, 132, 136, and 151, and at the nurses' station facing the hallway. -Cabinet doors were off and propped against the wall in resident rooms 122, 129, and 136. -The metal track for the sliding cabinet door was soiled/dirty in resident rooms 129 and 151. -An armrest was missing from the wheelchair in resident room 122. -Mineral deposits were observed on the faucet in resident rooms 122, 148, and 156. -The bathtub faucet covering was missing which exposed a straight line water pipe in the bathroom of resident room 156. Additionally, the hot water pressure was drastically reduced in the bathroom sink. -The pull string to activate the overbed light was missing in resident rooms 129 and 132. -Wall tiles were missing in the women's shower room and in the bathroom of resident room 148. -The drywall was chipped at the head of bed 1 in resident room 149 and the drywall had black/marred areas on the drywall in resident rooms 148 and 149. Interview on November 18, 2010, at 1:00 p.m., with the Maintenance Supervisor (MS) revealed staff was to notify the Maintenance Department of items in need of repair by completing a work order on the computer or by calling the Department. The MS stated repairs were recently made in the lobby and hallways; however, the MS was not aware of the identified areas needing	F 465	Care concerns to include cabinet doors. (See Attachment # 42) IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. a. A Performance Improvement monitor was developed and implemented 12/01/10 to monitor the Environment of Care to include cabinet doors in all applicable areas. The data will be collected weekly by the SNF Management Staff, compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment #43) I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. The metal track for the sliding cabinet door was in rooms 129 and 151 was cleaned on 11/19/10. II. Address how the facility will identify other residents having the potential to be affected by the same practices. a. On 12/02/10, an environment of care survey was conducted by the Nursing Home Administrator to include the tracks on the cabinets in each	

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F 465	<p>Continued From page 16</p> <p>The findings include:</p> <p>During the environmental tour of the facility on November 17-18, 2010, the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> -The formica was chipped on the closet door in resident rooms 122, 129, 132, 136, and 151, and at the nurses' station facing the hallway. -Cabinet doors were off and propped against the wall in resident rooms 122, 129, and 136. -The metal track for the sliding cabinet door was soiled/dirty in resident rooms 129 and 151. -An armrest was missing from the wheelchair in resident room 122. -Mineral deposits were observed on the faucet in resident rooms 122, 148, and 156. -The bathtub faucet covering was missing which exposed a straight line water pipe in the bathroom of resident room 156. Additionally, the hot water pressure was drastically reduced in the bathroom sink. -The pull string to activate the overbed light was missing in resident rooms 129 and 132. -Wall tiles were missing in the women's shower room and in the bathroom of resident room 148. -The drywall was chipped at the head of bed 1 in resident room 149 and the drywall had black/marred areas on the drywall in resident rooms 148 and 149. <p>Interview on November 18, 2010, at 1:00 p.m., with the Maintenance Supervisor (MS) revealed staff was to notify the Maintenance Department of items in need of repair by completing a work order on the computer or by calling the Department. The MS stated repairs were recently made in the lobby and hallways; however, the MS was not aware of the identified areas needing</p>	F 465	<p>resident room. The tracks were dirty in rooms 122, 131, 134, 135, 147, 149, 152, 154, 156. These were all cleaned by Housekeeping staff by 12/08/10</p> <p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. Skilled Nursing management staff will monitor all the resident rooms on a weekly basis for Environment of Care concerns to include the tracks for the sliding cabinet doors (See Attachment # 42)</p> <p>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>a. A Performance Improvement monitor was developed and implemented 12/01/10 to monitor the Environment of Care to include tracks to the sliding cabinet doors in all applicable areas. The data will be collected weekly by the SNF Management Staff, compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment #43)</p> <p>I. Address what corrective action will be accomplished for those residents</p>

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F 465	<p>Continued From page 16</p> <p>The findings include:</p> <p>During the environmental tour of the facility on November 17-18, 2010, the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> -The formica was chipped on the closet door in resident rooms 122, 129, 132, 136, and 151, and at the nurses' station facing the hallway. -Cabinet doors were off and propped against the wall in resident rooms 122, 129, and 136. -The metal track for the sliding cabinet door was soiled/dirty in resident rooms 129 and 151. -An armrest was missing from the wheelchair in resident room 122. -Mineral deposits were observed on the faucet in resident rooms 122, 148, and 156. -The bathtub faucet covering was missing which exposed a straight line water pipe in the bathroom of resident room 156. Additionally, the hot water pressure was drastically reduced in the bathroom sink. -The pull string to activate the overbed light was missing in resident rooms 129 and 132. -Wall tiles were missing in the women's shower room and in the bathroom of resident room 148. -The drywall was chipped at the head of bed 1 in resident room 149 and the drywall had black/marred areas on the drywall in resident rooms 148 and 149. <p>Interview on November 18, 2010, at 1:00 p.m., with the Maintenance Supervisor (MS) revealed staff was to notify the Maintenance Department of items in need of repair by completing a work order on the computer or by calling the Department. The MS stated repairs were recently made in the lobby and hallways; however, the MS was not aware of the identified areas needing</p>	F 465	<p>found to have been affected by the deficient practice.</p> <p>a. The wheelchair with the armrest missing was removed from the resident room on 11/18/10 and sent to Maintenance either for repairs or disposal.</p> <p>II. Address how the facility will identify other residents having the potential to be affected by the same practices.</p> <p>a. All other wheelchairs being used in the Skilled Nursing Facility had the potential to have parts missing. On 11/18/10, all other wheelchairs were checked by the Clinical Nurse Manager and/or Nursing Home Administrator and no other wheelchair was found with armrests missing.</p> <p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. Effective 12/10, the Clinical Nurse Manager or Skilled Nursing Caseworker will complete a weekly check of all wheelchairs and other equipment used by residents to assure they do not need to be repaired.</p>	

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F 465	<p>Continued From page 16</p> <p>The findings include:</p> <p>During the environmental tour of the facility on November 17-18, 2010, the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> -The formica was chipped on the closet door in resident rooms 122, 129, 132, 136, and 151, and at the nurses' station facing the hallway. -Cabinet doors were off and propped against the wall in resident rooms 122, 129, and 136. -The metal track for the sliding cabinet door was soiled/dirty in resident rooms 129 and 151. -An armrest was missing from the wheelchair in resident room 122. -Mineral deposits were observed on the faucet in resident rooms 122, 148, and 156. -The bathtub faucet covering was missing which exposed a straight line water pipe in the bathroom of resident room 156. Additionally, the hot water pressure was drastically reduced in the bathroom sink. -The pull string to activate the overbed light was missing in resident rooms 129 and 132. -Wall tiles were missing in the women's shower room and in the bathroom of resident room 148. -The drywall was chipped at the head of bed 1 in resident room 149 and the drywall had black/marred areas on the drywall in resident rooms 148 and 149. <p>Interview on November 18, 2010, at 1:00 p.m., with the Maintenance Supervisor (MS) revealed staff was to notify the Maintenance Department of items in need of repair by completing a work order on the computer or by calling the Department. The MS stated repairs were recently made in the lobby and hallways; however, the MS was not aware of the identified areas needing</p>	F 465	<p>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>a. A Performance Improvement monitor was developed and implemented effective 12/01/10 to monitor weekly the wheelchairs and other equipment used by residents to assure it is in proper working order by Skilled Nursing Caseworker. The data will be compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment # 44)</p> <p>I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. The faucets in rooms 122, 148, and 156, were cleaned on 11/20/2010. New faucets for these rooms were ordered on 12/09/10.</p> <p>II. Address how the facility will identify other residents having the potential to be affected by the same practices.</p> <p>a. On 11/19/10, all other resident rooms were checked for mineral deposits on faucets. Faucets in rooms 129, 130, 134, 135, 146, 150, 151, 152,</p>	

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F 465	Continued From page 16 The findings include: During the environmental tour of the facility on November 17-18, 2010, the following items were observed to be in need of repair: -The formica was chipped on the closet door in resident rooms 122, 129, 132, 136, and 151, and at the nurses' station facing the hallway. -Cabinet doors were off and propped against the wall in resident rooms 122, 129, and 136. -The metal track for the sliding cabinet door was soiled/dirty in resident rooms 129 and 151. -An armrest was missing from the wheelchair in resident room 122. -Mineral deposits were observed on the faucet in resident rooms 122, 148, and 156. -The bathtub faucet covering was missing which exposed a straight line water pipe in the bathroom of resident room 156. Additionally, the hot water pressure was drastically reduced in the bathroom sink. -The pull string to activate the overbed light was missing in resident rooms 129 and 132. -Wall files were missing in the women's shower room and in the bathroom of resident room 148. -The drywall was chipped at the head of bed 1 in resident room 149 and the drywall had black/marred areas on the drywall in resident rooms 148 and 149. Interview on November 18, 2010, at 1:00 p.m., with the Maintenance Supervisor (MS) revealed staff was to notify the Maintenance Department of items in need of repair by completing a work order on the computer or by calling the Department. The MS stated repairs were recently made in the lobby and hallways; however, the MS was not aware of the identified areas needing	F 465	153 also need to be replaced. New faucets were ordered on 12/09/10. b. All faucets in every resident room were cleaned and mineral deposits removed by 12/08/10. III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. a. Housekeeping staff was instructed on 12/08/10 by the Housekeeping Manager to clean mineral deposits daily from faucets in the Skilled Nursing Facility. (See Attachment (# 45)). IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. a. A Performance Improvement monitor was developed and implemented 12/01/10 to monitor the Environment of Care to include mineral deposits on faucets in all applicable areas weekly by the SNF Management Staff. The data will be compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment #43) I. Address what corrective action will be accomplished for those residents	

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F 465	<p>Continued From page 16</p> <p>The findings include:</p> <p>During the environmental tour of the facility on November 17-18, 2010, the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> -The formica was chipped on the closet door in resident rooms 122, 129, 132, 136, and 151, and at the nurses' station facing the hallway. -Cabinet doors were off and propped against the wall in resident rooms 122, 129, and 136. -The metal track for the sliding cabinet door was soiled/dirty in resident rooms 129 and 151. -An armrest was missing from the wheelchair in resident room 122. -Mineral deposits were observed on the faucet in resident rooms 122, 148, and 156. -The bathtub faucet covering was missing which exposed a straight line water pipe in the bathroom of resident room 156. Additionally, the hot water pressure was drastically reduced in the bathroom sink. -The pull string to activate the overbed light was missing in resident rooms 129 and 132. -Wall tiles were missing in the women's shower room and in the bathroom of resident room 148. -The drywall was chipped at the head of bed 1 in resident room 149 and the drywall had black/marred areas on the drywall in resident rooms 148 and 149. <p>Interview on November 18, 2010, at 1:00 p.m., with the Maintenance Supervisor (MS) revealed staff was to notify the Maintenance Department of items in need of repair by completing a work order on the computer or by calling the Department. The MS stated repairs were recently made in the lobby and hallways; however, the MS was not aware of the identified areas needing</p>	F 465	<p>a. A Performance Improvement monitor was developed and implemented 12/01/10 to monitor the Environment of Care to include water pressure and proper faucets in all applicable areas weekly by the SNF Management Staff. The data will be compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment #43)</p> <p>I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. The pull string to activate the overbed light was replaced in rooms 129 and 132 on 11/18/10.</p> <p>II. Address how the facility will identify other residents having the potential to be affected by the same practices.</p> <p>a. All other residents had the potential for overbed light string to be missing. On 11/19/10, the Nursing Home Administrator conducted a tour and checked all residents overbed lights. None were missing the pull string.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER WILLIAMSON ARH			STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503		
(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 465	Continued From page 17 repair.	F 465	<p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. Skilled Nursing Management staff will monitor all the resident rooms on a weekly basis for Environment of Care concerns to include overbed pull strings. (See Attachment # 42)</p> <p>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>a. A Performance Improvement monitor was developed and implemented 12/01/10 to monitor weekly by the SNF Management Staff the Environment of Care to include overbed pull strings in all resident rooms. The data will be compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment #43)</p> <p>I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. Wall tiles in bathroom of room 148 and women's shower room will be replaced by 12/08/10.</p>		

18-)

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

PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER WILLIAMSON ARH			STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503	
(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 465	Continued From page 17 repair.	F 465	<p>II. Address how the facility will identify other residents having the potential to be affected by the same practices.</p> <p>a. All other resident rooms and showers had the potential to have tiles missing. On 11/19/10, the Nursing Home Administrator conducted an environment of care tour in the Skilled Nursing Facility to include tiles in all areas. No other broken tiles were found.</p> <p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. Skilled Nursing Management staff will monitor all the resident rooms on a weekly basis for Environment of Care concerns to include tiles in bathrooms and shower rooms. (See Attachment # 42)</p> <p>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>a. A Performance Improvement monitor was developed and implemented 12/01/10 to monitor the Environment of Care weekly to include tiles in all applicable areas by the Skilled Nursing Management. The data will be compiled monthly and reported</p>	

18-2

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

PRINTED: 12/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER WILLIAMSON ARH			STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503		
(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 465	Continued From page 17 repair.	F 465	<p>quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment #43)</p> <p>I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. The drywall in rooms 148 and 149 will be repaired and painted by 12/20/2010.</p> <p>II. Address how the facility will identify other residents having the potential to be affected by the same practices.</p> <p>a. All other resident rooms had the potential for chipped or marred drywall. Marred drywall was found in rooms 135, 136, 147, 150, 153, 154.</p> <p>b. The Appalachian Regional Hospital system Project Director and system Maintenance Director are completing a project plan/quotes/purchase to paint every room in the Skilled Nursing Facility.</p> <p>III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>a. Skilled Nursing management staff will monitor all the resident rooms</p>		

18-3

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

PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER WILLIAMSON ARH			STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503		
(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 455	Continued From page 17 repair.	F 465	<p>on a weekly basis for Environment of Care concerns to include drywall chipping or marred. (See Attachment # 42)</p> <p>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>a. A Performance Improvement monitor was developed and implemented 12/01/10. The SNF Management staff will monitor the Environment of Care to include chipped or marred drywall in all applicable areas weekly. The data will be compiled monthly and reported quarterly to the Skilled Nursing Performance Improvement Committee. (See Attachment #43)</p>		

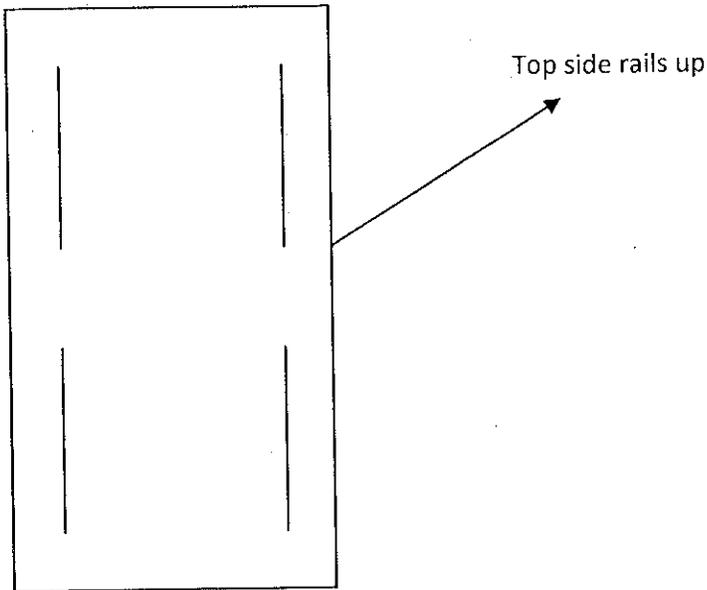
184

Resident does not attempt DOB by self but will reach for SR
to assist in turns and repositioning. Educated / discussed SR
risks in family & resident. SR 1 x 2 for mobility.

Resident # 1
Attachment # 1
Room # 131-1

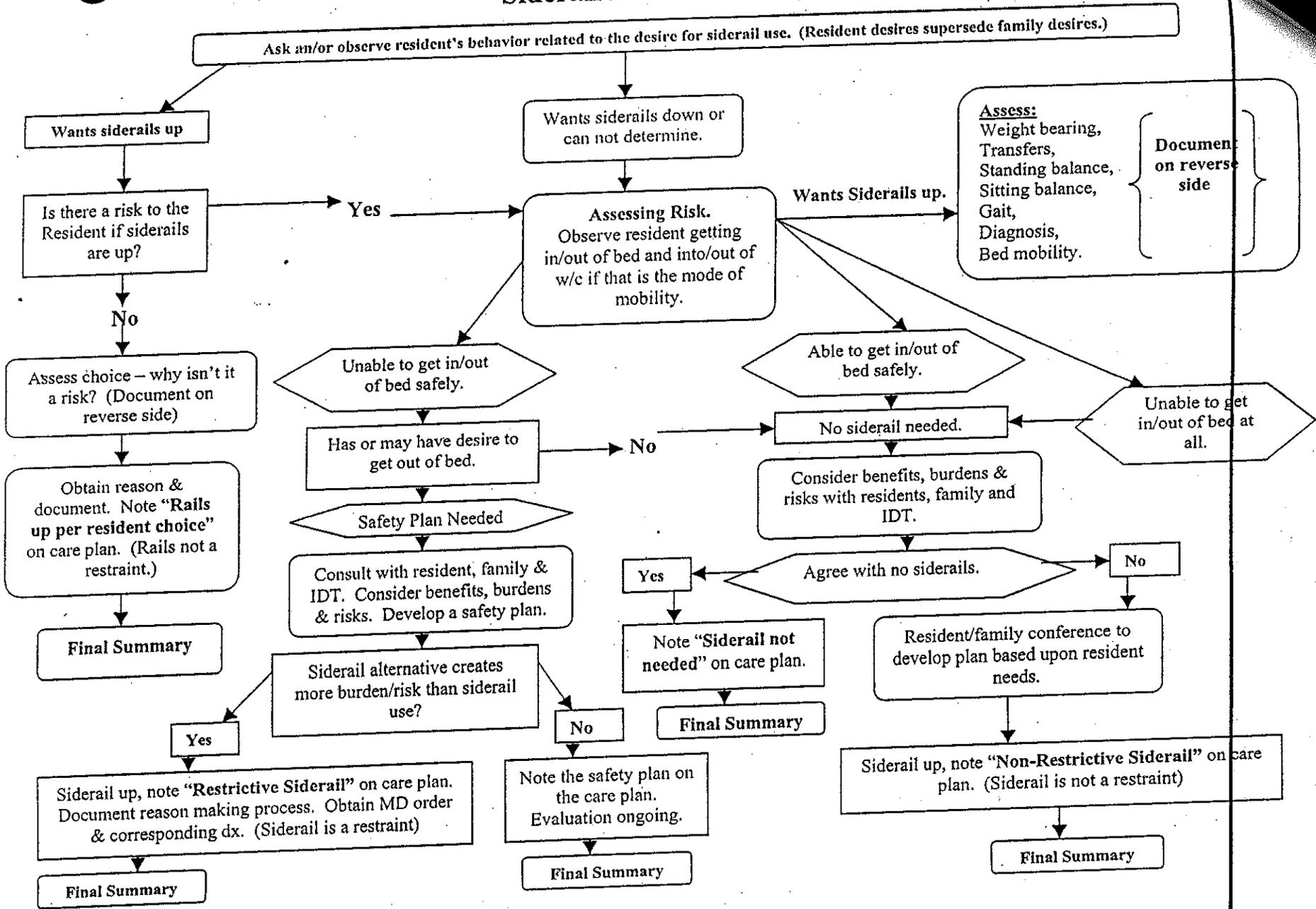
Attachment # 2

Inservice Side rails: 11/30/10



This is to be in each patients room on their board to inform staff of the designated number of side rails to be up for the individual resident (these will be highlighted – room number and initials only will be on top of the paper). Additional information is located in the care plan book with the side rail decision tree (see copy attached). If there is not one in residents room please let me know (this will be done with their 14 day admits).

Siderail Decision Tree



Resident Name: _____ Nurse sign: _____
 Date: _____

Attachment # 2



Appalachian Regional Healthcare
The Medical Centers of the Mountains **11/19/10**

Meeting held: Break Room

PRESENT:

See Sign In Sheet

Minutes taken by: Sonya Wasserman RN

DISCUSSION	ACTION
<p>First and for most: Thank you to all the staff for you help during state inspection. We were noted to have 6 deficiencies reported to us. This has been a learning experience that we can grow and improve because of. You all do an excellent job and give excellent patient care and I want each and everyone of you to know that I truly appreciate all the hard work you do.</p>	
<p>COMMUNICATION WITH RESIDENTS:</p> <p>All staff need to be aware of how they are communicating with staff and exactly what they are conveying. Examples: The resident asks for ice: DON'T SAY: The machine is broken – and go get the ice. CORRECT: I will get you some ice, and proceed to obtain the ice for the resident. Resident asks for an item we don't have but are able to and can obtain: DON'T SAY: We don't have that over here. CORRECT: I will check on it and get back to the resident and provide for their needs. CALL LIGHT ON: DON'T SAY: We just have 2 down the hall and we are busy. CORRECT: Attend to their needs without making "excuses." We seem to be getting in a habit of making excuses and conveying unnecessary information to the residents. It does not make things better by making excuses. Just state that you are going to take care and make sure you follow up with the resident. Often it is as simple and someone knowing their needs are being heard and addressed not the time frame or the why or why not.</p>	
<p>SKIN CARE:</p> <p>Do not do alternative skin care that is not ordered. I have noticed tegaderms on skin tears and combiderms on wounds that are not ordered. This is not acceptable and you must do the treatments that are ordered because they are a direct documented physician order. If the orders need to be re-evaluated they can be done with the physicians input.</p>	

<p>Policy: HAND HYGIENE: See Attached Copy of policy also: 1. No acrylic nails. 2. If not visibly soiled can use antibacterial hand rub provided 3. If hands are visibly soiled must wash with soap and water including when leaving a isolation room, after toileting, smoking, blowing or wiping nose, and before and after eating.</p>	<p>Attached copy for review</p>
<p>STATE INSPECTION: Some items: 1. You must wash hands or use alcohol based hand sanitizer between pt contact. If hands are soiled, you have been in isolation room, been to smoke, been to eat or have used the bathroom they must be washed with soap and water. 2. Medication Cart must be kept in site and locked when giving medications. 3. Make sure you refer to care plans for patients plan of care including side rails. This will also be listed on your report sheet. 4. Report sheets are to be updated each time you take off an order that needs to be conveyed on the report sheet (O2, nebs, diets, NPO, DNR, ect.) 5. Make sure that you are knocking on doors before entering. 6. Make sure doors are locked to clean, dirty utility rooms and dietary. 7. NO MEDICATIONS OR OINTMENTS ARE TO BE LEFT IN RESIDENTS ROOM AT ANY TIME FOR ANY REASON. 8. Cleanser for the tub is to be locked up in clean utility room NEVER to be left in bathroom (this is a hazard r/t resident exposure). 9. Each shift is responsible for cleaning, emptying trash and stocking the medication chart at the end of their shift (I will be checking on this) and this includes cleaning drawers, chart wheels ect. This is all inclusive. 10. Medication Carts and Med Room are to be cleaned completely including wheels and all aspects of cart on night shift on Sunday Night. You must sign that you have completed this on the sign in sheet in the medication room. 11. Do not leave the doors open the dietary cart when passing trays (this causes the temp to drop on the food).</p>	<p>See attached Policy on Hand Washing</p>

<p><u>LABS:</u> Make sure to document when physician was called and pass on the orders that were obtain to the next shift or the LPN or RN for continuity of care. All shifts are responsible for addressing labs on the residents. Night shift you need to make sure you are checking the printer for any labs, cultures ect that make have printed out during the night. You may have critical or bad labs that need to be addressed prior to the am. Do not just leave labs on the printer for the next shift (this is for all shifts). We are here to provide the best possible care for our residents results need to be addressed in a timely manner.</p>	
<p><u>Skilled Changes:</u> Nurse Aides are changing to 12 hour shifts effective Monday 11/15/10. See attached copy of who is responsible for what charting.</p>	<p>Copy attached.</p>
<p><u>Cleaning:</u> <u>LPNS:</u> Make sure you continue to clean down the medications carts and empty trash at the end of the shift (this includes keeping a neat and organized cart for the next shift fully stocked). Also make sure the med room is picked up and cleaned (noticed multi things not stocked and items on the shelves that do not belong <u>ALL STAFF:</u> The nurses station is to be picked up and clean at the end of your shift. Jackets do not go in the station, do not have papers or magazines in the station or leave water bottles ect on the desk. Clean utility room is to be cleaned and kept picked up. Do not use the last or end of a box and leave it sitting (the garbage goes in the dirty utility not left in the floor). It is everyone's responsibility to keep things picked up and in their place. <u>NURSE AIDES:</u> Do not have things on both sides of the hall all items must be on the same side of the hall and you must keep your linen carts covered.</p>	
<p><u>MDS 3.0:</u> Reminder if you make a write over you need to circle it and correct it on a progress note. Failure to correct will result in the person making the write over to recopy the sheet. Shortly you will see some changes especially with wound care. Also make sure that you fill out the entire wound care sheets. There will be a supplement sheet coming out shortly that will be done for decubs with each MDS assessment. <u>WE NOW DO NOT BACKSTAGE DECUBS.</u> They are what they are and the only way they are staged better is if they heal. They can progress to worse stage but we have to go back to not backstaging. This is being implemented because of the change over to MDS 3.0.</p>	

<p><u>DOCTORS:</u></p> <p>Enchl coming after the first of the year - new OB/GYN Dr. Baz is in practice and we are providing Chemo services on 1st floor. His office has been moved in with Dr. Vempaty's office. 2 Additional Internal Medicine doctors have signed and will be here around July 2011.</p>	
<p>Hands Off Communication:</p> <p>Make sure that anything you have done for a resident has been passed on at shift change and to the additional staff caring for this resident. This is for the continuum of care of the resident to ensure they receive the best possible care. This information is to be included on shift to shift change and as needed during the shift if impacting care.</p>	
<p><u>Medication Orders:</u></p> <p>Make sure you are getting an order for insertion of F/C and the rationale for. Make sure that all medication orders have the dose route of administration and frequency on the order and MAR. Also make sure that when you are writing psychotropic meds you are writing if for anxiety, depression, hallucinations ect. And that you leave an area to record for a response ie. S- sleeping or just R-response to medication. In addition make sure you are recording pain scale (flacc or verbal) rating, time, location and response for any pain medication administered. For Insulin make sure you chart the BS – glucose, site – where given and amount – units.</p>	<p>See additional psychotropic medication in-service</p>
<p><u>ABUSE:</u></p> <p>As always if you see or suspect that a resident is being abused the first thing to do is to make sure the resident is safe and is protected. Then you need to report the abuse or suspected abuse to a manager immediately. You would tell me if I am here or the house nurse coordinator after hours. I want to be called at home even after the abuse is reported to the house nurse coordinator. The Administrator Karen Reed is another person to report any abuse or suspected abuse too. The reporting must be done immediately it is the law. Even after you report to the house nurse coordinator after hours always call Karen Reed, Kathy Mullins or Sonya at home you can always get one of us after hours to report any suspected abuse claims.</p>	

<p><u>Customer Service:</u></p> <p>Simply put – “BE NICE” A – Acknowledge pt/visitor ect I – Introduce yourself (name ect) D – Duration (take the time for them) E – Explain what they ask or what your providing T – Thank you (thank them they have a choice)</p> <p>Please stay customer focused as always. Please, be sure that when you leave the residents room that you remember to ask them if there is anything else they need prior to your leaving their room. Our customers are the reason we are here. Be sure to let them know, thru your interactions with them, that you appreciate their business and support of our facility.</p>	
<p><u>Documenation:</u></p> <p>Make sure that ADL, Turn, Mood and Behavior sheets, Nurses notes, MARS/TARS, restraints, bladder training and any other documentation includes the month and year (date when applicable). Reminder that when putting in a Foley cath, NG Tube, G-tubes ect that you make sure you chart what size inserted. Also make sure that if you make a mistake on ADL or Mood/Behavior sheets that you circle the error and write the correction on a progress note.</p>	
<p><u>PHARM:</u></p> <p>Medication shortages: Nubain, Phenergan and Morphine are short across the nation. The physician may look at alternative medications during this shortage.</p> <p>There will be new labels coming up on your IV's and IVPB's they are a shredding label. They have a jagged area that is ment to shred the label when peeled off. Make sure that you are pulling this off before placing them in the trash. This is a HIPPA issue. If the label does not shred then pull off the entire label and place in a HIPPA container.</p> <p>You may have Epi in a different for in your crash carts r/t a nation wide shortage of the premixed formula's. It will be with a 10 ml NS flush and labeled in a bag together.</p>	
<p><u>EDUCATION RECORD:</u></p> <p>LPN/RN's make sure we are marking on the education record teaching to family/resident r/t isolation precautions for those residents in isolation. Document this on the education record.</p>	
<p><u>HIPAA:</u></p> <p>Please remember to always practice confidentiality. Make sure that you view and release information on a need to know basis only. Make sure that before you release any patient information, that you have checked with the resident or POA for approval of this release (verbal or Written). Only access information from a residents' medical record that you need to provide care to that resident.</p>	

<p><u>ICE:</u> Do not state to residents that the ice machine is "broken" just simply state that you will get them ice and make sure that you do. If there is any problem with the ice machine report to maintainece and if not fixed convey to me so I can follow up on this. Even if the ice machine is not working you are responsible to pass ice each shift and as needed by the resident. All shifts are to pass ice to the residents. Make sure that the residents have ice passed during your shift. Night shift make sure you are passing at the end of your shift and keep the noise to a minimum while passing ice. Make sure that you continue to utilize the ice bags for each resident.</p>	
<p><u>Safety:</u> Staff make sure you are plugging in the lifts when not in use so they are available for use. Make sure that you are using your personal protective equipment. Lifts for residents that require weight bearing assistance. Get another staff member to help you turn residents that are too large/difficult for you to turn alone. Gown, Gloves and mask as indicated for isolation or procedures. Also remember that if you are doing a task and something could splash in your face/eyes you must use your face shields or goggles. Some examples are emptying catheters and flushing, checking, or giving anything thru a feeding tube. NO exceptions safety is everyone's responsibility. Make sure to clean up any spills in the floors as this could cause a resident, visitor, or employee fall. Make sure to keep all walkways clear of any obstructions. Report any broken/loose tiles, rails, lights not working properly (overhead and call lights).</p>	
<p><u>Helping Hands:</u> Please remember the helping hands fund. We are asking each staff member to donate one dollar each pay period on pay day Friday. You can turn your money into me or put it in the can at the desk and I will turn it into HR. This is a good fund as it helps our fellow employees in their time of need.</p>	
<p><u>Supplies:</u> If you do not have a G-tube size that you need to change a residents' G-tube. Please leave me a note that you need a particular size if no other floor has it. You then need to pass this along in report to your relief to make sure that it is changed ASAP when the tube comes up.</p>	

CONFIDENTIAL PATIENT SAFETY WORK PRODUCT - Protected under the Patient Safety & Quality Improvement Act. Do not disclose unless authorized by policy or by persons with the authority to authorize such disclosure.

The meeting adjourned at

Handwritten signature of Sonya Wasserman in cursive script, reading "S Wasserman RN, BSN, CNM".

Sonya Wasserman RN, BSN, CNM

WILLIAMSON APPALACHIAN REGIONAL HOSPITAL

POLICY AND PROCEDURE

SUBJECT: Guideline for Hand Hygiene

POLICY:

It is the policy of Williamson Appalachian Regional Healthcare to follow the recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force for Hand Hygiene. The CDC has recommended guidelines (MMWR 2002;51 – NO.RR-16) on when to use non-antimicrobial soap and water, or an Alcohol-based hand rub. These recommendations are designed to improve hand-hygiene practices of Health Care Workers (HCW's) and to reduce transmission of pathogenic microorganisms to patients and personnel in health-care settings. **This guideline and its recommendations are not intended for use in food processing or food-service areas, and are not meant to replace guidance provided by FDA's Model Food Code.**

RECOMMENDATIONS**1. Indications for hand-washing and hand antisepsis**

When hands are visibly dirty, (hands showing visible dirt or visibly contaminated with proteinaceous material or are visibly soiled with blood or other body fluids (e.g., fecal material or urine) wash hands with either a non-anti-microbial soap and water or an anti-microbial soap and water.

1. If hands are not visibly soiled, an alcohol based hand rub may be used for routinely decontaminating hands in all other clinical situations described in items below. Alternatively, wash hands with an anti-microbial soap and water in all clinical situations as described below:
2. Decontaminate hands before having direct contact with patients.
3. Decontaminate hands before donning sterile gloves when inserting a central intra-vascular catheter.
4. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure.
5. Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or a blood pressure, and lifting a patient)
6. Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled.
7. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care

WILLIAMSON APPALACHIAN REGIONAL HOSPITAL

POLICY AND PROCEDURE

SUBJECT: Guideline for Hand Hygiene

8. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
9. Decontaminate hands after removing gloves

Wash hands with non-anti-microbial soap and water or with anti-microbial soap and water if:

1. Exposure to *Bacillus anthracis* is suspected or proven.
2. Leaving an isolation area
3. After blowing or wiping the nose
4. After toileting or smoking
5. Before and after eating

Installation of Alcohol-Based Hand Rub Dispensers

Dispensers containing Alcohol-based hand rub solutions are not be installed near a heat or ignition source, electrical outlet, or light switch.

Definitions:

- Alcohol-Based Hand Rub: An alcohol-containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands.
- Antimicrobial Soap: Soap containing an antiseptic agent
- Antiseptic Agent: Antimicrobial substances that are applied to the skin to reduce the number of microbial flora. Examples include alcohols, chlorhexidine, PCMX, quaternary ammonium compounds and triclosan.
- Plain Soap: Detergents that do not contain antimicrobial agents.
- Waterless Antiseptic Agent: An antiseptic agent that does not require water. After applying such an agent, the hands are rubbed together until the agent has dried.

Hand-hygiene technique

WILLIAMSON APPALACHIAN REGIONAL HOSPITAL

POLICY AND PROCEDURE

SUBJECT: Guideline for Hand Hygiene

1. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Follow manufacturer's recommendations regarding the volume of product to use.
2. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off faucet. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis.
3. Liquid, bar, leaflet or powdered forms of plain soap are acceptable when washing hands with a non-anti-microbial soap and water. When bar soap is used, soap racks that facilitate drainage and small bars of soap should be used. Liquid soap will be used in our facility.
4. Multi-use cloth towels of the hanging or roll type are not recommended for use in health-care setting.

Other Aspects of Hand Hygiene

1. Keep natural nail tips less than ¼ inch long
2. Artificial fingernails or extenders are not recommended when having direct contact with patients at high risk.
3. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur
4. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients.
5. Change gloves during patient care if moving from a contaminated body site to a clean body site
6. Always follow Standard Precautions.

Reference: Center for Disease Control

WILLIAMSON APPALACHIAN REGIONAL HOSPITAL

POLICY AND PROCEDURE

SUBJECT: Guideline for Hand Hygiene

Community Chief Nursing Officer

Date

Infection Control Nurse

Date

**Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care**

Resident #1

Attachment #4

Room # 131-1

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
1-9-09	NON-RESTRICTIVE SIDE RAILS <i>Resident has been educated on risks/benefits of siderails. She chooses to keep her siderails up.</i>	No decrease in ROM or injury X 90 Days	<ol style="list-style-type: none"> (1) ENCOURAGE RESIDENT TO EXERCISE UPPER AND LOWER EXTERMITIES/JOINTS ON THEIR OWN OR WITH RNA OR THERAPY, WHICH EVER APPLIES (2) ENCOURAGE RESIDENT TO USE CALL LIGHT FOR ASSISTANCE AS NEEDED TO HELP RAISE AND LOWER SIDE RAILS IF NEEDS ASSISTANCE IF ABLE (3) PT/OT TO MEASURE ROM ON ADMISSION AND PRN (4) RESIDENT UNABLE TO AMBULATE D/T MEDICAL CONDITION (5) RESIDENT FEELS SAFE WITH THE RAILS UP TO SERVE AS A REMINDER OF THE PAREMITER OF THE BED (6) ENCOURAGE RESIDENT TO BE UP OOB IN CHAIR AS MUCH AS POSSIBLE AND TO BE ACTIVE IN ACTIVITIES (7) SIDE RAIL ASSESSMENT ON ADMISSION AND QUARTERLY (8) CLINICAL MONITORING 	NSG	mm	4/09	

FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT



Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

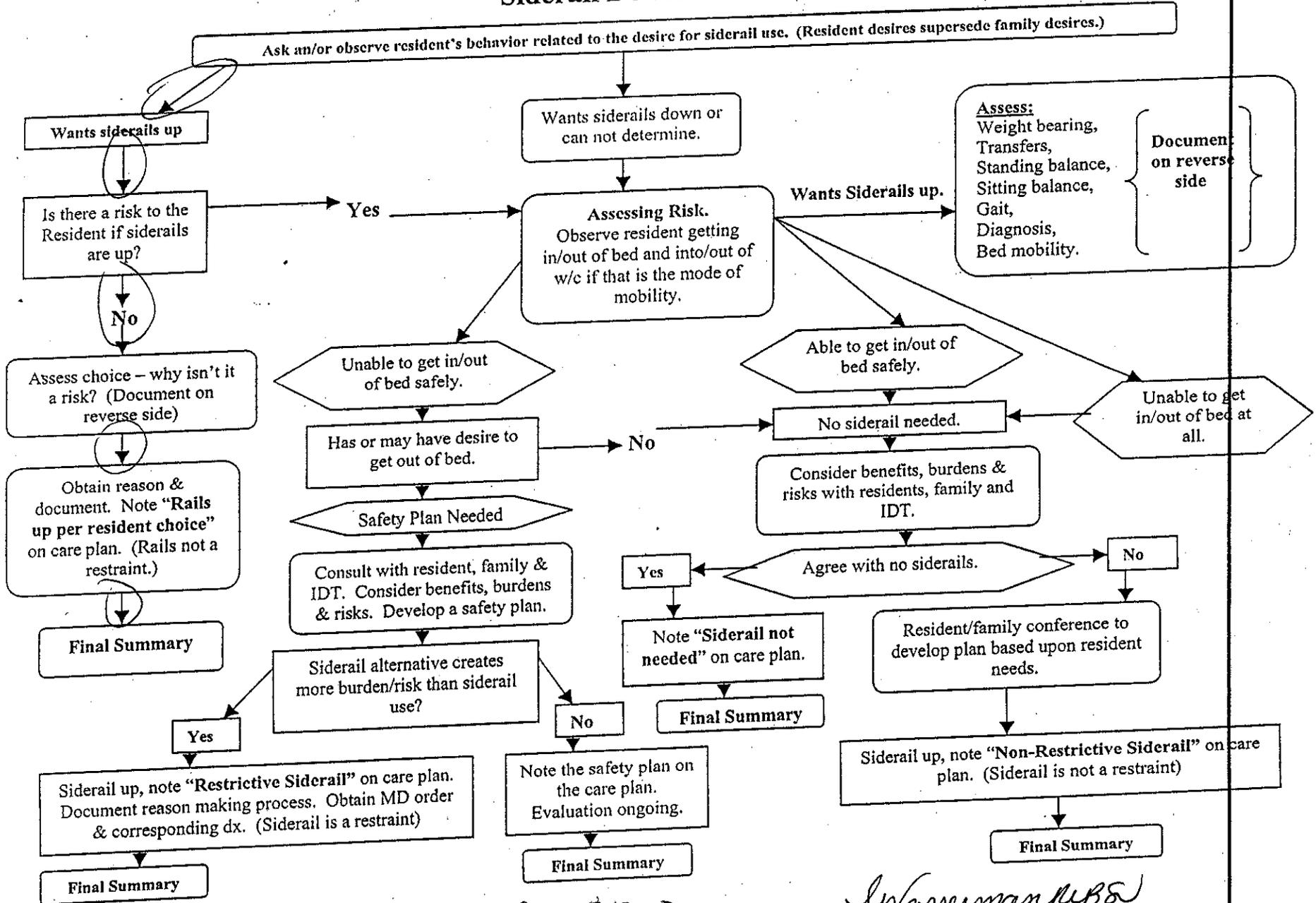
Resident # 1

Attachment # 4

Room # 131-1

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev 4/09	Continue	Cont	Continue	NSG	mm	7/09	
Rev 7/2/09	Cont	cont	cont	NSG	sw	10/09	
Rev 10/1/09	Cont	cont	cont	NSG	sw	1/2010	
Rev 11/1/10	Cont	cont	cont	NSG	sw	4/10	
Rev 4/10	Cont	cont	cont	NSG	sw	7/10	
Rev 10/10	Cont	cont	cont	NSG	sw	10/10	
11/30	Cont SR ↑ x 2 used for bed mobility	cont	cont	NSG	sw		

Siderail Decision Tree



Resident #2 Attachment #5

Resident Name: Room # 130-2 Nurse sign: [Signature]
 Date: 11/30/10

Resident and family request SRT x 2 used for bed mobility and transfers. Bottom rails & RIT does get confused and attempts OOB by self. Educated RIT risks cont to request. SRT x 2 will be used for mobility and transfers.

Resident # 2
Attachment # 5
Room # 130-2

**Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care**

Resident #2

Attachment # 6

Room # 130-2

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
9/30/10	NON-RESTRICTIVE SIDE RAILS <i>SRT's used for bed mobility</i>	No decrease in ROM or injury X' 90 Days	<ol style="list-style-type: none"> 1) ENCOURAGE RESIDENT TO EXERCISE UPPER AND LOWER EXTERMITIES/JOINTS ON THEIR OWN OR WITH RNA OR THERAPY, WHICH EVER APPLIES 2) ENCOURAGE RESIDENT TO USE CALL LIGHT FOR ASSISTANCE AS NEEDED TO HELP RAISE AND LOWER SIDE RAILS IF NEEDS ASSISTANCE IF ABLE 3) PT/OT TO MEASURE ROM ON ADMISSION AND PRN 4) RESIDENT UNABLE TO AMBULATE D/T MEDICAL CONDITION 5) RESIDENT FEELS SAFE WITH THE RAILS UP TO SERVE AS A REMINDER OF THE PAREMITER OF THE BED 6) ENCOURAGE RESIDENT TO BE UP OOB IN CHAIR AS MUCH AS POSSIBLE AND TO BE ACTIVE IN ACTIVITIES 7) SIDE RAIL ASSESSMENT ON ADMISSION AND QUARTERLY 8) CLINICAL MONITORING 	NSG	SW	12/10	

FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT



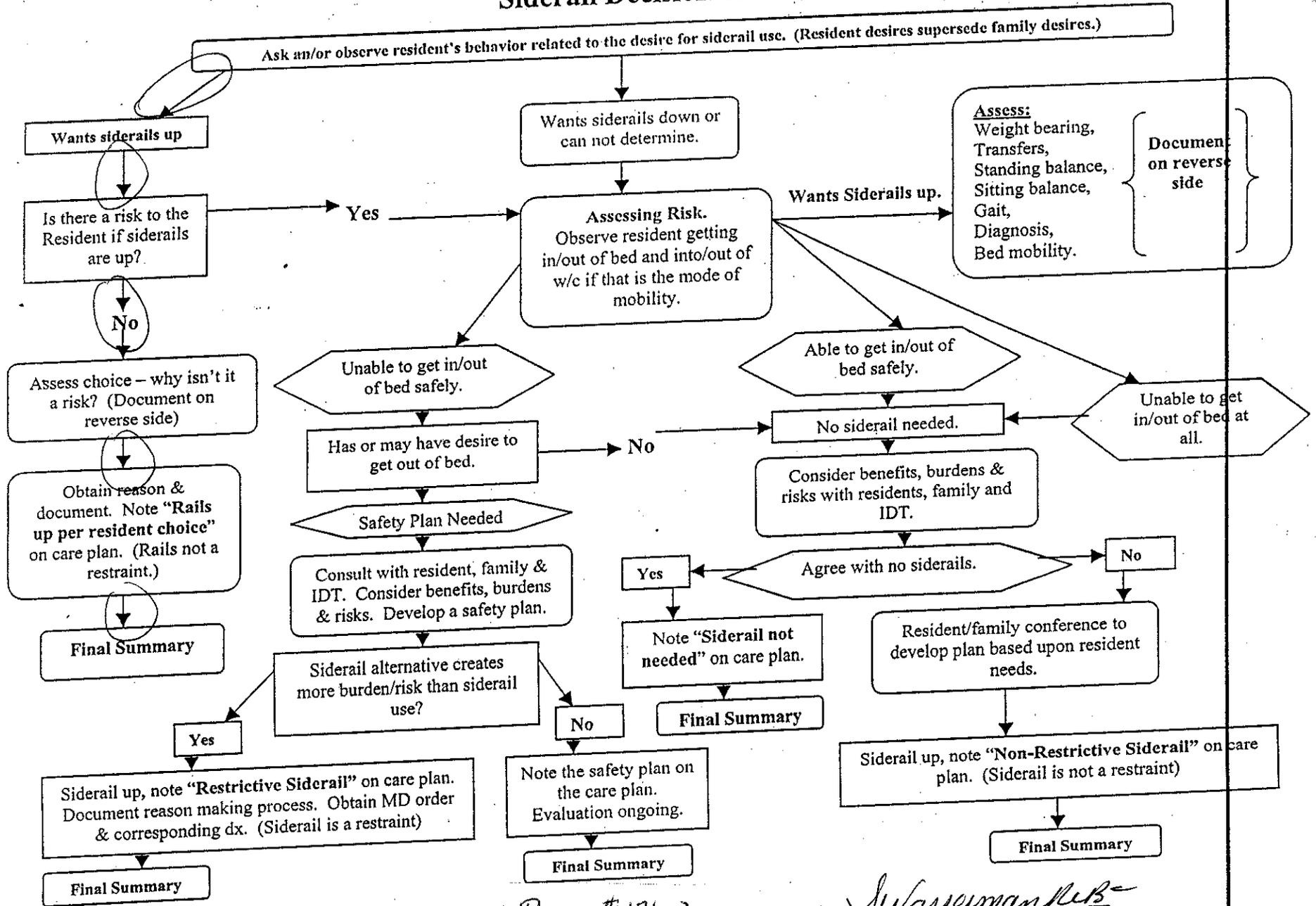
Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

Resident #2 - Attachment #6

Room #130-2

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
11/30/10	Non restrictive and up per residents choice used top 2 SR for bed mobility and transfers	cont 11/30 11/30	SR ↑ x 2 re-educated resident and POA R/t use of SR up, benefit outweighs risks as to enable resident to turn and	NSG	SW		

Siderail Decision Tree



Resident # 4 Attachment # 7

Resident Name: Room # 131-2
 Date: 11/30/10

Nurse sign: *S. Wasserman R. B.*

SRT x 4 resident uses top 2 rails for bed mobility and
side to side turns. Educated family and resident R/H
side rail risks. SRT on bottom used to pull and position
self in bed to lean up.

Resident # 4
Attachment # 17
Room # 131-2

Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

Room # 131-2

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rw/Re copy 9/26/08	NON-RESTRICTIVE SIDE RAILS Resident does not self transfer requires mechanical lift.	No decrease in ROM or injury X: 90 Days	(1) ENCOURAGE RESIDENT TO EXERCISE UPPER AND LOWER EXTERMITIES/JOINTS ON THEIR OWN OR WITH RNA OR THERAPY, WHICH EVER APPLIES (2) ENCOURAGE RESIDENT TO USE CALL LIGHT FOR ASSISTANCE AS NEEDED TO HELP RAISE AND LOWER SIDE RAILS IF NEEDS ASSISTANCE IF ABLE (3) PT/OT TO MEASURE ROM ON ADMISSION AND PRN (4) RESIDENT UNABLE TO AMBULATE D/T MEDICAL CONDITION (5) RESIDENT FEELS SAFE WITH THE RAILS UP TO SERVE AS A REMINDER OF THE PAREMITER OF THE BED (6) ENCOURAGE RESIDENT TO BE UP OOB IN CHAIR AS MUCH AS POSSIBLE AND TO BE ACTIVE IN ACTIVITIES (7) SIDE RAIL ASSESSMENT ON ADMISSION AND QUARTERLY (8) CLINICAL MONITORING FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT	NSG	mm.	12/08	

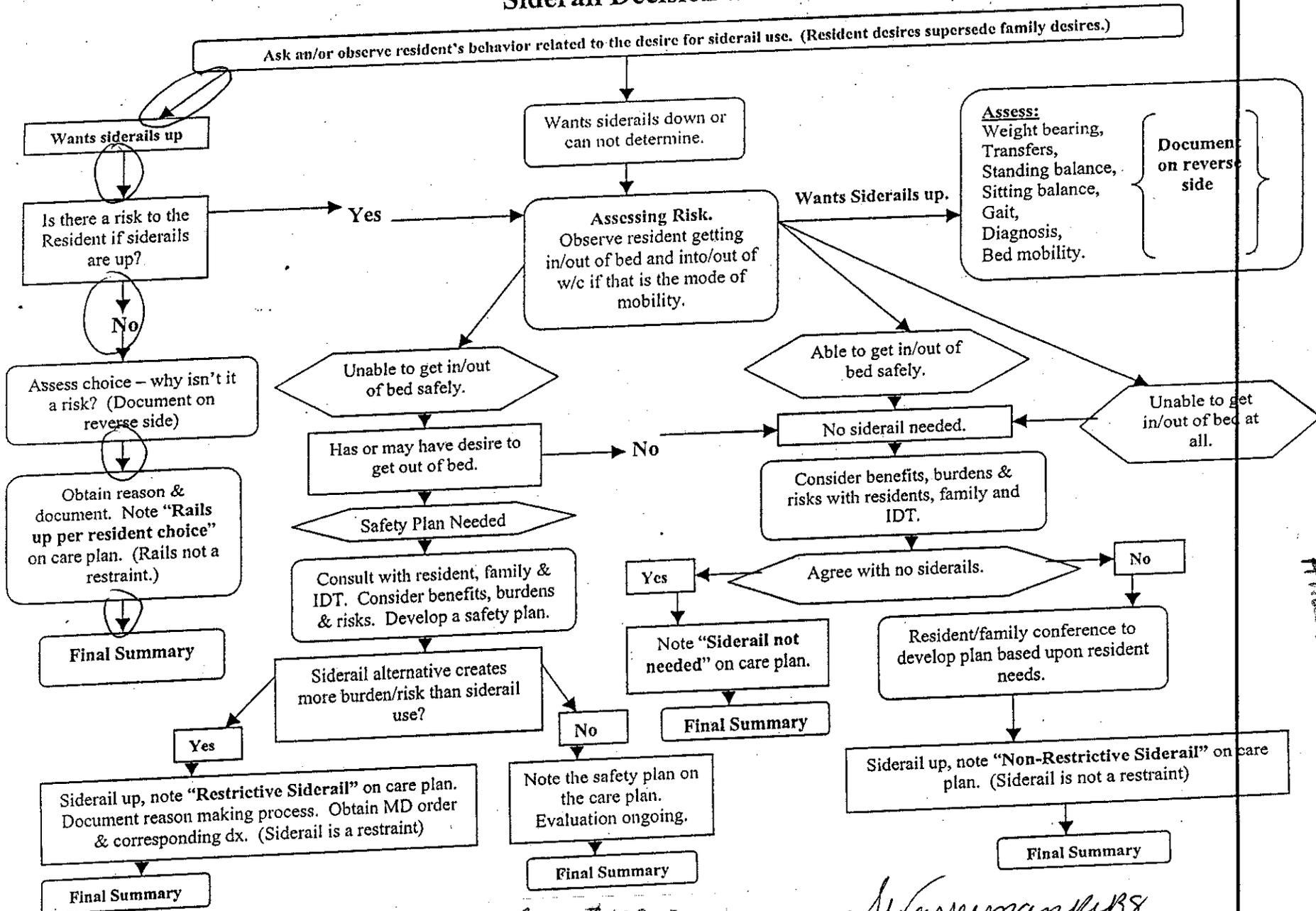


Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

Room # 131-2

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev. 12/08	Continue Non Rest Siderculus	Cont	Continue	NSG	mm	3/09	
Rev 3/09	Continue	Continue	Continue	NSG	mm	6/09	
6/2009 Rev	Cont	Cont	Cont	NSG	SW	6/9/2009	
Rev 9/09	Cont	Cont	Cont	NSG	SW	12/09	
Rev 12/09	Cont	Cont	Cont	NSG	SW	3/10	
Rev 3/10	Cont	Cont	Cont	NSG	SW	6/10	
Rev 6/10	Cont	Cont	Cont	NSG	SW	9/10	
	SRT x4 pulls on top to position from side to side and pulls self up c bottom 2 side rails, request up	11/30	SRT x4 use for mobility (resident to POA educated PT uses, benefit for use of mobility outdoors needs)				

Siderail Decision Tree



Resident # 11
Attachment # 9

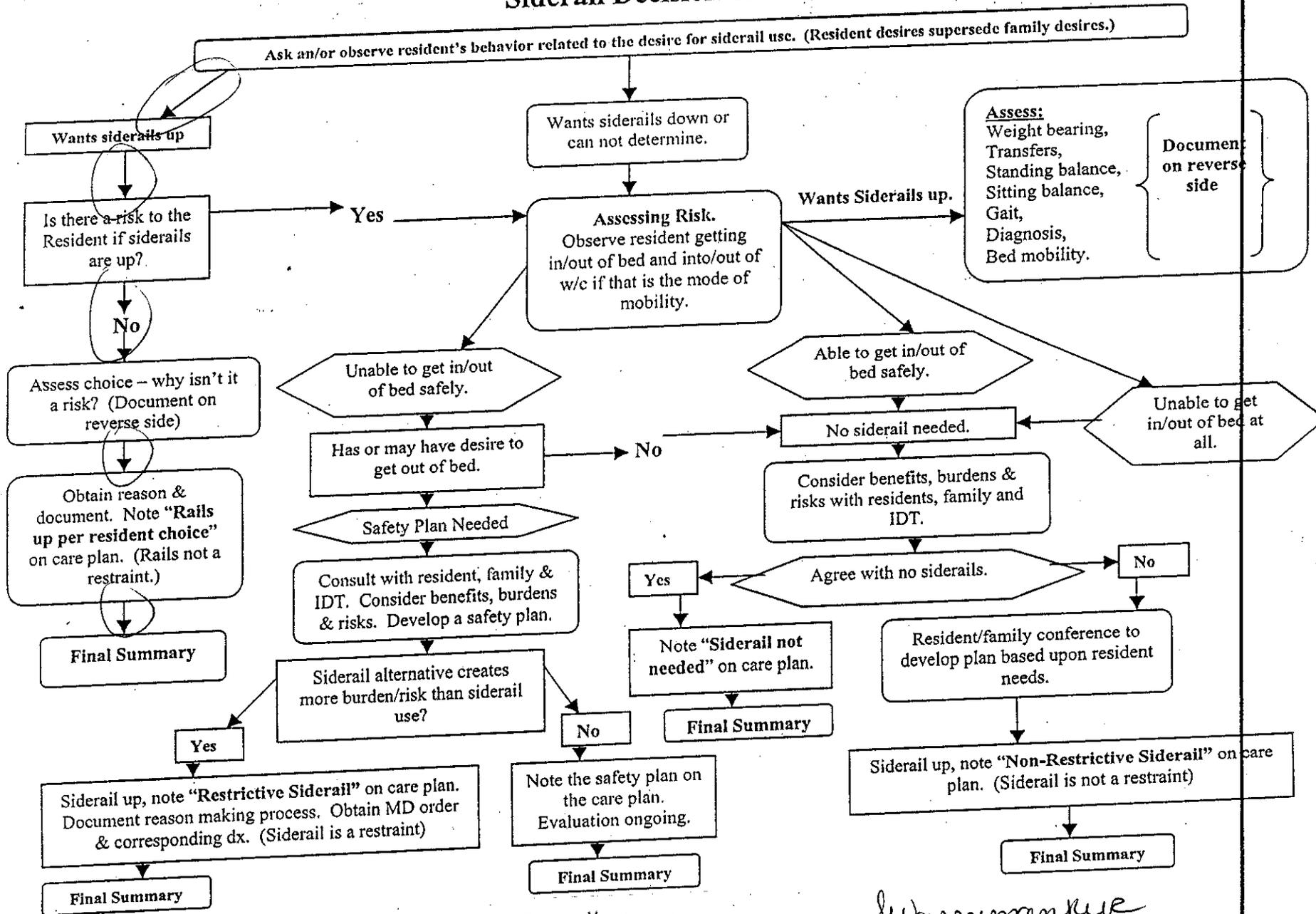
Resident Name: Room # 129-2
Date: 11/30/10

Nurse sign: Wasserman MB8

Resident is A&O x 3 c̄ good safety awareness requests
SRT x 4 when in bed. Educated on risks will monitor, cont
to request SRT x 4 while in bed. Hx recent fall at home
RH Cloddiness, bed rails and trapez low used for
bed mobility. Wants up when sleeping / at night
especially. Can use SRT when pt requests

Resident #11
Room 129-2
Attachment
#9

Siderail Decision Tree



Resident #12

Attachment # 10

Resident Name: Room #132-2
 Date: 11/30/10

Nurse sign: *[Signature]*

SR ↑ x 4 per resident and family request, does not attempt OOB by self. Educated R/H risk cont to request SR ↑ x 4, will attempt to assist c turns by grasping onto side rails c turns. Bottom side rails noted to keep legs from sliding when asleep.

Resident # 12
Attachment # 10
Room # 132-2

**Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care**

Attachment # 10

Resident # 12

Room # 132-2

Problem Number _____

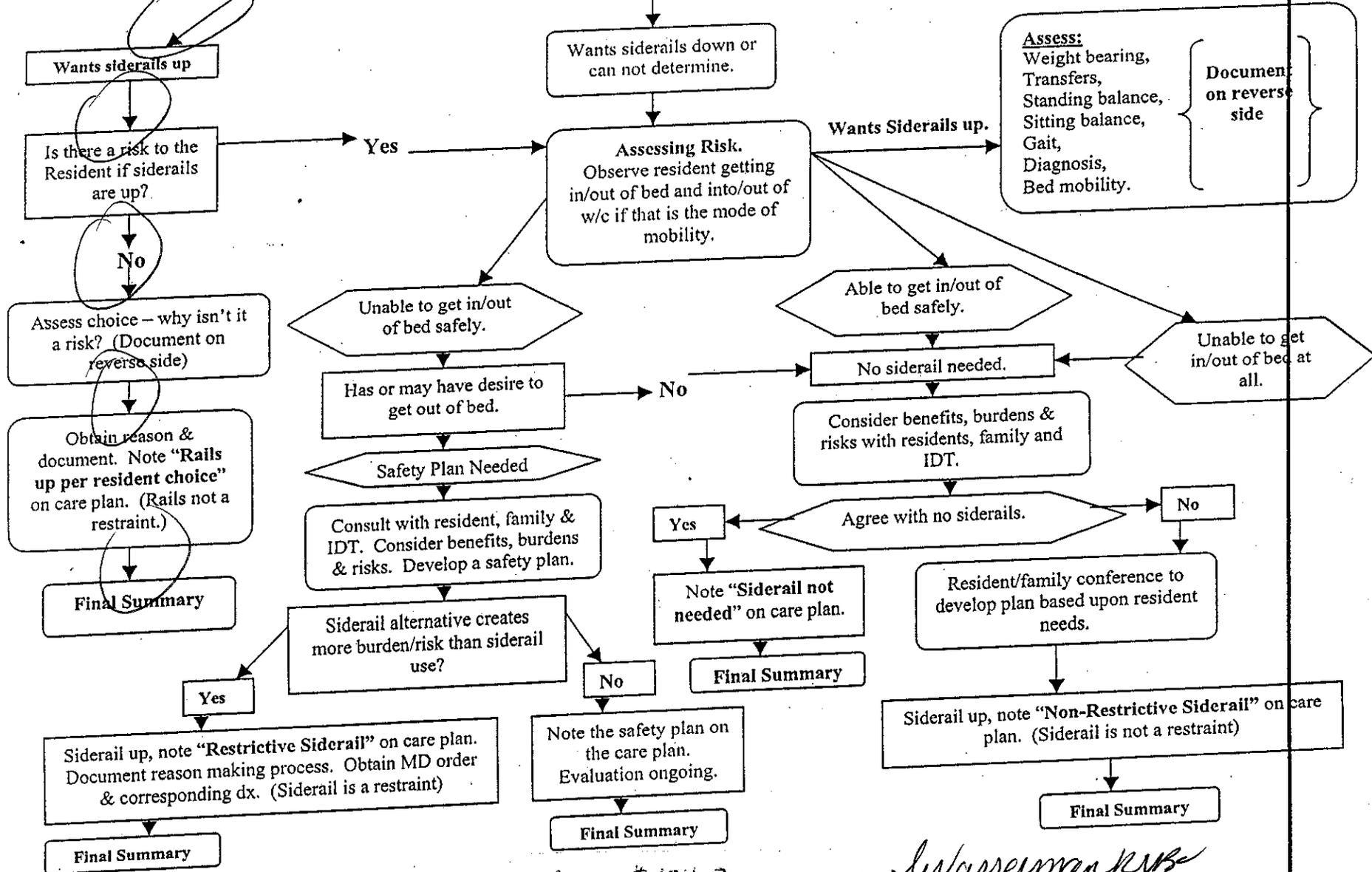
DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
11/2/10	NON-RESTRICTIVE SIDE RAILS / PW choice ↑ x 4 when in bed - Uses for assist c bed mobility & muscle tone prior to admit noted a poor control lower limbs & turns	No decrease in ROM or injury X 90 Days	<ol style="list-style-type: none"> 1) ENCOURAGE RESIDENT TO EXERCISE UPPER AND LOWER EXTERMITIES/JOINTS ON THEIR OWN OR WITH RNA OR THERAPY, WHICH EVER APPLIES 2) ENCOURAGE RESIDENT TO USE CALL LIGHT FOR ASSISTANCE AS NEEDED TO HELP RAISE AND LOWER SIDE RAILS IF NEEDS ASSISTANCE IF ABLE 3) PT/OT TO MEASURE ROM ON ADMISSION AND PRN 4) RESIDENT UNABLE TO AMBULATE D/T MEDICAL CONDITION 5) RESIDENT FEELS SAFE WITH THE RAILS UP TO SERVE AS A REMINDER OF THE PAREMITER OF THE BED 6) ENCOURAGE RESIDENT TO BE UP OOB IN CHAIR AS MUCH AS POSSIBLE AND TO BE ACTIVE IN ACTIVITIES 7) SIDE RAIL ASSESSMENT ON ADMISSION AND QUARTERLY 8) CLINICAL MONITORING 	NSG	SCD	2/11	

FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT



Siderail Decision Tree

Ask an/or observe resident's behavior related to the desire for siderail use. (Resident desires supersede family desires.)



Resident # 8
Attachment # 11

Resident Name: Room # 134-2
Date: 11/30/10

Nurse sign: [Signature]

SKT x 3 RH resident request used for bed motility and
transfers per resident request. Educated RH risks of
side rails cont to request SKT x 2.

Resident # 8
Attachment # 11
Room # 134-2

**Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care**

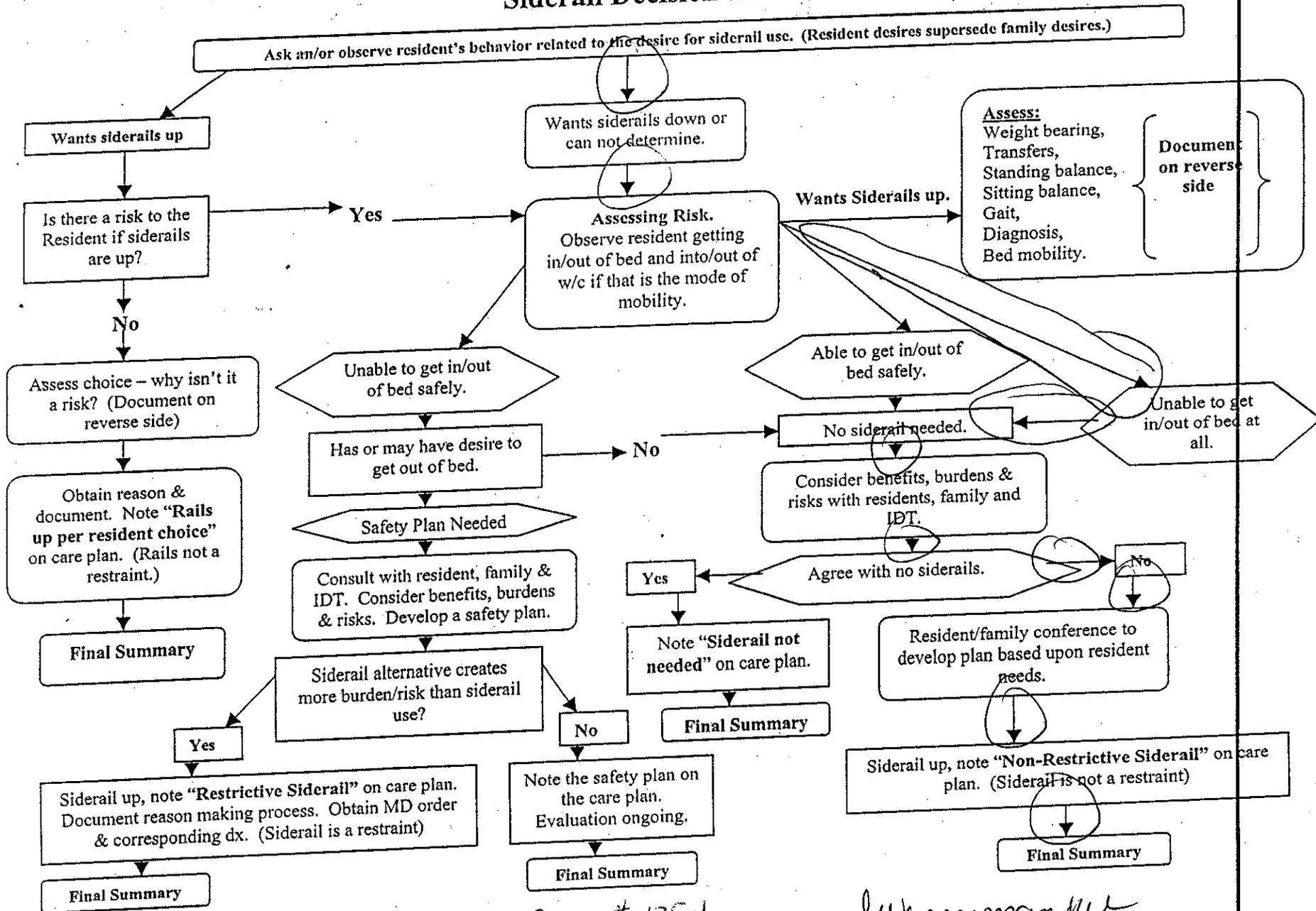
Resident # 8
Room # 134-2

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
11/30/10	SIDE RAILS UP PER RESIDENTS CHOICE <i>SRT x 3 per choice pt use for bed mobility and transfers by resident</i>	No decrease in ROM or injury X 90 Days	<ol style="list-style-type: none"> 1) ENCOURAGE RESIDENT TO EXERCISE UPPER AND LOWER EXTERMITIES/JOINTS ON THEIR OWN OR WITH RNA OR THERAPY, WHICH EVER APPLIES 2) ENCOURAGE RESIDENT TO USE CALL LIGHT FOR ASSISTANCE AS NEEDED TO HELP RAISE AND LOWER SIDE RAILS IF NEEDS ASSISTANCE 3) PT/OT TO MEASURE ROM ON ADMISSION AND PRN 4) RESIDENT USES SIDE RAILS TO TURN SIDE TO SIDE IN BED AND RAISE AND LOWER HEAD OF BED AND TO HELP TRANSFER AS NEEDED 5) RESIDENT FEELS SAFE WITH THE RAILS UP TO SERVE AS A REMINDER OF THE PAREMITER OF THE BED 6) ENCOURAGE RESIDENT TO BE UP OOB AS MUCH AS POSSIBLE AND TO BE ACTIVE IN ACTIVITIES 7) SIDE RAIL ASSESSMENT ON ADMISSION AND QUARTERLY 8) CLINICAL MONITORING FREQUENTLY FOR ANY PROBLEMS OR INJURIES 	NSG	SW	2/11	



Siderail Decision Tree



Resident #13
Attachment #12

Resident Name: Room # 135-1
Date: 11/30/10

Nurse sign: [Signature]

SRP x 2 per family request. used when teens hold on
to rails. Educated R/H risk cont to request up x 2 non
restrictive, does not attempt OOB.

Resident #13
Attachment #12
Room #135-1

Appalachian Regional Healthcare, Inc.

Interdisciplinary Plan of Care

Resident # 13

Room # 135-1

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
11-4-08	NON-RESTRICTIVE SIDE RAILS Resident cannot and does not attempt self transfers	No decrease in ROM or injury X 90 Days	(1) ENCOURAGE RESIDENT TO EXERCISE UPPER AND LOWER EXTERMITIES/JOINTS ON THEIR OWN OR WITH RNA OR THERAPY, WHICH EVER APPLIES (2) ENCOURAGE RESIDENT TO USE CALL LIGHT FOR ASSISTANCE AS NEEDED TO HELP RAISE AND LOWER SIDE RAILS IF NEEDS ASSISTANCE IF ABLE (3) PT/OT TO MEASURE ROM ON ADMISSION AND PRN (4) RESIDENT UNABLE TO AMBULATE D/T MEDICAL CONDITION (5) RESIDENT FEELS SAFE WITH THE RAILS UP TO SERVE AS A REMINDER OF THE PERIMETER OF THE BED (6) ENCOURAGE RESIDENT TO BE UP OOB IN CHAIR AS MUCH AS POSSIBLE AND TO BE ACTIVE IN ACTIVITIES (7) SIDE RAIL ASSESSMENT ON ADMISSION AND QUARTERLY (8) CLINICAL MONITORING FREQUENTLY FOR ANY	NSG	mm	2/09	

PROBLEMS OR INJURIES AND DOCUMENT



Attachment #12

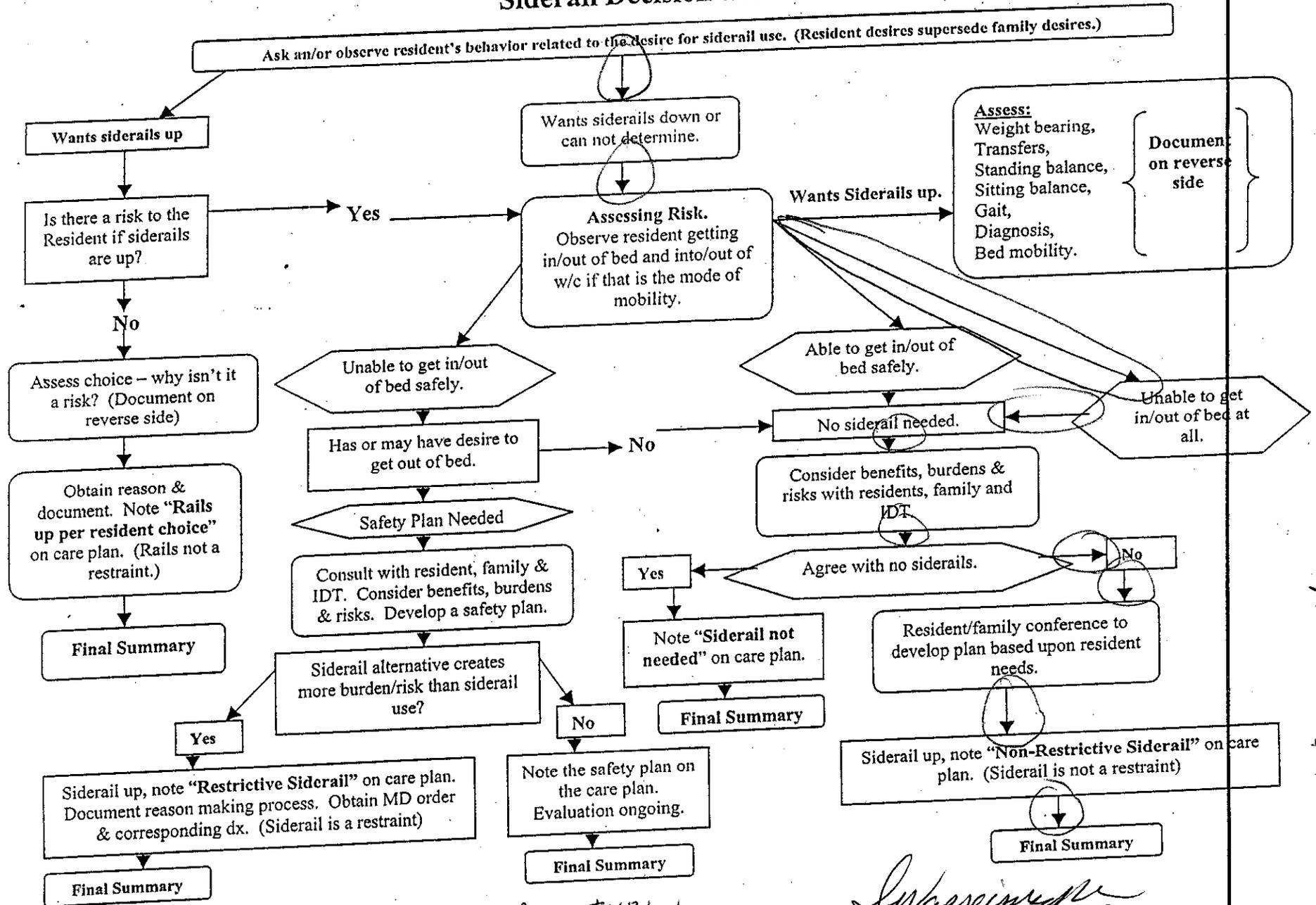
Resident # 13

Room # 135-1

Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev 2/09	Non Restrictive Side Rails	Cont	Continue	Continue	mm	5/09	
Rev 5/09	Continue	cont	cont	cont	sw	8/09	
Rev 8/09	cont	cont	cont	cont	sw	11/09	
Rev 11/09	Cont	cont	cont	cont	sw	2/2010	
Rev 2/10	Cont	cont	cont	cont	sw	5/10	
Rev 5/10	Cont	cont	cont	cont	sw	8/10	
Rev 8/10	Cont	cont	cont	cont	sw	11/10	
Rev 11/10	Cont	cont	cont	cont	sw	2/11	
	SR ↑ x 2 non-vest	cont	cont	cont	sw		

Siderail Decision Tree



Resident # 14
Attachment # 13

Resident Name: Room #136-1
Date: 11/30/10

Nurse sign: *[Signature]*

This resident does not attempt OOB by self, has a habit of rubbing legs and feet together even when sleeping is more to have leg drop off side of bed when bottom rails are ~~down~~ down. SR ↑ x 4, educated and discussed risks and options c-sons. Cont to cse SR ↑ x 4.

Resident #14
Attachment #13
Room # 136-1

Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

Resident #14
Room # 136-1

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
12/21/09	NON-RESTRICTIVE SIDE RAILS <i>Used to assist in turns, does not attempt OOB by self + 4 RH pod control of limbs</i>	No decrease in ROM or injury X' 90 Days	<ol style="list-style-type: none"> 1) ENCOURAGE RESIDENT TO EXERCISE UPPER AND LOWER EXTERMITIES/JOINTS ON THEIR OWN OR WITH RNA OR THERAPY, WHICH EVER APPLIES 2) ENCOURAGE RESIDENT TO USE CALL LIGHT FOR ASSISTANCE AS NEEDED TO HELP RAISE AND LOWER SIDE RAILS IF NEEDS ASSISTANCE IF ABLE 3) PT/OT TO MEASURE ROM ON ADMISSION AND PRN 4) RESIDENT UNABLE TO AMBULATE D/T MEDICAL CONDITION 5) RESIDENT FEELS SAFE WITH THE RAILS UP TO SERVE AS A REMINDER OF THE PERIMETER OF THE BED 6) ENCOURAGE RESIDENT TO BE UP OOB IN CHAIR AS MUCH AS POSSIBLE AND TO BE ACTIVE IN ACTIVITIES 7) SIDE RAIL ASSESSMENT ON ADMISSION AND QUARTERLY 8) CLINICAL MONITORING 	NSG	SW	3/20/10	

FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT



**Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care**

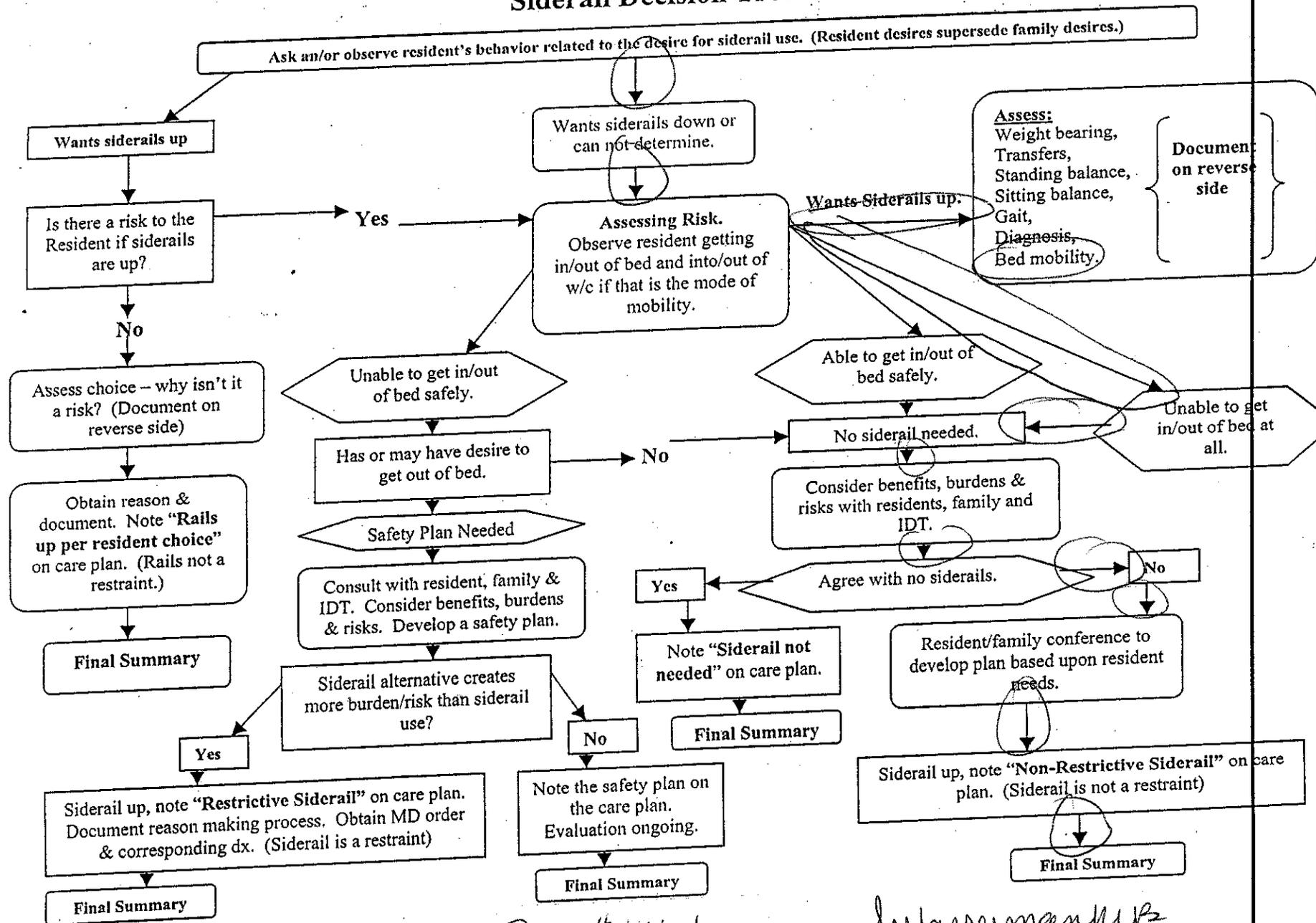
Attachment # 13

Resident # 14

Room # 136-1

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev 3/10	Cont- Non Restrictive Side Rails	cont	cont	NSG	SW	4/10	
Rev 6/10	Cont	cont	cont	NSG	SW	9/10	
Rev 9/10	cont	cont	cont	NSG	SW	12/10	

Siderail Decision Tree



Resident #15
Attachment #14

Resident Name Room #146-1
Date: 11/30/10

Nurse sign: [Signature]

Resident requests SR ↑ x 2, family requests Ctx dementia & resident, will pull and attempt to assist c turns, holds on to SR & positioning and turns. Educated R/H asks cont to request SR ↑ x 2.

Resident # 15
Attachment # 14
Room # 146-1

**Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care**

*Attachment # 14
Resident # 15
Room # 146-1*

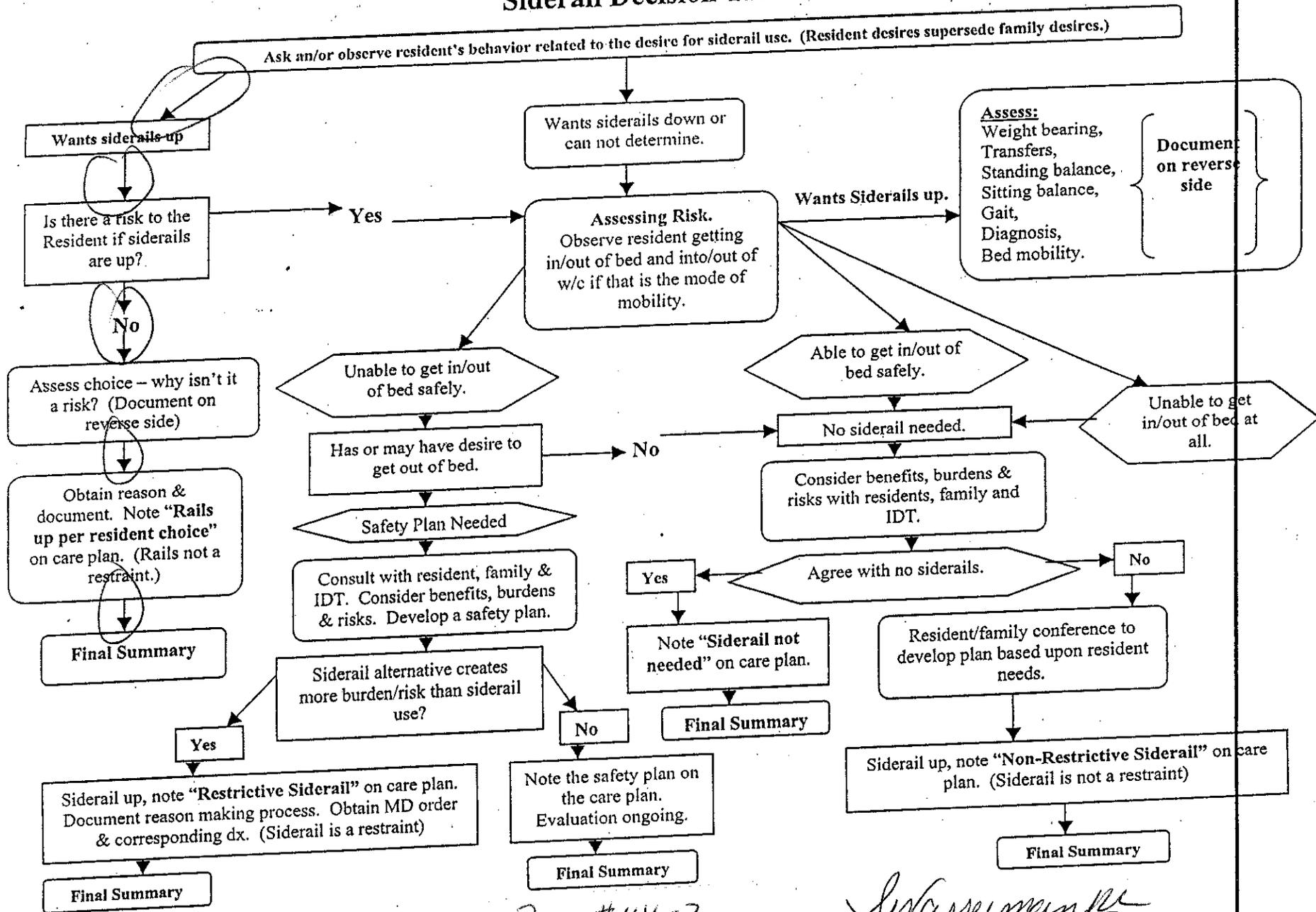
Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
11/26/10	NON-RESTRICTIVE SIDE RAILS <i>SRT x 2, does not attempt OOB but will reach and attempt to assist 0 turns and positioning</i>	No decrease in ROM or injury X' 90 Days	<ol style="list-style-type: none"> 1) ENCOURAGE RESIDENT TO EXERCISE UPPER AND LOWER EXTERMITIES/JOINTS ON THEIR OWN OR WITH RNA OR THERAPY, WHICH EVER APPLIES 2) ENCOURAGE RESIDENT TO USE CALL LIGHT FOR ASSISTANCE AS NEEDED TO HELP RAISE AND LOWER SIDE RAILS IF NEEDS ASSISTANCE IF ABLE 3) PT/OT TO MEASURE ROM ON ADMISSION AND PRN 4) RESIDENT UNABLE TO AMBULATE D/T MEDICAL CONDITION 5) RESIDENT FEELS SAFE WITH THE RAILS UP TO SERVE AS A REMINDER OF THE PAREMITER OF THE BED 6) ENCOURAGE RESIDENT TO BE UP OOB IN CHAIR AS MUCH AS POSSIBLE AND TO BE ACTIVE IN ACTIVITIES 7) SIDE RAIL ASSESSMENT ON ADMISSION AND QUARTERLY 8) CLINICAL MONITORING 	NSG	<i>SW</i>	<i>2/11</i>	

FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT



Siderail Decision Tree



Resident # 6
Attachment # 15

Resident Name: Room #146-2
Date: 11/30/10

Nurse sign: [Signature]

Resident requests SRP x 4, uses for mobility and turns.
Educated R/H risk of use cont to request SRP x 4.

Resident #6
Attachment #15
Room # 146-2

Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

Attachment # 15

Resident # 6

Room # 146-2

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
6/9/10	NON-RESTRICTIVE SIDE RAILS <i>Resident requests x 4 (per pt request)</i>	No decrease in ROM or injury X 90 Days	<ol style="list-style-type: none"> 1) ENCOURAGE RESIDENT TO EXERCISE UPPER AND LOWER EXTERMITIES/JOINTS ON THEIR OWN OR WITH RNA OR THERAPY, WHICH EVER APPLIES 2) ENCOURAGE RESIDENT TO USE CALL LIGHT FOR ASSISTANCE AS NEEDED TO HELP RAISE AND LOWER SIDE RAILS IF NEEDS ASSISTANCE IF ABLE 3) PT/OT TO MEASURE ROM ON ADMISSION AND PRN 4) RESIDENT UNABLE TO AMBULATE D/T MEDICAL CONDITION 5) RESIDENT FEELS SAFE WITH THE RAILS UP TO SERVE AS A REMINDER OF THE PAREMITER OF THE BED 6) ENCOURAGE RESIDENT TO BE UP OOB IN CHAIR AS MUCH AS POSSIBLE AND TO BE ACTIVE IN ACTIVITIES 7) SIDE RAIL ASSESSMENT ON ADMISSION AND QUARTERLY 8) CLINICAL MONITORING 	NSG	SW	9/10	

FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT

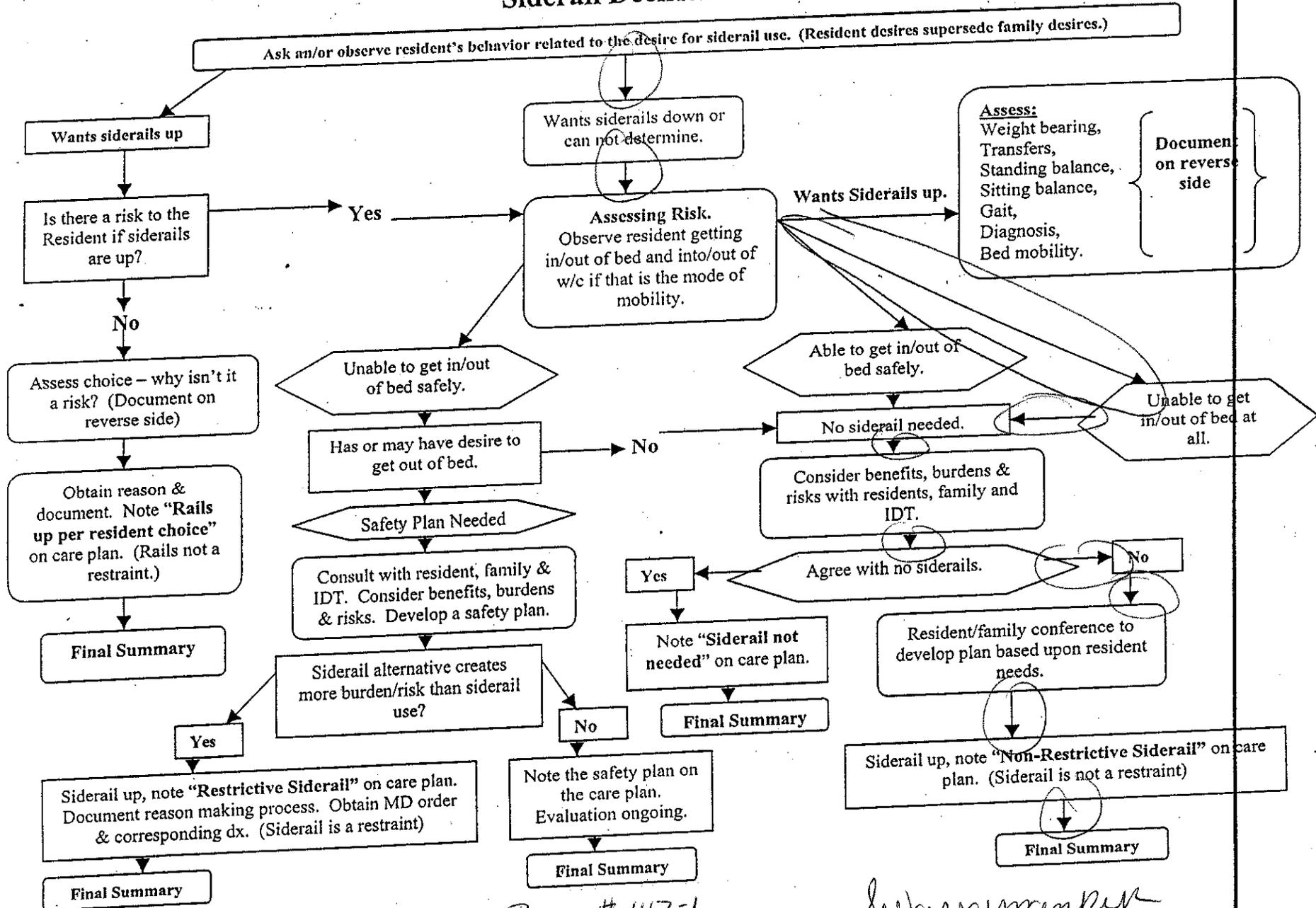


**Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care**

Attachment #15
Resident # 6
Room # 146-2

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev 9/10	Cont SRT 4 per resident choice for mobility and bath. Does not attempt SOB by self	cont	cont	NSG	SW	12/10	

Siderail Decision Tree



Resident # 16

Attachment # 16

Resident Name: Room # 147-1
 Date: 11/30/10

Nurse sign: [Signature]