

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

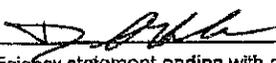
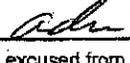
RECEIVED
PRINTED 09/02/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2011
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NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 WEST WILSON BYPASS MONTICELLO, KY 42633
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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
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F 000	INITIAL COMMENTS	F 000		
F 221 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure three of twenty-four sampled residents were assessed to have medical symptoms that required the use of devices that restricted movement (Residents #8, #9, and #10). Residents #8 and #9 were observed to utilize a "lap buddy" (device used to prevent rising) while out of bed in a wheelchair, and Resident #10 was observed to be in a reclined Geri chair (chair that prevents rising).</p> <p>The findings include: A review of the facility restraint policy (undated) revealed the facility would only use physical restraints (devices that restrict movement) to treat medical symptoms that were unable to be treated by the use of other measures. According to facility policy, physical restraints were to be evaluated to determine the medical symptoms that warranted the use of the restraint and/or the use of the least restrictive device available to treat the medical symptom if it was not treatable</p>	F 221	Please See Attachment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		9/9/2011

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

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F 221	<p>Continued From page 1</p> <p>by other measures. Based on policy, an interdisciplinary restraint reduction/elimination team would meet quarterly and/or as needed to review restraint usage, promote safety, and decrease use of restraints in the facility. In addition, a pre-restraining assessment was to be completed prior to the use of a restraint.</p> <p>1. A review of the medical record of Resident #9 revealed the resident was admitted to the facility on 05/20/11, with diagnoses that included Weakness, Dementia, and Osteoarthritis. Resident #9's Minimum Data Set (MDS) dated 05/26/11, revealed the resident had impaired cognition and would attempt to get up unassisted. The MDS also revealed the resident required extensive assistance with transfers and mobility.</p> <p>Further record review revealed on 05/28/11, Resident #9 attempted to get out of bed by his/her self and slid out of the wheelchair. The record revealed a physician's order was obtained on 05/31/11, for a "lap buddy" to be used when Resident #9 was up in a wheelchair. However, there was no evidence the facility had assessed the resident to have a medical symptom to support the use of the lap buddy.</p> <p>Observation on 08/02/11, at 4:30 PM., revealed Resident #9 sitting in a wheelchair with a "lap buddy" in place and the resident's family member was present. Resident #9's family member stated although he/she had observed Resident #9 remove the lap buddy in the past, the resident was unable to remove the device when prompted.</p> <p>Interview on 08/04/11, at 10:10 AM, with Certified Nursing Assistant (CNA) #1 revealed she could</p>	F 221		

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F 221	<p>Continued From page 2</p> <p>not recall how long the "lap buddy" had been utilized for Resident #9. The CNA stated Resident #9 required the use of the lap buddy when in a wheelchair because the resident would lean forward or to the side and would attempt to get up from the chair without required assistance.</p> <p>Interview on 08/04/11, at 1:25 PM, with LPN #5 revealed Resident #9 required the use of the "lap buddy" when up in a wheelchair to prevent the resident from "leaning forward and falling out of the wheelchair." Further interview revealed the resident removed the "lap buddy" at times but was unable to remove the device if requested.</p> <p>Interview on 08/04/11, at 5:50 PM, with the Occupational Therapist (OT) revealed the use of the "lap buddy" had been utilized for Resident #9 since "Memorial Day" weekend, a timeframe of approximately ten weeks. According to the therapist, the resident had not been assessed by the therapist for the use of the device prior to its use.</p> <p>2. A review of the medical record of Resident #10 on 07/18/11, revealed diagnoses that included Alzheimer's disease, Dementia, Arthritis, and History of Cerebral Vascular Accident. A physician's order dated 01/03/07, revealed a reclining "Gen" chair (to prevent rising) was to be used for Resident #10 when he/she was out of the bed because the resident "slides and scoots down in the chair." Further review of the medical record revealed no evidence that an assessment had been completed prior to the use of the reclined Geri chair.</p> <p>Observation on 08/04/11, at 2:00 PM, 3:30 PM,</p>	F 221		

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F 221	<p>Continued From page 3</p> <p>and 5:30 PM, revealed Resident #10 was in a reclined Geri chair.</p> <p>An interview with an Occupational Therapist (OT) on 08/04/11, at 5:50 PM, revealed the therapist had not conducted an assessment related to the use of the "Geri" chair for Resident #10.</p> <p>An interview with the Minimum Data Set (MDS) Coordinator conducted on 08/04/11, at 5:55 PM, revealed there was no documentation related to the use of the "Geri" chair for Resident #10 at the time of the use of the device.</p> <p>3. A review of the medical record for Resident #8 revealed the resident was admitted to the facility on 03/19/09, with diagnoses of Cerebral Palsy, Seizure Disorder, and Ataxia. A physician's order dated 03/27/09, revealed an order for staff to "apply lap buddy to wheelchair to aid with correct positioning while up." Further review of the medical record revealed an assessment related to the use of the "lap buddy" had not been documented.</p> <p>Observations of Resident #8 on 08/02/11, at 3:50 PM and 4:45 PM, on 08/03/11, at 11:10 AM, and 08/04/11, at 9:00 AM, revealed Resident #8 was in a wheelchair with a "lap buddy" in place.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #5 on 08/04/11, at 2:30 PM, revealed Nursing or Therapy usually conducted the initial assessment prior to the initiation of a restraint, and the LPN was responsible to conduct a restraint reduction assessment. LPN #5 was not aware that there was not an initial assessment for restraint use for Resident #8.</p>	F 221		

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F 221	Continued From page 4 LPN #5 further stated that although Resident #8 scored as a "Priority Candidate" for restraint reduction, due to the resident's seizure activity, the resident was not a candidate for restraint reduction. An interview with the Occupational Therapist (OT) conducted on 08/04/11, at 5:50 PM, revealed Therapy had not conducted an assessment related to the use of the "lap buddy" device for Resident #8.	F 221			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, a review of facility policy, and a review of employee files it was determined the facility failed to implement the facility's policy that had been developed to prohibit the mistreatment, neglect, and abuse of residents. The facility failed to ensure an Abuse Registry background check had been completed for one of five employees (CNA #6) prior to employment. The findings include: A review of the facility's policy titled "Resident Abuse Policy" (no date) revealed the facility was to perform, prior to an individual's employment: 1) A criminal background check with the local	F 226	Please See Attachment		

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F 226	Continued From page 5 Police Department and State Police Department. 2) Check information if available from previous and current employers. 3) Check the Abuse Registry in each state in which employees have worked in an effort to uncover information about any past criminal prosecutions related to abuse, neglect, or mistreatment. Record review of employee files on 08/04/11, revealed CNA #6 was hired on 04/13/11. Documentation in the employee's personnel file revealed no evidence the facility had completed a Nurse Aide/Abuse Registry background check of the employee prior to employment. Interview with the Human Resources (HR) Manager on 08/04/11, at 3:45 PM, revealed CNA #6 had been hired in 2010, terminated on 03/23/11, and rehired on 04/13/11. The HR Manager stated it was her responsibility to obtain the Nurse Aide Abuse Registry information on new employees but stated she had failed to obtain the Abuse Registry information prior to rehiring CNA #6.	F 226		
F 248 SS=C	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and a review of policies and	F 248	Please See Attachment	

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F 248	<p>Continued From page 6</p> <p>activity schedules, the facility failed to ensure an ongoing program of activities to accommodate the individual resident interest and enhance the individual physical, mental, and psychosocial needs of the residents. During the group interview conducted with residents (Residents #18, #19, #14, #20, #21, #22, and #23) on 08/03/11, at 3:30 PM, the residents stated they did not have activities and were bored.</p> <p>The findings include:</p> <p>A review of the facility's undated Activity policy revealed activities would be provided to reflect the interests of each resident, an activity cart would be provided for weekend activities, and religious services would be provided on Sunday afternoons. In addition, the policy indicated the resident's attendance during activities would be documented on a daily basis.</p> <p>During a group interview conducted on 08/03/11, at 3:30 PM, residents (Residents #18, #19, #14, #20, #21, #22, and #23) complained weekends at the facility were "boring" and that "all" the residents had to do was to "look at the four walls" in their individual rooms. The residents further stated "sometimes" the facility provided church services on the weekends.</p> <p>A review of the facility activity calendar(s) for the months of May, June, and July 2011, revealed the residents had access to an "Activity Cart" on Saturdays and "Church" on Sundays.</p> <p>An interview conducted with the facility's Activity Director on 08/03/11, at 4:10 PM, revealed the Activity Director and the Activity staff did not work</p>	F 248		

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F 248	Continued From page 7 on weekends and depended on Nursing staff and Certified Nursing Assistants (CNAs) to provide activities for the residents. The Activity Director stated she did not document the activities on the residents' activity sheets because she did not work on the weekends and had not provided the activity. An interview was conducted with the facility's Director of Nursing (DON) on 08/03/11, at 4:30 PM. The DON confirmed the three Activity staff members did not work on the weekends. The DON stated the CNAs were supposed to provide coloring books and other activity items of the resident's interest, and that the residents had the opportunity to attend church on Sundays. An interview conducted with the CNA on 08/04/11, at 4:10 PM, revealed the CNA staff did not have time to provide activities to the residents on the weekends and to also provide assistance with the resident care needs.	F 248		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	Please See Attachment	

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F 441	<p>Continued From page 8</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper infection control practices were maintained for two of twenty-four sampled residents (Residents #3 and #18). During wound care, the treatment nurse failed to utilize handwashing technique in accordance with accepted standards of practice when she performed wound care for the two identified residents.</p> <p>The findings include:</p>	F 441		

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F 441	Continued From page 9 A review of the Dressing Change policy (no date given) revealed during wound care treatment, staff was to remove the old dressing using clean technique, dispose of the old dressing properly, and clean the area and reapply a new dressing as directed by physician's orders. 1. Review of the medical record for Resident #3 revealed the facility admitted the resident on 08/15/09, with diagnoses that included Paraplegia, Colostomy, Seizure Disorder, Graves' Disease, and Chronic Pain. Further review of Resident #3's physician's orders revealed an order dated 07/02/10, for treatment to the resident's wound and indicated staff was to cleanse the wound with a medicated solution, "apply wet/moist dressing daily to sacral ulcer," cover the wound with a dressing, and change the dressing "daily and PRN (as needed)." Review of an additional physician's order revealed staff was permitted to use Dakin's (used to prevent and treat skin and wound infections) solution for the wound care treatment. During observation of a wound care treatment for Resident #3 on 08/03/11, at 10:30 AM, Licensed Practical Nurse (LPN) #5 was observed to wash her hands, prepare dressing supplies, and remove the soiled dressing/packing from the resident's wound with gloved hands. LPN #5 then removed her soiled gloves and put on clean gloves without washing her hands, as is an accepted practice within the standards of nursing practice. LPN #5 then cleansed the wound area, packed the wound with Dakin's soaked gauze, and applied a clean dressing.	F 441			

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F 441	<p>Continued From page 10</p> <p>2. A review of the medical record of Resident #24 revealed the facility readmitted the resident on 07/23/11, with diagnoses that included Diabetes and a Diabetic Ulcer to the left foot. A review of the physician's orders revealed staff was to cleanse the diabetic ulcer (wound) on the resident's left foot with normal saline, apply Santyl (debrides dead tissue) ointment to the wound bed, and cover the wound with Amerigel (antimicrobial) followed by a dry gauze wrap.</p> <p>Observation on 08/04/11, at 9:15 AM, of a wound care treatment performed by LPN #5 revealed the LPN opened dressing supplies and arranged the supplies on the resident's overbed table. The nurse was observed to put on clean gloves, remove the soiled dressing from the resident's wound, remove the soiled gloves, and put on a clean pair of gloves. The LPN failed to wash her hands between glove changes, as is an accepted practice within the standards of nursing practice. LPN #5 cleansed the wound with Normal Saline and 4x4 gauze, and then dried the wound with a gauze dressing. The LPN was observed to apply Santyl to the wound, cover the wound with Amerigel patch and dry 4x4 gauze, and then wrap the area with a gauze dressing and secure the dressing to the wound with tape. At that time, the nurse was observed to remove and discard the soiled gloves and wash her hands.</p> <p>An interview with LPN #5 on 08/04/11, at 9:35 AM, revealed the LPN had been employed by the facility for three years and had performed the duties of treatment nurse since 07/01/11. LPN #5 stated she was trained to wash hands before and after wound care, but was unaware of the need to wash hands between glove changes during the</p>	F 441		

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F 441	Continued From page 11 administration of wound care treatments.	F 441		
F 460 SS=C	<p>An interview with the Assistant Director of Nursing (ADON) conducted on 08/04/11, at 2:40 PM, revealed LPN #5 performed the duties of the treatment nurse. However, according to the ADON, she had not observed LPN #5's technique when the LPN performed wound care and dressing changes.</p> <p>483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY</p> <p>Bedrooms must be designed or equipped to assure full visual privacy for each resident.</p> <p>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure each bedroom was designed to assure full visual privacy for each resident. Observations of all resident rooms in the facility revealed that privacy curtains did not provide full visual privacy.</p> <p>The findings include: Observations during the initial tour on 08/02/11, and throughout the survey, revealed that privacy curtains in resident rooms were hung in the middle of the room and did not extend past the foot of the beds. Even though curtains could be</p>	F 460	Please See Attachment	

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

PRINTED: 09/02/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2011
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633	
(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 460	Continued From page 12 extended, the residents could view each bed in a mirror located in the room. Observations of resident rooms 3, 7, 15, and 20 revealed the rooms had four beds each (A, B, C, and D), and the D beds, located near the door, did not have privacy curtains located around the foot of the bed to ensure privacy if the entrance door to the room was opened. An interview with Certified Nursing Assistant (CNA) #5 on 08/03/11, revealed the CNA had been employed by the facility for two years and the privacy curtains had always been too short and failed to provide each resident privacy. An interview with the Environmental Services Supervisor (ESS) on 08/04/11, revealed the ESS was unaware the curtains did not provide full visual privacy for each resident. An interview with the facility's Administrator on 08/04/11, revealed the Administrator was unaware the privacy curtains did not provide full visual privacy for every resident.	F 460		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	Please See Attachment	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633	
(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 514	<p>Continued From page 13 preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain accurate clinical record information related to code status for one of twenty-four sampled residents (Resident #4). A review of the medical record revealed physician's orders that Resident #4 had a resuscitation status of "Full Code" (full resuscitative measures). However, a review of the Comprehensive Care Plan revealed Resident #4's resuscitation status was "Do not Resuscitate" (DNR).</p> <p>The findings include:</p> <p>A review of the facility policy (undated) revealed documentation for each resident was to be kept current and in binders located at the nurses' station. The policy revealed Pharmacy would provide copies of physician's orders on a monthly basis for each resident in the facility. According to policy, a nurse would review the order, verify the orders were correct, and then send the orders to the physician's office for the physician's verification and signature.</p> <p>A review of a document dated 06/17/11, entitled Power of Attorney, in Resident #4's medical record revealed the resident's designated Power of Attorney (POA) had determined the resident's resuscitative status was "DNR."</p> <p>A review of a care plan developed by facility staff</p>	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
(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 514	<p>Continued From page 14</p> <p>dated 06/28/11, revealed Resident #4 had a resuscitation status of "DNR." In addition, an observation of the exterior of the resident's medical record and signage (red dot) on the door to Resident #4's room revealed the resident's resuscitation status was "DNR." However, a review of physician's orders for June 2011 and July 2011 revealed Resident #4's resuscitative status was "Full Code."</p> <p>State Registered Nurse Aide (SRNA) #4 was observed to provide care to Resident #4 on 08/04/11. Interview with the SRNA on 08/04/11, at 1:15 PM, revealed the "red dot" on the door to Resident #4's room indicated the resident's resuscitative status was "DNR."</p> <p>Observation on 08/04/11, revealed SRNA #7 also provided care to Resident #4. Interview with SRNA #7 on 08/04/11, at 1:00 PM, also revealed the "red dot" on the door to Resident #4's room indicated the resident's resuscitative status was "DNR."</p> <p>Interviews with Registered Nurse #1 and Registered Nurse #2 on 08/04/11, at 8:45 AM, revealed they were responsible for the development of resident care plans and revealed Resident #4 had been admitted to an acute care facility and upon the resident's return to the facility (date unable to be recalled by the nurses) it was "understood" that Resident #4's resuscitative status had changed from "Full Code" to "DNR." The nurses stated the resident's resuscitative status had been changed on the care plan but a physician's order had not been written. According to the nurses, "It (the resuscitative status) should be a physician's order, because we would need to</p>	F 514		

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: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2011
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
(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 514	Continued From page 15 be following physician's orders."	F 514			

Hicks Golden Years Nursing Home

F221

483.13 Please accept our credible allegation of compliance

Physical Restraints

1. Resident #9 has been assessed and a medical symptom established to support the use of a lap buddy. An assessment for the use of the reclining geri chair has been completed for resident #10. Resident # 8 has had an assessment done related to the use of the lap buddy. Clinical records for residents # 8,9 and 10 have been reviewed for proper restraint documentation and those found not in compliance have had the proper documentation completed and placed in their clinical records.
- 2 The following things are being done to identify residents who may be affected by the deficient practice:
 - a. All residents are being assessed. (See pre-restraining assessment)
 - b. Any residents who are found to be affected by this, will be pre-screened by P.T. (see rehab referral)
 - c. If they are found to have a medical or physical symptom that requires some type of device, the family will be notified to sign a consent form. (see consent form)
 - d. Physician's order will include the presence of a medical condition. (see physician order form)
 - e. Documentation will be placed in the medical records.
 - f. Care plans will be updated.
 - g. Restraints will be checked q 30 min and released q 2 hours. Charting will be done q shift.
 - h. Restraint elimination assessments will be done quarterly so the least restrictive device will be used.
3. Policies and Procedures have been updated. (see attachments)
Inservices are being conducted to inform employees all policies, procedures, pre-screening, charting, proper use of restraints, and that no restraints will be applied until all pre-screening is done and consent signed by family and Physicians orders given. Inservices are being done with all Nurses and nursing assistants. All new employees will be inserviced at the time of hire.
4. Assessments will be done by LPN's. Assessments will be done initially and then quarterly or if there has been a change of condition they will be done more frequently. This will be monitored by Amy Huff RN QA coord.
5. A restraint committee has been formed to monitor all residents who have restraints or any changes that may need to be made to the policies and procedures. Any changes will be made by the committee. They will meet monthly. The committee consists of the following:
Amy Huff RN QA coord, Debbie Tucker RN Don
Glenda Turner Rn Asst DON, Lila Hancock Rn, MDS Coord
Kila Tucker Rn, Lorene Brummett, LPN Supervisor
Stephanie Dick, Physical Therapist Assistant and Dir of Therapy Dept.
6. Amy Huff, RN, Coord for QA will monitor the following monthly:
 - a. All residents who are currently using devices.
 - b. Monitoring to make sure all consents and Physicians orders are in place.
 - c. That pre-restraining assessments are being done.
 - d. That all residents have a medical or a physical symptom that requires devices.
 - e. That all residents are being monitored, that they are being charted on, and that elimination assessments are being done quarterly to see if device can be d/c or decrease to a less restrictive device. She will monitor that restraints are being checked q 30 mins and released q 2 hours.
 - f. That the restraint committee will meet at least quarterly. Any changes will be followed through such as the residents medical records, care plans, etc.
 - g. Assessments will be monitored monthly to ensure assessments are being done timely and correctly by LPN's.
(see QA monitoring form)
7. This will be monitored for one year.
8. Completion date: 9-18-2011

Hicks Golden Years Nursing Home

F226
483.13

(Develop/Implement Abuse/Neglect, ETC Policies)

1. Please accept our credible allegation of compliance .
The facility has completed a Nurse Aide/Abuse Registry back ground check on employee #6 with documentation of this being placed in the employee's personnel file.
2. All files of current employees will be reviewed to ensure a Nurse Aide/Abuse Registry background check has been completed and is in their current personnel file.
3. Policies and procedures will be reviewed and revised as indicated to ensure all employees prior to hire has a Nurse Aide/Abuse Reigstry background check done. Staff will be inserviced on performing back ground checks on all individuals prior to employment. (see attachment C)
4. Amy Huff Rn Q.A. Coord. will monitor monthly all new employees to ensure that all background checks has been done appropriately. This will prevent any deficient practice from occuring. All employee records have been checked to assure all background checks have been made according to our policies. Courtney Lee, office secretary will assist in this monitoring.
The following will be checked:
 - a. Abuse Registry for Nursing Department
 - b. Criminal background checks-local Police Department
 - c. Criminal background check-State Police Department
 - d. All appropriate checks are in employees files.Q.A. will monitor all employees that require background checks for Abuse/Neglect Registry for one year.

Monthly Q.A. reports will be gone over with the Q.A. committe monthly.

Darrell Hicks Adm.
Debbie Tucker RN DON
Glenda Turner RN Asst DON
Amy Huff RN Q.A. Coord.
Dr Stephanie Southard MD-Medical Director (when available)
Lila Hancock Rn, MDS Cordinator
Rhonda Decker Soc/Act Director
Alta McGinnis Med Records Coord

Completion date: 9-18-2011

Hicks Golden Years Nursing Home

F248

483.15 Please accept our credible allegation of compliance

1. Activity department has conducted activity assessments on the following residents: #18, #19, #14, #20, #21, #22, #23 to find out their current interests and preferences in activities. Changes have been made to include these in our activity program for weekends. (see attachments)
2. Schedules have been changed to assure that activities will be offered 7 days a week to group and in room residents. (see staff schedules for August and September)
3. All other residents are being assessed to ensure that their interests and preferences for activities so that they will receive activities of their choice. Their requests will be incorporated into the program to assure that they will all receive activities that will help with their mental, physical and psychosocial well being. All residents will be offered group activities or in room, one on one to meet their needs. This will be provided 7 days a week.
4. All activity assessments will be updated quarterly (with MDS) to see if desires or needs have changed. These will be monitored by Rhonda Decker Soc/Act Coord on a ongoing bases.
5. Activity assessments will be done by Rhonda Decker with all new residents as they enter the nursing facility, to ensure they will have appropriate activities of their choice. (see attachment)
6. Activity personnel will monitor attendance and participation daily for residents involved in any type of activity, whether it be group or in-room activity. (see attachment)
7. Activity choices will also be discussed at the Monthly Resident Council meetings to see if the residents are happy with activities, especially on weekends.
8. Q.A. Coord., Amy Huff RN, will monitor monthly to insure that residents choices are being incorporated into the activity program. She will monitor the following:
 - a. Activities are being offered 7 days a week.
 - b. Interviews will be done monthly with 9 residents to see if they are happy with their choices.
 - c. Any complaints that the residents have will be addressed with Rhonda Decker, Soc/Act Coord
 - d. Will monitor daily participation sheets
 - e. Rhonda Decker Soc/Act Coord will assist with monitoring.
 - f. Quarterly activity assessment will be monitored to assure they are being done timely and correctly.
 - g. Report will be reviewed by the Q.A. committee monthly. Committee includes the following:

Darrell Hicks Adm.
Debbie Tucker RN DON
Glenda Turner RN Asst DON
Amy Huff RN Q.A. Coord.
Dr Stephanie Southard MD-Medical Director (when available)
Lila Hancock Rn, MDS Cordinator
Rhonda Decker Soc/Act Director
Alta McGinnis Med Records Coord

9. Completion date: 9-18-2011

F441

483.65

(Infection control)

- 1) **The treatment nurse will be in serviced on accepted standards of practice in hand washing technique when performing wound care for residents #3 and #18.**

The wound care treatment nurse will be in-serviced on washing her hands between glove changes when performing treatments for residents # 3 & # 18.

- 2) **All nursing staff will be in serviced on proper hand washing technique in accordance with accepted standards of practice.**

Nursing staff will be in-serviced on washing hands between glove changes when performing wound care.

- 3) **Policies & procedures on hand washing technique will be reviewed & revised as indicated.**

- 4) **Quality Assurance will monitor hand washing during wound care monthly to ensure proper technique is being performed.**

- 5) **Completion date 9-18-2011**

F460
483.70

(Bedrooms assure full visual privacy)

- 1) Resident rooms 3, 7, 15, & 20 have been measured & the tracking & curtains ordered. These curtains & tracking are to be placed so the D beds located in these rooms will have full visual privacy when the entrance door to the room is opened.
Curtains have been ordered & will be placed in the middle of residents rooms so they will extend past the foot of the beds ensuring residents cannot be viewed in the mirror located in the room.
- 2) All resident rooms have been checked & curtains & tracking ordered for those rooms that did not provide full visual privacy for each resident while care is being performed.
- 3) Policies & procedures on visual privacy for residents will be reviewed & revised as indicated.
Staff will be in serviced on providing visual privacy for each resident while care is being provided.
- 4) Quality assurance will monitor monthly to ensure visual privacy is provided for all residents while care is being provided.
- 5) Completion date 07/18/11.

Hicks Golden Years Nursing Home

**F514
483.75**

Records-Code Status

Please accept our credible allegation of compliance 9-18-2011

- 1. The clinical records of resident #4 has been reviewed and measures taken to ensure the code status on the physician's orders and the care plans are correct and reflect the wishes of the resident's power of attorney. Resident #4 code staus in the clinical record, physicians order care plan as well as the symbol on the door and bed have all been corrected to match and reflect the residents power of attorneys wishes.**
- 2. Clinical records for all residents will be reviewed to ensure physicians orders and care plans reflect their current code status.**
- 3. Staff will be inserviced on obtaining orders for resident's code status. Policies and procedures relating to residents code status will be reviewed and revised as indicated.
(see attachment H)**
- 4. Quality assurance Coord, Amy Huff Rn will be monitoring all new admissions, and re-admissions to ensure that all Code Status preference is correct and is the resident's and/or families desires. All new orders will be monitored daily by nurse checking all new orders. Changes will be made to all medical records at that time. 30 day orders will be monitored monthly by Medical records LPN. (all current residents orders have been checked to make sure their Code Status preference is correct.)**

Amy Huff RN, Q.A. Cord. will be monitoring all changes monthly. She will continue to monitor this for 1 year to assure that this problem does not re-occur.

Report will be gone over with Q.A. committee monthly. This includes the following:

**Darrell Hicks Adm.
Debbie Tucker RN DON
Glenda Turner RN Asst DON
Amy Huff RN Q.A. Coord.
Dr Stephanie Southard MD-Medical Director (when available)
Lila Hancock Rn, MDS Cordinator
Rhonda Decker Soc/Act Director
Alta McGinnis Med Records Coord**

- 5. Date completed: 9-18-2011**

PHYSICAL RESTRAINT ELIMINATION ASSESSMENT

INSTRUCTIONS: Restrained individuals should be reviewed AT LEAST QUARTERLY to determine whether or not they are candidates for restraint reduction, less restrictive restraining measures, or total restraint elimination. For each category listed below, assess the resident by circling the corresponding score(s) that best describe his/her current status in the appropriate assessment column. Add the column of numbers to obtain the total score. **Continue evaluation and review on the reverse.**

CATEGORY OF EVALUATION	ASSESSMENT DATE				COMMENTS		
	/	/	/	/			
PHYSICAL FUNCTIONING							
AMBULATION							
Complete bedrest/Chairbound	3	3	3	3			
Non-ambulatory/Wheelchair mobile c assist	2	2	2	2			
Ambulates with assist of two	2	2	2	2			
Ambulates with assist of one	1	1	1	1			
Independent with cane, walker, or wheelchair	0	0	0	0			
WEIGHT BEARING/TRANSFER							
Non-weight bearing	2	2	2	2			
Partial weight bearing/assist of one for transfer	1	1	1	1			
Full weight bearing/no assist for transfers	0	0	0	0			
BED MOBILITY							
Use of assistive device to turn side to side	1	1	1	1			
Totally immobile and unable to change position without assist	0	0	0	0			
SITTING BALANCE							
Leans to a side, forward, backward	3	3	3	3			
Slides down	2	2	2	2			
Normal sitting balance	0	0	0	0			
ADLs (Bathing, dressing, grooming)							
Requires total assist of two	3	3	3	3			
Requires total assist of one	2	2	2	2			
Requires minimal supervision	1	1	1	1			
Self care	0	0	0	0			
PHYSICAL LIMITATIONS							
Contractures/Paralysis	3	3	3	3			
Amputations/Prosthesis	3	3	3	3			
Feeding tube/IV, Foley, continuous oxygen	3	3	3	3			
History of vertigo, hypotension, seizures	3	3	3	3			
History of falls	3	3	3	3			
Significant weight loss	3	3	3	3			
No physical limitations	0	0	0	0			
VISION STATUS							
Legally blind	3	3	3	3			
Poor with glasses	2	2	2	2			
Adequate with glasses/without glasses	0	0	0	0			
ORIENTATION							
Disoriented (x 3 spheres)	3	3	3	3			
Disoriented (x 2 spheres)	2	2	2	2			
Forgetful/Short attention span	1	1	1	1			
Oriented to time, place and person	0	0	0	0			
COMPREHENSION							
Unable to follow simple directions	2	2	2	2			
Directions must be frequently repeated	1	1	1	1			
Follows directions	0	0	0	0			
BEHAVIOR/MOOD							
Combative/Severely agitated	3	3	3	3			
Exhibits/Expresses fears or anxieties	2	2	2	2			
No fears or anxieties expressed	0	0	0	0			
ACTIVITY PARTICIPATION							
Unable to actively participate	2	2	2	2			
Participates with assistance	1	1	1	1			
Participates independently	0	0	0	0			
MEDICATION THERAPY							
Currently taking antipsychotics	5	5	5	5			
Currently taking antidepressants	5	5	5	5			
Currently taking anti-anxiety	5	5	5	5			
Not taking any chemical restraint	0	0	0	0			
RECORD TOTAL SCORE HERE					0-20 Priority Candidate	21-35 Good Candidate	35+ Poor Candidate

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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NAME--Last

First

Middle

Attending Physician

Record No.

Room/Bed

FIRST ASSESSMENT

1. Candidate status as determined by TOTAL SCORE on reverse. Priority Good Poor

2. Candidate for restraint reduction or elimination program? Yes No Plan of Care Updated Yes No

If Yes; Date program to start ____/____/____ Restraint consent signed? Yes No

Action Plan _____

Less restrictive measures to be used _____

If No; State specific reason, medical symptoms or targeted behavior _____

3. Additional Comments _____

Nurses Signature _____ Review Date ____/____/____

SECOND ASSESSMENT

1. Candidate status as determined by TOTAL SCORE on reverse. Priority Good Poor

2. Candidate for restraint reduction or elimination program? Yes No Plan of Care Updated Yes No

If Yes; Date program to start ____/____/____ Restraint consent signed? Yes No

Action Plan _____

Less restrictive measures to be used _____

If No; State specific reason, medical symptoms or targeted behavior _____

3. Additional Comments _____

Nurses Signature _____ Review Date ____/____/____

THIRD ASSESSMENT

1. Candidate status as determined by TOTAL SCORE on reverse. Priority Good Poor

2. Candidate for restraint reduction or elimination program? Yes No Plan of Care Updated Yes No

If Yes; Date program to start ____/____/____ Restraint consent signed? Yes No

Action Plan _____

Less restrictive measures to be used _____

If No; State specific reason, medical symptoms or targeted behavior _____

3. Additional Comments _____

Nurses Signature _____ Review Date ____/____/____

FOURTH ASSESSMENT

1. Candidate status as determined by TOTAL SCORE on reverse. Priority Good Poor

2. Candidate for restraint reduction or elimination program? Yes No Plan of Care Updated Yes No

If Yes; Date program to start ____/____/____ Restraint consent signed? Yes No

Action Plan _____

Less restrictive measures to be used _____

If No; State specific reason, medical symptoms or targeted behavior _____

3. Additional Comments _____

Nurses Signature _____ Review Date ____/____/____

PHYSICAL RESTRAINT ELIMINATION ASSESSMENT

RESTRAINT RELEASE RECORD

**PLEASE NOTE: Restrained individuals must be checked at least every 30 minutes.
In addition, restraints must be released for the purpose of exercise, toileting, etc. at least every two hours.**

REASON FOR RESTRAINT	RESTRAINT ORDERED (Circle)	REMOVAL REASON CODES
Waist Wrist Geri Chair Ankle Other _____	Pelvic Belt Vest Siderails 2 Full 1 Full 2 Half 1 Half	A-Supervised meals B-Supervised group activities C-Care provided by CNA D-One-to-one with volunteer E-One-to-one with social worker F-2-3 hrs. with periodic evaluation G-Total elimination of restraint H- _____ I- _____ J- _____

DATE	30 MINUTE CHECK WHEN RESTRAINED			RELEASE EVERY TWO HOURS FOR PERSONAL CARE			TOTAL HOURS RELEASED PER SHIFT AND REASONS (USE REASON CODES ABOVE)			COMMENTS/ RESIDENT'S RESPONSE (Negative or Positive)
	Shift Initials			Shift Initials						
	Month/	Year		11-7	7-3	3-11	11-7	7-3	3-11	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										

INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE

Additional Comments/Summary: _____

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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RESTRAINT RELEASE RECORD

PLEASE NOTE: Restrained individuals must be checked at least every 30 minutes.
In addition, restraints must be released for the purpose of exercise, toileting, etc. at least every two hours.

REASON FOR RESTRAINT	RESTRAINT ORDERED (Circle)	REMOVAL REASON CODES
	Waist Pelvic Siderails Wrist Belt 2 Full Geri Chair Vest 1 Full Ankle 2 Half Other 1 Half	A-Supervised meals B-Supervised group activities C-Care provided by CNA D-One-to-one with volunteer E-One-to-one with social worker F-2-3 hrs. with periodic evaluation G-Total elimination of restraint H- _____ I- _____ J- _____

DATE	30 MINUTE CHECK WHEN RESTRAINED			RELEASE EVERY TWO HOURS FOR PERSONAL CARE			TOTAL HOURS RELEASED PER SHIFT AND REASONS (USE REASON CODES ABOVE)			COMMENTS/ RESIDENT'S RESPONSE (Negative or Positive)
	Shift Initials			Shift Initials						
Month/Year	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	
17										
18										
19										
20										
21										
22										
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25										
26										
27										
28										
29										
30										
31										

INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE

Additional Comments/Summary: _____

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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Rehab Referral

Admission
 Quarterly
 Annual
 Other: _____

Name: Last	First	Middle	Attending Physician
------------	-------	--------	---------------------

(Check one box for each category)		
1. Unplanned significant weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Use of restraints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Pressure wounds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Impaired transfer status	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Positioning problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Impaired locomotion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Impaired bed mobility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Impaired ambulation/mobility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Impaired dressing skills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Splint indicated	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Decreased active/passive ROM	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Impaired toileting status	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Impaired personal hygiene skills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Impaired bathing skills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Impaired self-feeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Swallowing difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Altered diet consistency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Impaired communication status	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Impaired cognitive status	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. At risk for falls	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Recommended Evaluation

Physical therapy
 Occupational Therapy
 Speech Language Pathology
 N/A

COMMENTS:

Completed By: _____ Date: _____

Policy for Devices and Restraints

1. Prior to using any type of device or restraint that will restrict a residents movements, the following will be determined:
 - a. Assessment will be done.
 - b. The presence of a specific medical or physical symptom that requires the use of a device or physical restraint.
 - c. How the use of the device will treat the medical symptom.
 - d. How the use of the device will protect the resident's safety.
 - f. How the use of the restraint will assist the resident in attaining and/or maintaining their highest level of physical and psychosocial well-being
 - g. Physical Therapy will do pre-screening
2. Documentation of assessments, and pre-screening will be placed in the residents medical record. Care plans will be updated as indicated. Any ongoing assessments will be done timely and placed in medical records. Physicians orders will reflect the presence of a medical symptom. Consent forms signed by responsible party will be placed in medical records.
3. All Nursing Department will be inserviced at the time of hire and then yearly as indicated as to the proper use of devices. This will also include how to check q 30 minutes and release q 2 hours. They will also be inservice on how to accurately document. (nurses and nursing assistants)
4. Restraint committee will review monthly all residents who are in restraints or positioning devices to see if there has been a change that would require a new assessment to be completed. All changes will be made to residents medical record and care plans.
5. QA, Amy Huff, RN Coord, will monitor monthly to assure that the correct steps are being taken to assure that our residents are being monitored correctly and they are not being placed in restraints without the proper assessment and documentation.

Date implemented 9-5-2011

Procedure for Using Restraints

(complete the following steps for restraint usage)

1. Complete pre-restraining assessments on any resident prior to the placement of a restraint.
2. after the pre-restraining assessment is completed the resident and/or the residents responsible party is to be explained the potential negative outcomes and the risks associated with the use of restraints as well as the potential for positive outcomes associated with restraint usage.
3. Restraint orders are to be obtained by the physician, stating when and where the restraint is to be used as well as the medical symptom that is to be treated by the used of the restraint.
4. Physical restraint elimination/reduction assessments are to be completed on a quarterly bases.
5. Charting is to be done every shift on a restraint release record that will indicate the type of restraint, the reason for its use, and that the restraint is checked every 30 minutes and released every 2 hours.

Date Implemented 8-5-11

In-Service
(Required Documentation for Restraints)
(Restraint Policies & Procedures)

- 1) Restraint Policy
- 2) Restraint Consent Form
- 3) Restraint Order
- 4) Restraint Pre-Restraining Assessment
- 5) Restraint Reduction/Elimination Form
- 6) Daily Restraint Release Record

Signature of Individual Providing In-service: _____

Attendance:



Restraint Consent Form

Resident _____ Room # _____

Type of restraint to be used: _____

Where & when is restraint to be used:

Medical symptom that will be treated with restraint: _____

How restraint will treat medical symptom & assist resident in attaining or maintaining highest practicable level of physical or psychological well-being:

Potential negative outcomes of restraint use: declines in physical functioning, muscle condition, contractures, increase incidence of infection, development of pressure ulcers, delirium, agitation, incontinence, may constitute an accident hazard, increase incidence of falls & head trauma R/T falls & other accidents (e.g., strangulation, entrapment), loss of autonomy, dignity, respect, may show signs of withdrawal, depression, or reduced social contact, can reduce independence, functional capacity & quality of life.

Potential negative outcomes & risks of restraint use as well as how the use of restraints will aide resident in attaining or maintaining his/her highest practicable level of physical or psychological well being has been explained to the resident &/or responsible party.

The use of this restraint will be reviewed periodically to determine if the resident is a candidate for restraint reduction or elimination.

Resident Signature Date

Responsible Party Signature & Relationship to resident Date

Witness Date

Witness Date

Restraint Orders

Resident _____ **Room #** _____

Type or restraint: _____

Time frame for restraint use:

- 1) **When is restraint to be used?** _____
- 2) **Where is restraint to be used?** _____

Medical Symptom being treated by use of restraint: _____

Physician Signature

Date

Quality Assurance Monitoring for Physical Restraints

1. List of residents who are currently using restraint devices:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. For the residents listed above, does each resident have a consent form signed by responsible party? Yes _____ No _____

If no, explain why: _____

3. For the residents listed above, does each resident have a restraint order with a medical symptom listed as to why the restraint is being used. Yes _____ No _____

If no, then explain why: _____

4. For the residents listed above, does each resident have a PRE-Restraining Assessment, Restraint Elimination Assessment, and a Restraint Release Record. Yes _____ No _____

If no, then explain why: _____

Date completed: _____
Signature of Q.A. Coord. _____
Date reported to DON _____
Date reported to Administrator _____
Date reported to QA Committee _____

Policy
(Restraints)

Prior to restraining a resident the following will be determined:

- 1) The presence of a specific medical symptom that requires the use of the restraint.
- 2) How the use of the restraint will treat the medical symptom.
- 3) How the use of the restraint will protect the resident's safety.
- 4) How the use of the restraint will assist the resident in attaining &/or maintaining their highest practicable level of physical & psychosocial well-being.

Documentation of medical symptoms that warrant the use of restraints will be documented in the resident's medical records, ongoing assessments & care plans.

Physicians orders is to reflect the presence of the medical symptom.

Residents who utilize restraints will be monitored for a systematic & gradual process toward reducing the usage of restraints as indicated.

Date Implemented 8-24-2011

Written by: Glenda Turner RN

Approved by: Debbie Tucker RN, DON

**Procedure for Using Restraints
(Complete the following steps for Restraint Usage)**

- 1) Complete pre-restraining assessments on any resident prior to the placement of a restraint.
- 2) In an emergency situation the pre-restraining assessment is to be completed as soon as possible.
- 3) After the pre-restraining assessment is completed the resident &/or the residents responsible party is to be explained the potential negative outcomes & risks associated with the use of restraints as well as the potential for positive outcomes associated with restraint usage.
- 4) Restraint orders are to be obtained stating when & where the restraint is to be used as well as the medical symptom that is to be treated by the use of the restraint.
- 5) Physical restraint elimination/reduction assessments are to be completed on a quarterly basis.
- 6) Charting is to be done every shift on a restraint release record that will indicate the type of restraint, the reason for its use, and that the restraint is checked every 30 minutes & released every 2 hours.

Date Implemented 8-5-2011
Written by: Glenda Turner RN
Approved by: Debbie Tucker RN, DON

Monthly Q.A. Monitoring for Abuse/Neglect Policies

1. Was all new employees background checks done timely and correctly:

Yes _____ No _____

2. If not, explain:

Date completed:

Q.A. signature:

Date D.O.N. notified

Date Administrator notified

Date reported to Q.A. committee:

attachment c

Policy/Procedure
(Nurse Aide/Abuse Registry Background Checks)

In an effort to safe guard residents background checks are to be done on all individuals prior to their hire or rehire.

- 1) The following background checks will be done on all potential employees:
 - A) Nurse aide abuse registry.
 - B) Criminal background check from the local police department.
 - C) Criminal background check from the state police department.
 - D) Check information from past & present employers if available.

- 2) A check list will be kept identifying the dates background checks were requested received, & placed in each employees file.

Revised by Glenda Turner RN, ADON on 8-23-2011
Approved by Kim Gibbons, Office Supervisor on 8-23-2011

ATTITUDE (PSYCHOSOCIAL WELL-BEING)

Attitude: Enthusiastic Cooperative Cheerful Willing to try Motivated Depressed Uncooperative Withdrawn
 Apathetic Dwells on illness/other problems

Attitude toward life and activities in general: Interested Disinterested

SPECIAL PRECAUTIONS, LIMITATIONS, CONSIDERATIONS

Diabetic Limited liquids Pureed or Soft Restraints _____ Combative Verbally Abusive Sexually Aggressive
 Alcohol limitations No cigarettes Assist in writing Assist in ADL's Heart problems CVA Pacemaker Cardiac dysrhythmias
 Prone to seizure Sun sensitive meds Wanders Allergies (describe) _____

Other comments _____

NAME: Last	First	Middle	Attending Physician	Record #	Room/Bed

QUARLERLY ACTIVITY EVALUATION

PREFERENCE INTERVIEW

Resident Family or significant other Staff

Show residents the response options and say: "While you are in this facility..." Enter codes in boxes. Coding: 1. Very important 2. Somewhat important 3. Not very important 4. Not important at all 5. Important but can't do or no choice 9. No response or non responsive

Interview for Daily Preferences	Interview for Activity Preferences
A. How important is it to you to choose what clothes to wear?	A. How important is it to you to have books, newspapers, and magazines to read?
B. How important is it to you to take care of your personal belongings or things?	B. How important is it to you to listen to music you like?
C. How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?	C. How important is it to you to be around animals such as pets?
D. How important is it to you to have snacks available between meals?	D. How important is it to you to keep up with the news?
E. How important is it to you to choose your own bed time?	E. How important is it to you to do things with groups of people?
F. How important is it to you to have your family or a close friend involved in discussions about your care?	F. How important is it to you to do your favorite activities?
G. How important is it to you to be able to use the phone in private?	G. How important is it to you to go outside to get fresh air when the weather is Good?
H. How important is it to you to have a place to lock your things to keep them safe?	H. How important is it to you to participate in religious services or practices?

ACTIVITY PURSUIT PATTERNS

(P- Past interest C- Current interest N- No interest)

*Specify type of activity on resident's plan of care (Example: Cards - Bridge)

P	C	N	ACTIVITY	P	C	N	ACTIVITY	P	C	N	ACTIVITY
			Cards				Spiritual/Religious activities				Golfing
			Games				Trips/Shopping				Helping Others/Volunteer work
			Crafts/Arts/Hobbies				Spending time outdoors				Parties/Social events
			Exercise/Walking/Jogging				Walking/Wheeling outdoors				Keeping up with the news
			Sports				Watching TV/Radio				Community outings
			Music				Watching Movies				Groups/Organizations
			Reading/Audio books				Gardening /Plants				Other:
			Writing				Talking/Conversing				Other:
			Baking/Cooking				Woodshop/Tool shop				Other:
			Computer				Hunting/Fishing				Other:

When would you prefer to participate in scheduled activities? Morning_ Afternoon Evening Night None of these: explain _____

Preferred activity setting: Own Room Day/Activities room Inside Facility/Off unit Outside Facility Other: _____

Do you take naps? YES NO If yes, what time of day and how long? _____

Would you like to have a service related job assignment? If yes, type _____

NAME: Last Middle	First	Attending Physician	Record #	Room/Bed
----------------------	-------	---------------------	----------	----------

Monthly attendance and participation record.

Individual Resident Activities

Code: 1 = Active Participation 2 = Passive Participation 3 = Encouragement Needed 4 = Independent 5 = Participates with assistance 6 = Refused/ Resisted																															
Activities	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Hobbies																															
Indoor Outdoor Walks																															
Spiritual/Religious																															
Music																															
Exercise																															
Groups / Organizations																															
Games (Type)																															
Sports																															
Arts and Crafts																															
Happy Hour / Coffee Time																															
Parties / Social Events																															
Shopping																															
Writing / Puzzle Books																															
Reads																															
Listens to Radio																															
Views Television																															
Watching Movies																															
Knits/Crochets/ Embroiders/Sews																															
Resident Council																															
Talking / Conversing																															
Distributes, Mail, Cards, Paper, Etc.																															
Special Interest																															
Gardening / Plants																															
Visits other Residents																															
Visits outside Home																															
Other																															
Cards																															
Trips																															

Activity Policy

1. Initial activity assessments will be completed on each new admission to determine their interests and needs.
2. Each resident will be provided an ongoing program of activities that is designed to appeal to his or her interests as determined by the initial activity assessment. This will be provided 7 days a week.
3. Residents will be provided activities on an on going basis to promote or enhance their highest practicable level of mental, physical, and psychosocial well being.
4. Initial activity assessment will include past and current interests. They will be updated quarterly to see if their interests have changed or their ability to be involved. Changes will be made to accomodate the resident in what ever their need is. Rhonda Decker, Activity Director will monitor the assessments and change the residents activity program to meet their specific need.
5. Activities will be provided as group activities or in room, as a one on one activity. Residents will be encouraged to participate in either one. This will be provided 7 days a week.
6. Individual attendance and participation forms will be filled out daily on each resident in the facility. These will be monitored to see if there is a change in a residents participation. This will be preformed 7 days a week
7. Activities will be provided by staff seven days a week.
8. Activity calenders that reflect resident's current interests will be posted monthly.
9. Activities will be discussed monthly at the Resident's Council Meetings to see if there are any problems. or any changes they would like to see with activities.
10. Q.A. will monitor monthly to insure the residents needs for activities are being met. Interviews will be held monthly to see that their interests are being included in the present activity program.

Revised 9-5-2011

mead®

sunday

Rhonda
Marsha
Pam
Emily
Monday

tuesday

Astutsky Schedule

wednesday

thursday

friday

saturday

August

213/152
week 31
CINR Holiday (C)
First of Ramadan

219/146
week 32

8 220/145

9 221/144

10 222/143

11 223/142

12 224/141

13 225/140

226/139
week 33

15 227/138

16 228/137

17 229/136

18 230/135

19 231/134

20 232/133

233/132
week 34

22 234/131

23 235/130

24 236/129

25 237/128

26 238/127

27 239/126

240/125
week 35

29 241/124

30 242/123

31 243/122
(Eid) al Fitr

Rhonda
Marsha
Pam
Emily

Marsha
Pam
Emily

Marsha
Rhonda
Pam
Emily

Marsha
Rhonda
Emily

Marsha
Rhonda
Pam

July 2011
S M T W T F S
1 2 3
4 5 6 7 8 9
10 11 12 13 14 15 16
17 18 19 20 21 22 23
24 25 26 27 28 29 30
31

September 2011
S M T W T F S
1 2 3
4 5 6 7 8 9 10
11 12 13 14 15 16 17
18 19 20 21 22 23 24
25 26 27 28 29 30

MM4450-10

mead®

sunday

Rhonda
Marsha
Pam
Emily
Monday

tuesday

wednesday

thursday

friday

saturday

Activity Schedule

September

August 2011
S M T W T F S
1 2 3 4 5 6
7 8 9 10 11 12 13
14 15 16 17 18 19 20
21 22 23 24 25 26 27
28 29 30 31

October 2011
S M T W T F S
1
2 3 4 5 6 7 8
9 10 11 12 13 14 15
16 17 18 19 20 21 22
23 24 25 26 27 28 29
30 31

247/118
week 36

Marsha

5 248/117
Labor Day (C, US)

Rhonda
Emily
Pam

6 249/116

Marsha
Emily
Rhonda
Pam

7 250/115

Marsha
Emily
Rhonda

8 251/114

Marsha
Pam
Rhonda

9 252/113

Marsha
Pam
Rhonda

253/112

Pam

254/111
week 37
Patriot Day (US)

Pam

12 255/110

Marsha
Emily
Rhonda

13 256/109

Marsha
Emily
Rhonda

14 257/108

Marsha
Emily
Rhonda

15 258/107
Declaration of
Independence (M)

Marsha
Pam
Rhonda

16 259/106
Independence Day
(M)

Marsha
Rhonda

260/105

Pam

261/104
week 38

Pam

19 262/103

Marsha
Emily
Rhonda

20 263/102

Marsha
Emily
Rhonda

21 264/101

Marsha
Emily
Rhonda
Pam

22 265/100

Marsha
Rhonda

23 266/099
Autumn begins

Marsha
Pam
Rhonda

267/098

Rhonda

268/097
week 39

Rhonda

26 269/096

Marsha
Emily
Pam

27 270/095

Marsha
Emily
Pam

28 271/094
Rosh Hashanah
begins at sundown

Marsha
Emily
Pam

29 272/093
Rosh Hashanah

Marsha
Pam

30 273/092

Pam
Emily

Quality Assurance Monitoring for Activities

Date: _____

1. Are all activities being provided 7 days a week: Yes _____ No _____

2. List of Resident's interviewed concerning activities and interests being met monthly.

_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Complaints from the Residents concerning activities: _____

4. Was daily monitoring of residents participation in activities done: Yes _____ No _____
If no, explain why: _____

5. Is quarterly activity assessment being done: Yes _____ No _____
If no, explain why _____

Date completed: _____

Date reported to D.O.N: _____

Date reported to Administrator: _____

Date reported to Activity Director: _____

Date reported to Q.A. Committee: _____

Activity Policy

- 1) Initial activity assessments will be completed on each new admission to determine their interests & needs.
- 2) Each resident will be provided an ongoing program of activities that is designed to appeal to his or her interests as determined by the initial activity assessment.
- 3) Residents will be provided activities on an on going basis to promote &/or enhance their highest practicable level of mental, physical and psychosocial well being.
- 4) Initial activity assessments will include residents past & current interests.
- 5) Activity assessments will be up dated quarterly &/or as indicated to ensure any change in interest has been identified.
- 6) Activities will be provided daily to residents as they tolerate.
- 7) In room activities will be provided to residents who are unable to attend out of room activities.
- 8) Individual participation forms will be completed on residents to maintain a record of activities attended.
- 9) Activities will be provided by staff seven days a week.
- 10) Activity calendars that reflect resident's current interests will be posted monthly.

Revised on 8-23-2011

Written by Glenda Turner RN, ADON

Approved by Debbie Tucker RN, DON

Approved by Rhonda Decker, Activity Director

Individual Resident Activities

Attachment 5

Code: 1 = Active Participation 2 = Passive Participation 3 = Encouragement Needed 4 = Independent 5 = Participates with assistance 6 = Refused/Resisted																															
Activities	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Hobbies																															
Indoor Outdoor Walks																															
Spiritual/Religious																															
Music																															
Exercise																															
Groups / Organizations																															
Games (Type)																															
Sports																															
Arts and Crafts																															
Happy Hour / Coffee Time																															
Parties / Social Events																															
Shopping																															
Writing / Puzzle Books																															
Reads																															
Listens to Radio																															
Views Television																															
Watching Movies																															
Knits/Crochets/ Embroiders/Sews																															
Resident Council																															
Talking / Conversing																															
Distributes, Mail, Cards, Paper, Etc.																															
Special Interest																															
Gardening / Plants																															
Visits other Residents																															
Visits outside Home																															
Other																															
Cards																															
Trips																															
					</																										

Policy
(Washing Hands during Wound Care)

- 1) Prior to starting dressing change wash hands
- 2) Apply clean gloves.
- 3) Prepare dressing supplies
- 4) Remove soiled dressing.
- 5) Remove soiled gloves
- 6) Wash hands
- 7) Apply clean gloves.
- 8) Clean wound.
- 9) Remove soiled gloves.
- 10) Wash hands.
- 11) Apply clean gloves
- 12) Dress wound
- 13) Remove soiled gloves
- 14) Wash hands

Revised on 8-25-2011
Revised by Glenda Turner RN
Approved by Debbie Tucker RN, DON

Attachment G

Policy
(Providing Full Visual Privacy for Residents)

Ceiling suspended curtains will be maintained in each residents room to ensure they have full visual privacy from other individuals while care is being provided &/or as the resident desires.

Full visual privacy will be provided by the staff while care is being provided.

Curtains &/or tracking will be supervised & maintained by the Housekeeping Supervisor & the Maintenance department.

Written by Glenda Turner RN
Approved by Debbie Tucker RN, DON
Date Implemented 8-23-2011

Quality Assurance-Changes in Code Status

Date: _____

Residents name: _____

What does the new order say: _____

Make changes to the following:

Medical records _____

Care plans (resident, CNA book, room care plans) _____

Door _____

Bed _____

Name: _____

Date: _____

Please give to Amy Huff Rn Q.A. Coord

Monthly Q.A. Code Status Monitoring Form

Date: _____

Names of New admits and Re-admits

Code status monitoring checked and reviewed for accuracy on all new admits and re-admits: Yes _____ No _____

Was all 30 day orders checked for correct Code Status:
Yes _____ No _____

Was all new orders checked for change in Code Status:
Yes _____ No _____

Was any problems identified: Yes _____ No _____

Explain: _____

Q.A. signature: _____

Date D.O.N. notified: _____

Date Administrator notified: _____

Date reported to Q.A. committee: _____

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

PRINTED: 08/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633
---	--

(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
--------------------	--	---------------	---	----------------------

DEFERRED
 Division of Health Care
 Southern Enforcement Branch

K 000	INITIAL COMMENTS	K 000		
	<p>TYPE OF STRUCTURE: 1977 One-story unprotected frame Type 111(211) with a complete automatic sprinkler system throughout.</p> <p>A life safety code survey was initiated and concluded on April 21, 2011. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>			
K 052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility</p>	K 052	<p>Please accept our credible allegation of complainece. 8-25-11</p> <p>The five fire doors identified will be changed so they cannot be reset while the facility fire alarm is still showing fire conditions. The fire alarm system will be updated to ensure it funcnctions in accordance with the NFPA standards.</p> <p>Policies and procedures will be reviewed and revised as indicated. Quality Assurance will monitor monthly to ensure fire doors are</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		8/26/2011

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.

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

PRINTED: 08/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2011
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 052	<p>Continued From page 1</p> <p>failed to ensure the building fire alarm system functioned as required by NFPA standards. This deficient practice affected five of five smoke compartments, staff, and all the residents. The facility has the capacity for 60 beds with a census of 58 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 08/02/11, at 3:15 PM, with the Director of Maintenance (DOM), a test of the facility fire alarm system revealed the fire doors would close when the alarm was activated but could be reset while in the silent mode to the open position while the system was still showing fire conditions. An interview with the DOM on 08/02/11, at 3:15 PM, revealed the DOM was not aware fire doors should not be able to be reset while the fire alarm system was still showing fire conditions.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.</p>	K 052	<p>working.properly.</p> <p>Completion date 8-25-11</p> <p>See Attachment I and J</p>		

Policy
(Fire Doors)

- 1) Fire doors will be monitored on going to ensure they can not be reset while the fire alarm system is showing fire conditions.
- 2) Fire alarm system will be checked periodically by the SimplexGrinnell Company to ensure it is working properly.
- 3) Facilities maintenance department will perform routine fire drills.
- 4) During routine fire drills maintenance personnel will ensure fire alarm system is working correctly.
- 5) Maintenance personnel will notify SimplexGrinnell if a problem is noted with the fire alarm system.

Revised on 8-25-2011

Written by Glenda Turner RN

Approved by Delbert Denney, Maintenance Department Supervisor

