

Resident will often request T (Hx CVA & some cognitive deficits). Assessed SRA & 4 RIT moving of legs while sleeping & leg often sliding OOB can cause risk for coming OOB unintended, some rigid and spastic movements noted.

Resident #16
Attachment #16
Room # 147-1

Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

Attachment #16
 Resident #16
 Room 147-1

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev. Recopy 9/20/08	NON-RESTRICTIVE SIDE RAILS Resident cannot self transfer	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	NSG Rehab	mm EB	12/08	

PROBLEMS OR INJURIES AND DOCUMENT



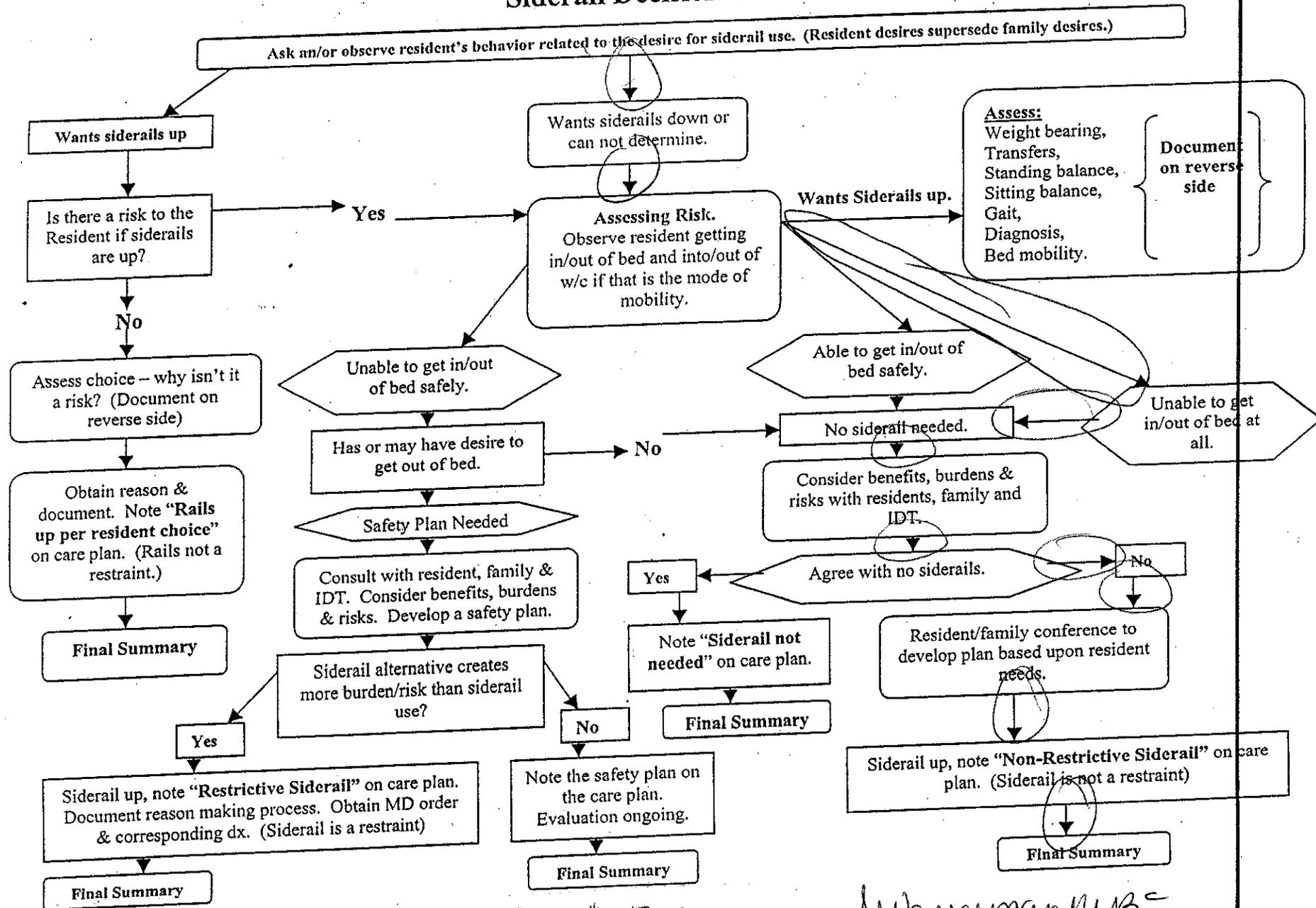
Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

Attachment # 16
 Resident # 16
 Room # 147-1

Non Restrictive Side Rails

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
12/08	Careplan Review	Continue	Continue	NSG	mm	3/09	
Rev 3/09	Careplan Review	Continue	Continue	NSG	mm	6/09	
5/16/09	Transfer Acute ER						
5/22/09	Re-admit SUF						
6/20/09 Rev	Cont	Cont	Cont	NSG	SW	9/20/09	
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	
Rev 9/10	Cont	Cont	Cont	NSG	SW	12/10	
11/30/10	Cont OEP x 4 RIT assist turns nonrestrictive clothes not attempt OOB by self may have uncontrolled leg movement & risk of limb OOB unintentional	Cont	Cont	NSG	SW		

Siderail Decision Tree



Resident #17

Attachment #17

Resident Name: Room #147-2

Nurse sign: *S. Wasserman*

Date: 11/30/10

SRT x 4 educated family R/H risks and hazards of both options ↑ risk ↓ skills down. Resident does not attempt OOB by self is noted to have Hx seizures and Hx C. Palsy. Due to her medical conditions she is noted to have severe uncontrolled spastic movements at times. SRT x 4 and padded. Does not prevent free willful movements

Resident #17
Attachment #17
Room #147-2

Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

Attachment #17
 Resident #17
 Room # 147-2

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Review + rccopy 8-11-08	NON-RESTRICTIVE SIDE RAILS ↑ x4 R/H C. Palsey, and Hx of Seizure activity. (Padded SR) Does not attempt OOB but does have uncontrolled muscle movement R/H C. Palsey	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	11-08	

PROBLEMS OR INJURIES AND DOCUMENT



Attachment #17

Resident #17

Room 147-2

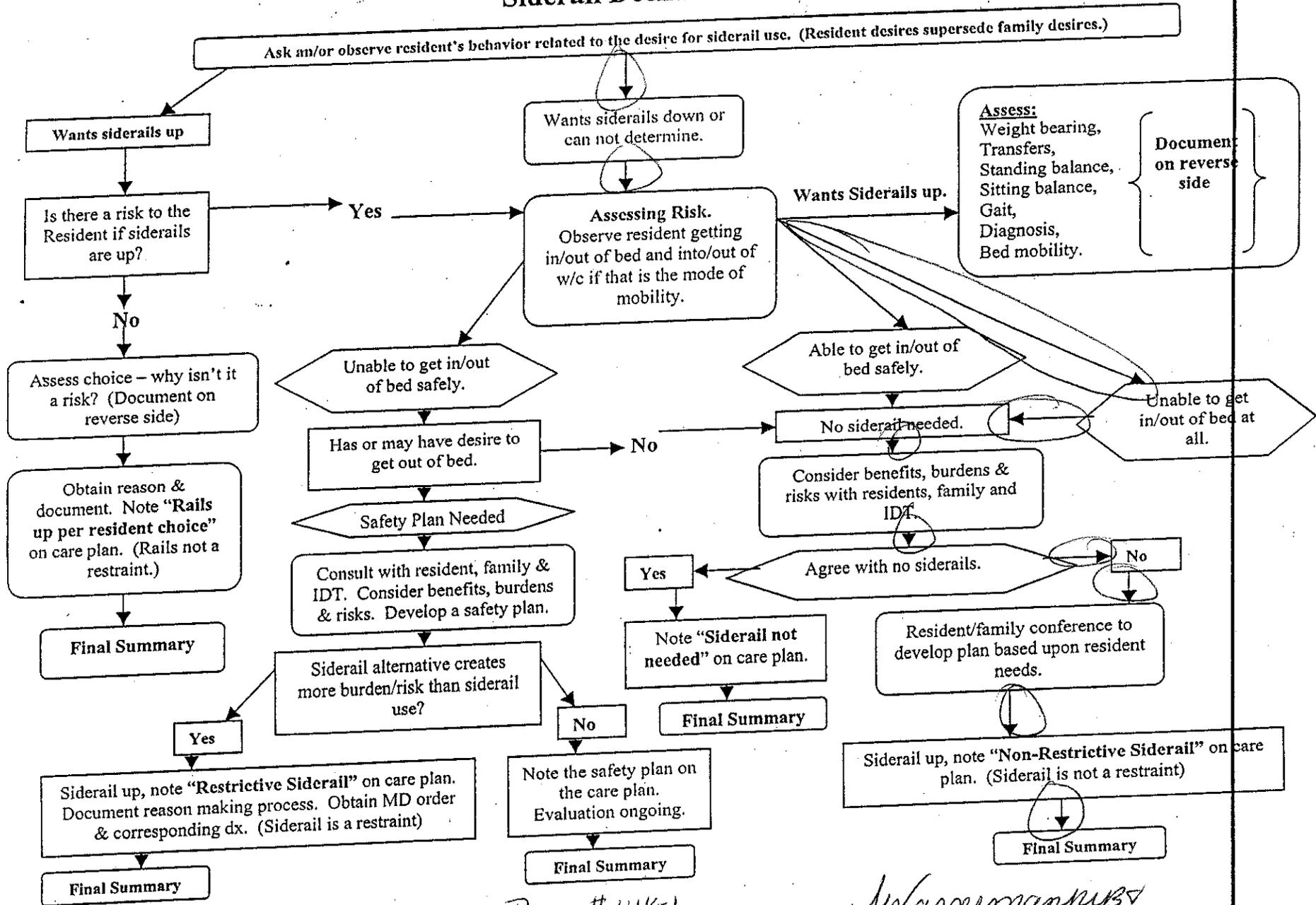
Appalachian Regional Healthcare, Inc.

Interdisciplinary Plan of Care

Non Restrictive Side Rails

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev 11/08	Continue	Cont.	Continue	NSG	mm	2/09	
Rev 2/09	Continue	Cont.	Continue	NSG	mm	5/09	
5/09 REV	Cont	cont	cont	NSG	sw	8/09	
Rev 8/09	Cont	cont	cont	NSG	sw	11/09	
Rev 11/09	cont	cont	cont	NSG	sw	2/10	
Rev 2/10	cont	cont	cont	NSG	sw	5/10	
Rev 5/10	cont	cont	cont	NSG	sw	8/10	
Rev 8/10	cont	cont	cont	NSG	sw	8/10 11/10	

Siderail Decision Tree



Resident #18

Attachment #18

Resident Name: Room #148-1
 Date: 11/30/10

Nurse sign: *Wassermann*

SR T x 4 (educated R/H risks - family) R/H dx C. Palsey
and and uncontrolled spastic movements. Side rails padded
and T x 4 do not prevent free movement but can
prevent harm R/H spastic movements.

Resident # 18
Attachment # 18
Room # 148-1

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

*Attachment #18
Resident #18
Room # 148-1*

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
4/1/2009	NON-RESTRICTIVE SIDE RAILS <i>Resident's family requests side rails up, educated on risks and cant request to keep side rails up, Resident has Dx of Cerebral Palsy with contractures, Anxiety SR x 4 rltc. Pilsen/Paided to prevent injury does not attempt OOB</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 FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT 	NSG	SW	7/2009	

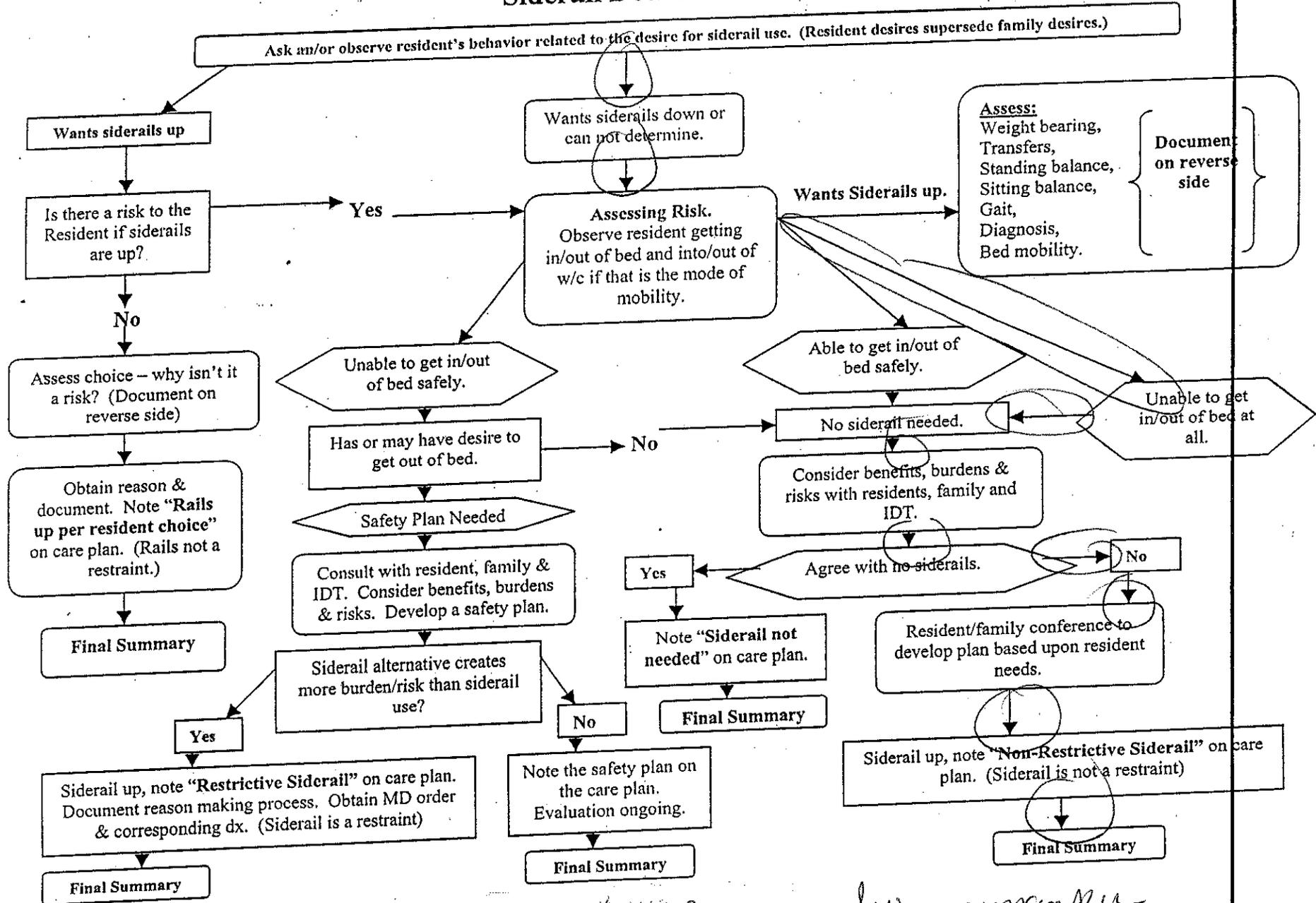


**Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care**

Attachment # 18
Resident # 18
Room # 148-1

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev 7/2/09	Non Rest Side Rails - cont	cont	cont	NSG	SW	10/09	
Rev 10/1/09	cont	cont	cont	NSG	SW	1/2010	
Rev 1/1/10	cont	cont	cont	NSG	SW	4/10	
Rev 4/10	cont	cont	cont	NSG	SW	7/10	
Rev 7/10	cont	cont	cont	NSG	SW	10/10	
Rev 10/10	cont	cont	cont	NSG	SW	1/11	

Siderail Decision Tree



Resident # 19

Attachment # 19

Resident Name: Room # 148-2
 Date: 11/30/10

Nurse sign: *S. Wasserman*

SR 7x4 RIT Hx CVA, limb often will fall to side of bed risk of pulling resident to floor. Does not attempt OOB. Uses top and bottom rails to pull self up and turn and position self. Educated family RIT risks vs. benefit. Cont to use SR 7x4. Additional Hx of seizure activity padded side rails RIT this and uncontrolled movement of limbs.

Resident #19
Attachment #19
Room # 148-2

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

Attachment # 19
Resident # 19
Room # 148-2

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
1/7/09	<p>NON-RESTRICTIVE SIDE RAILS</p> <p>Resident's family educated on uses of side rails - vu</p> <p>Continue to request side rails.</p> <p>Resident is dependant on staff for bed mobility, ↑x4 uses bottom rails to pull up doesn't attempt OOB by self</p>	<p>No decrease in ROM or injury X' 90 Days</p>	<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 FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT 	NSG	mm	4/109	

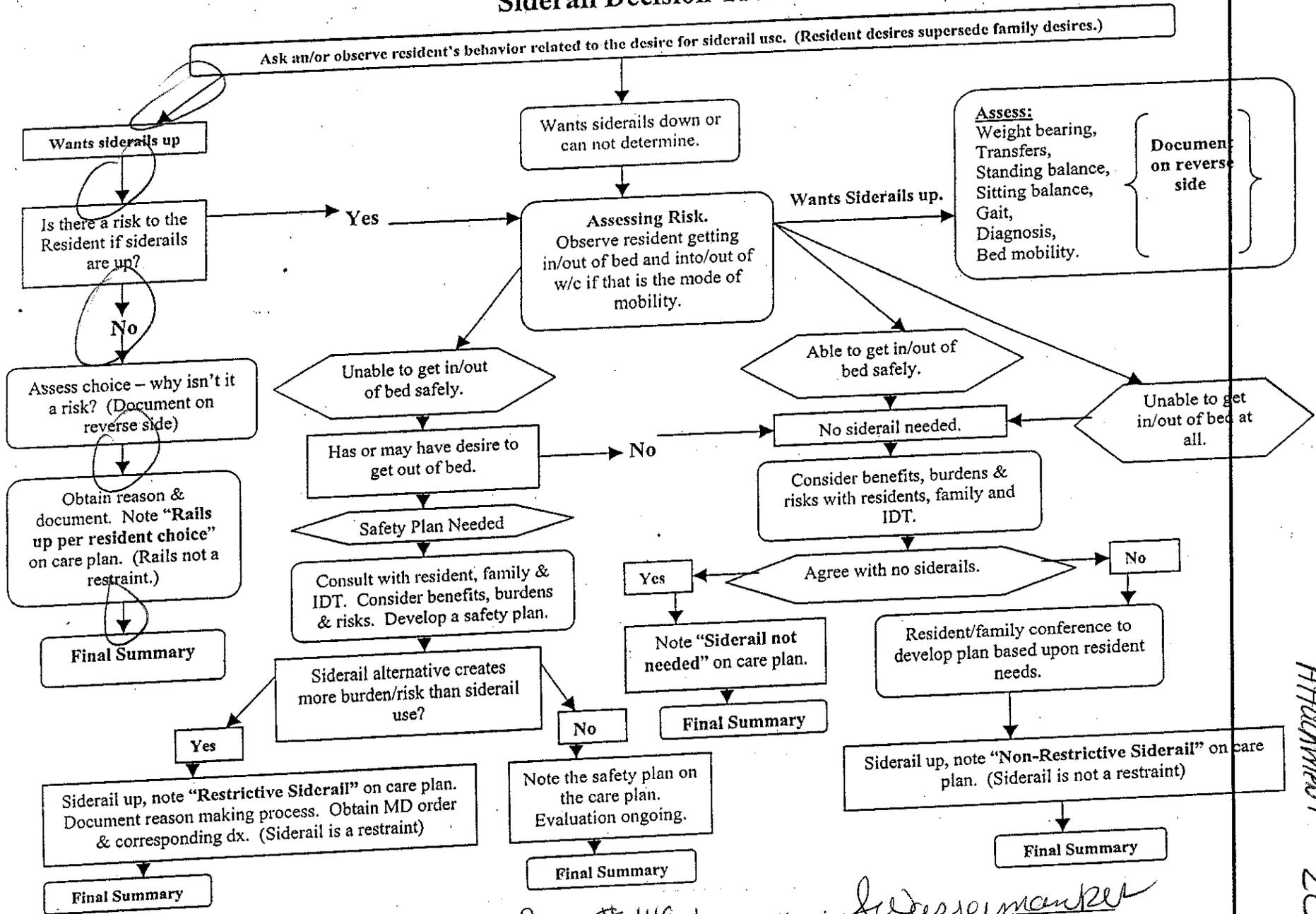


Appalachian Regional Health ~~Co~~, Inc.
 Interdisciplinary Plan of Care

Attachment #19
 Resident #19
 Room # 148-2

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev. 4/1/2009	cont Nonrestrictive Side Rails Cont	cont	cont	cont	sw	7/09	
Rev 7/2/09	cont	cont	cont	cont			
Rev 10/2/09	cont	cont	cont	cont	sw	10/09	
Rev 11/1/10	cont	cont	cont	cont	sw	1/2010	
Rev 4/1/10	cont	cont	cont	cont	sw	4/2010	
Rev 7/1/10	cont	cont	cont	cont	sw	7/10	
Rev 10/1/10	cont	cont	cont	cont	sw	10/10	
					sw	1/11	

Siderail Decision Tree



SRDecision

Resident Name: Room # 149-1
 Date: 11/30/10

Nurse sign: [Signature]

Resident # 20

Attachment # 20

SR #2 residents choice, used for bed mobility and transfers,
educated pt and family on SR risks, went to request SR
#2.

Resident #20
Attachment #20
Room #149-1

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

Attachment #20

Resident #20

Room # 149-1

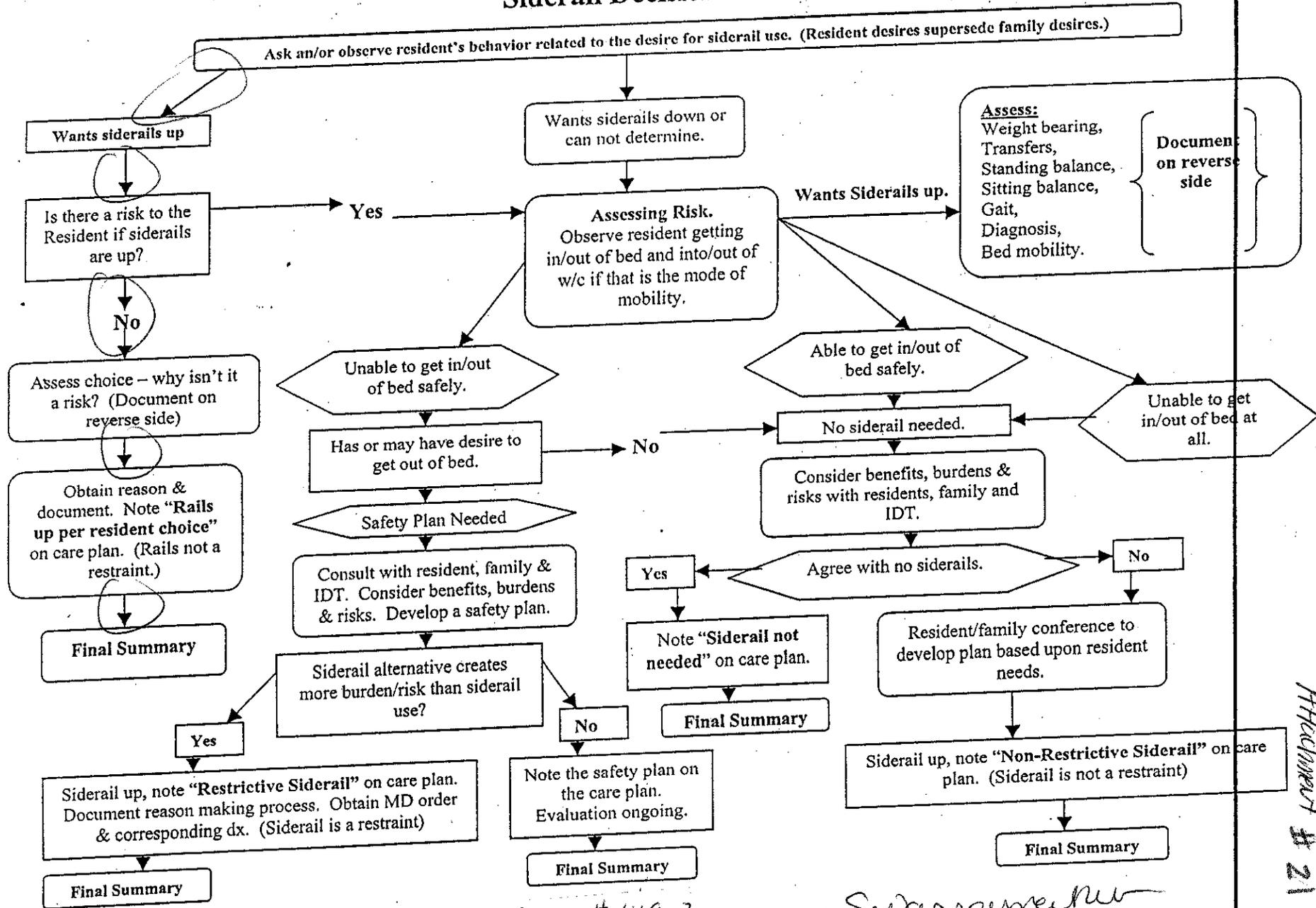
Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
11/10/10	SIDE RAILS UP PER RESIDENTS CHOICE <i>Used for transfers and bed mobility ↑ X2</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 PERIMETER 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 	NSG	SW	2/11	

(8) CLINICAL MONITORING FREQUENTLY FOR ANY PROBLEMS OR INJURIES



Siderail Decision Tree



Resident # 21

Attachment # 21

Resident Name: Room # 149-2 Nurse sign: Selassame
 Date: 11/30/10

Resident and family requests SK 1 x 2 educated on risks
cont to request SK 1 x 2. Does not attempt OOB by self
uses to 2 side rails for transfers and repositioning.

Resident #21
Attachment #21
Room #149-2

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

Attachment #21

Resident #21

Room #149-2

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev 4/10	RT per chair cont	cont	cont	NSG	SW	7/10	
Rev 7/10	Cont	cont	cont	NSG	SW	10/10	
Rev 10/10	cont	cont	cont	NSG	SW	1/11	

Appalachian Regional Healthcare, Inc.

Interdisciplinary Plan of Care

Attachment #21

Resident #21

Room 149-2

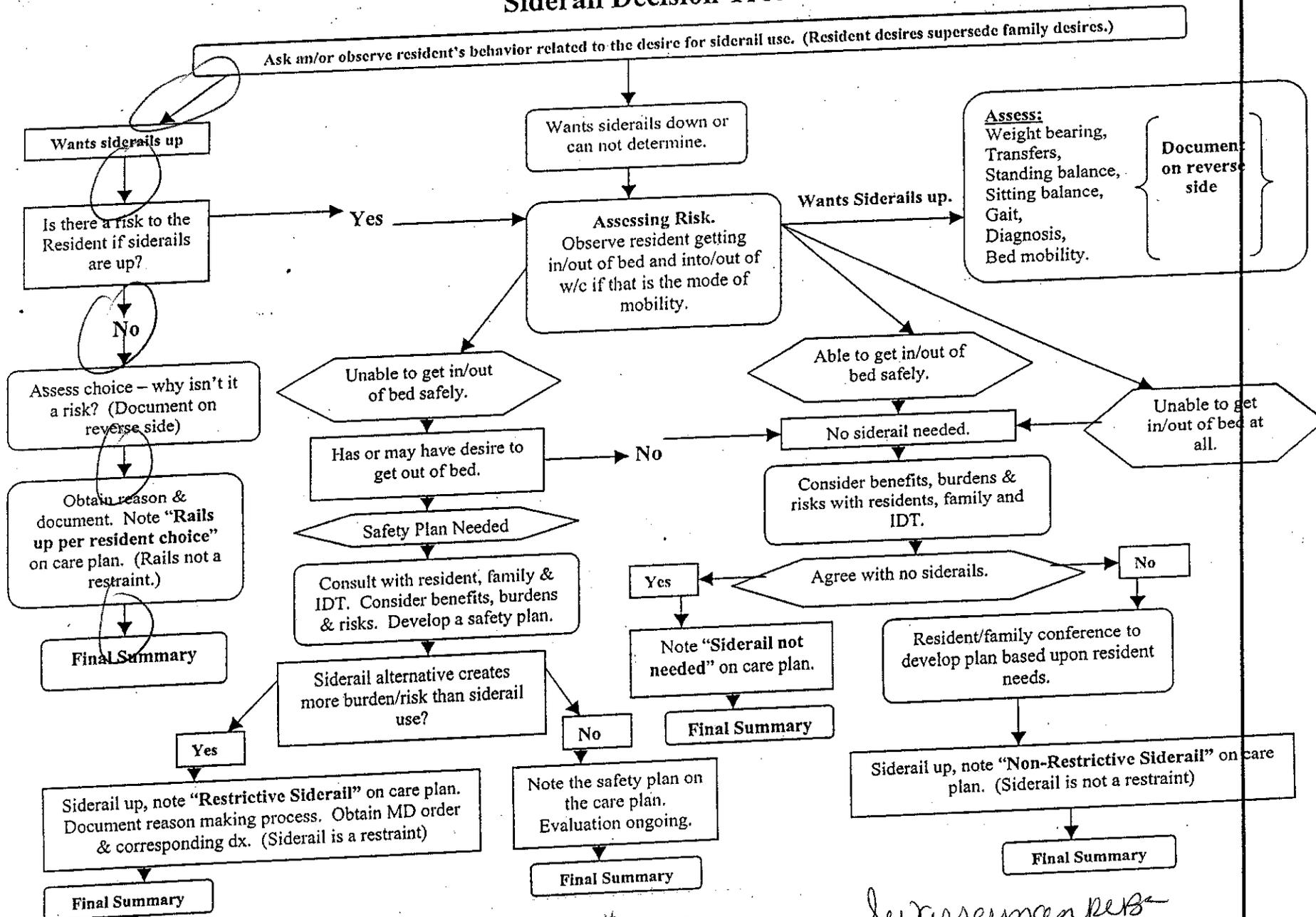
Problem Number

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
1/20/10	SIDE RAILS UP PER RESIDENTS CHOICE <i>↑ x 2 uses 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 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 PERIMETER 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 	NSC	See	4/10	

(8) CLINICAL MONITORING FREQUENTLY FOR ANY PROBLEMS OR INJURIES



Siderail Decision Tree



Resident # 22

Attachment # 22

Resident Name: Room #150-2
 Date: 11/30/10

Nurse sign: *L. Wasserman RBS*

SLA x 2 PW resident request, educated on risks RT and
cont to request SLA x 2. Uses for bed mobility and transfers.

Resident #22
Attachment #22
Room # 150-2

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

Attachment # 22
Resident # 22
Room # 150-2

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
<i>11/18/2009</i>	<i>SIDE RAILS UP PER RESIDENT'S CHOICE Resident A:0x3 requests top 2 side rails ↑ used for transfers and 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 (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 PERIMETER 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 	<i>NSG</i>	<i>SW</i>	<i>2/10</i>	

(8) CLINICAL MONITORING FREQUENTLY FOR ANY PROBLEMS OR INJURIES



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

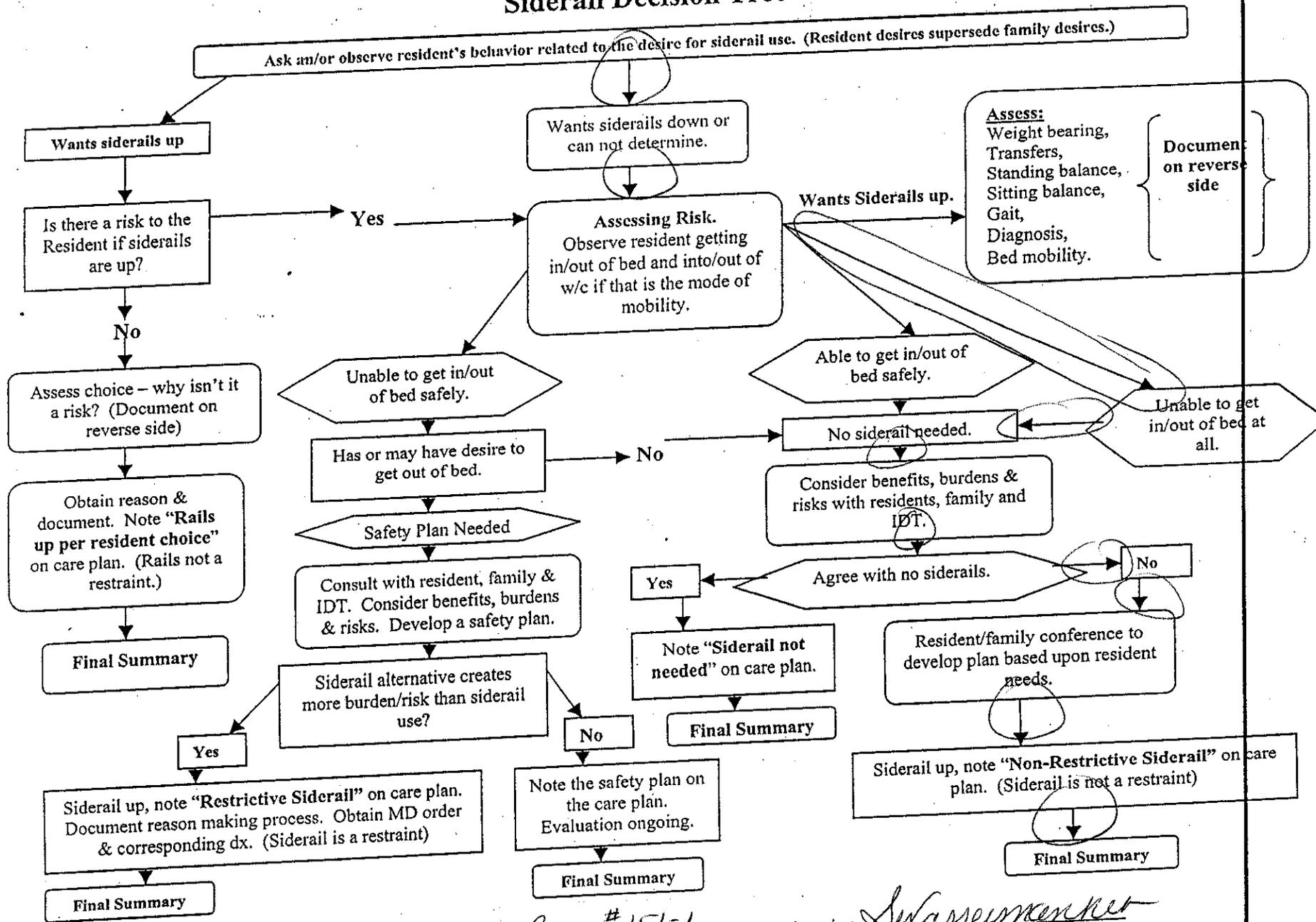
Attachment # 22

Resident # 22

Room # 150-2

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	DATE	RESOLVED
<i>Rev 2/10</i>	<i>SRT - cont</i>	<i>cont</i>	<i>cont</i>	<i>NSG</i>	<i>SW</i>	<i>5/10</i>	
<i>Rev 5/10</i>	<i>cont</i>	<i>cont</i>	<i>cont</i>	<i>NSG</i>	<i>SW</i>	<i>8/10</i>	
<i>Rev 8/10</i>	<i>cont</i>	<i>cont</i>	<i>cont</i>	<i>NSG</i>	<i>SW</i>	<i>11/10</i>	
<i>Rev 11/10</i>	<i>cont</i>	<i>cont</i>	<i>cont</i>	<i>NSG</i>	<i>SW</i>	<i>2/10</i>	

Siderail Decision Tree



Resident #5-

Attachment #23

Resident Name: Room # 151-1
 Date: 11/30/10

Nurse sign: *Swasey*

Resident requests / family requests SRT x 2 agree to
RH uses to attempt to assist turns and repositioning.
Educated RH uses cont to request P x 2

Resident #5
Attachment # 23
Room # 151-1

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

Attachment #23

Resident #5

Room # 151-1

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
3/11/10	SIDE RAILS UP PER RESIDENTS CHOICE	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	6/1/10	



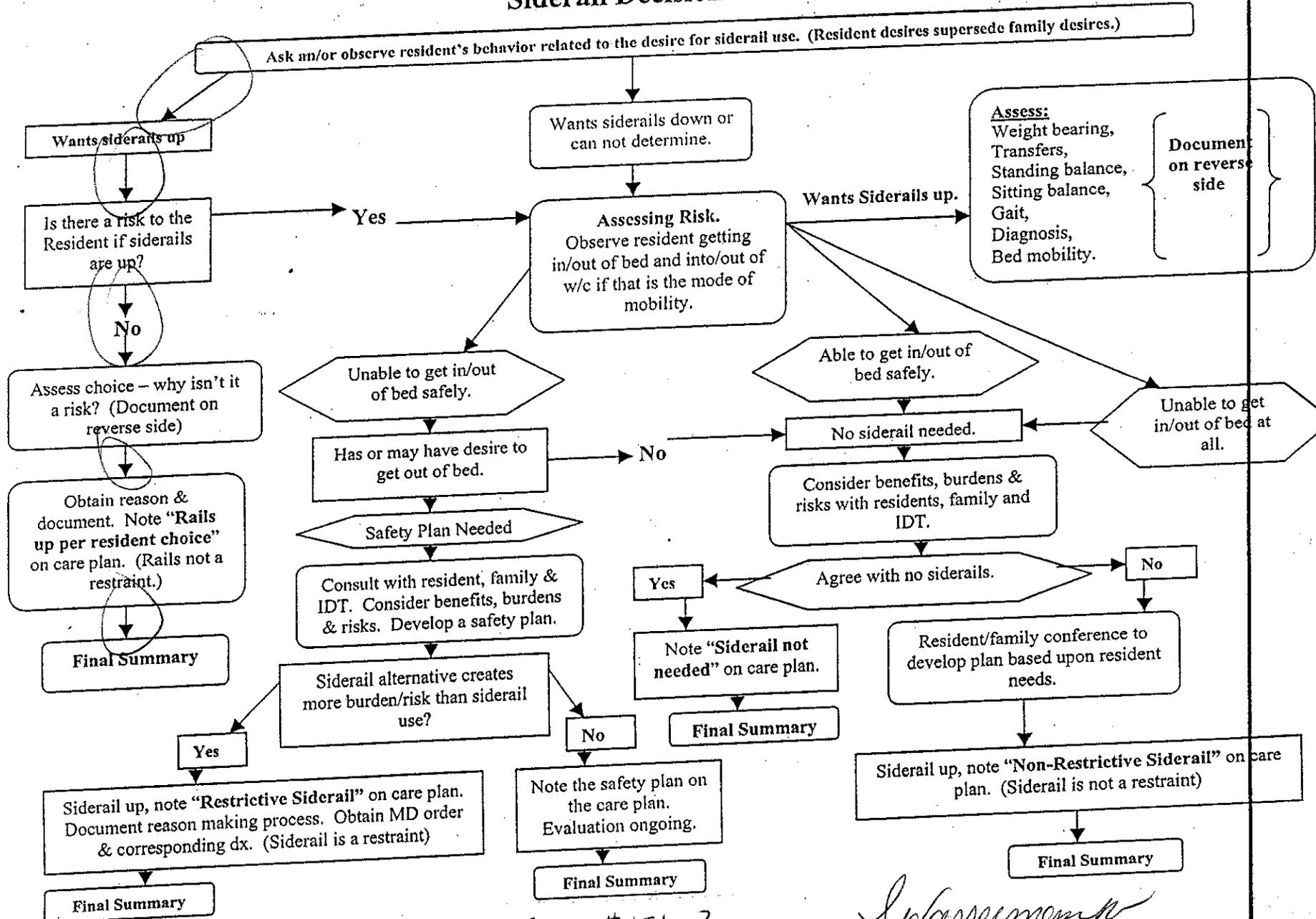
**Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care**

Attachment # 23

Resident #5
Room # 151-1

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev 6/10 Rev 9/10 Rev 12/10	<p>SRT per choice cont</p> <p>Cont SRT x 2 key choice and moded non resistive uses upper 2 rails for mobility assist staff does not attempt OOB key self</p>	<p>cont cont</p>	<p>cont cont</p>	<p>NSG NSG</p>	<p>sw su</p>	<p>9/10 12/10</p>	

Siderail Decision Tree



Room # 151-2
 Moved from 152-1

Resident # 23
 Attachment # 24

Resident Name: Room #151-2
 Date: 11/30/10

Nurse sign: *[Signature]*

SR ↑ x 2, educated R/T risks, uses for bed mobility
and transfers. Educated R/T risks client to request
SR ↑ x 2

Resident # 23
Attachment # 24
Room # 151-2
Moved from 152-1

Appalachian Regional Healthcare, Inc.
Interdisciplinary Plan of Care

Attachment # 24

Resident # 23

Room # 151-2

* Moved from 152-1

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
3-1-09	SIDE RAILS UP PER RESIDENTS CHOICE Resident uses side rails for bed mobility	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 PERIMETER 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	mm	6-09	



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

Attachment #24

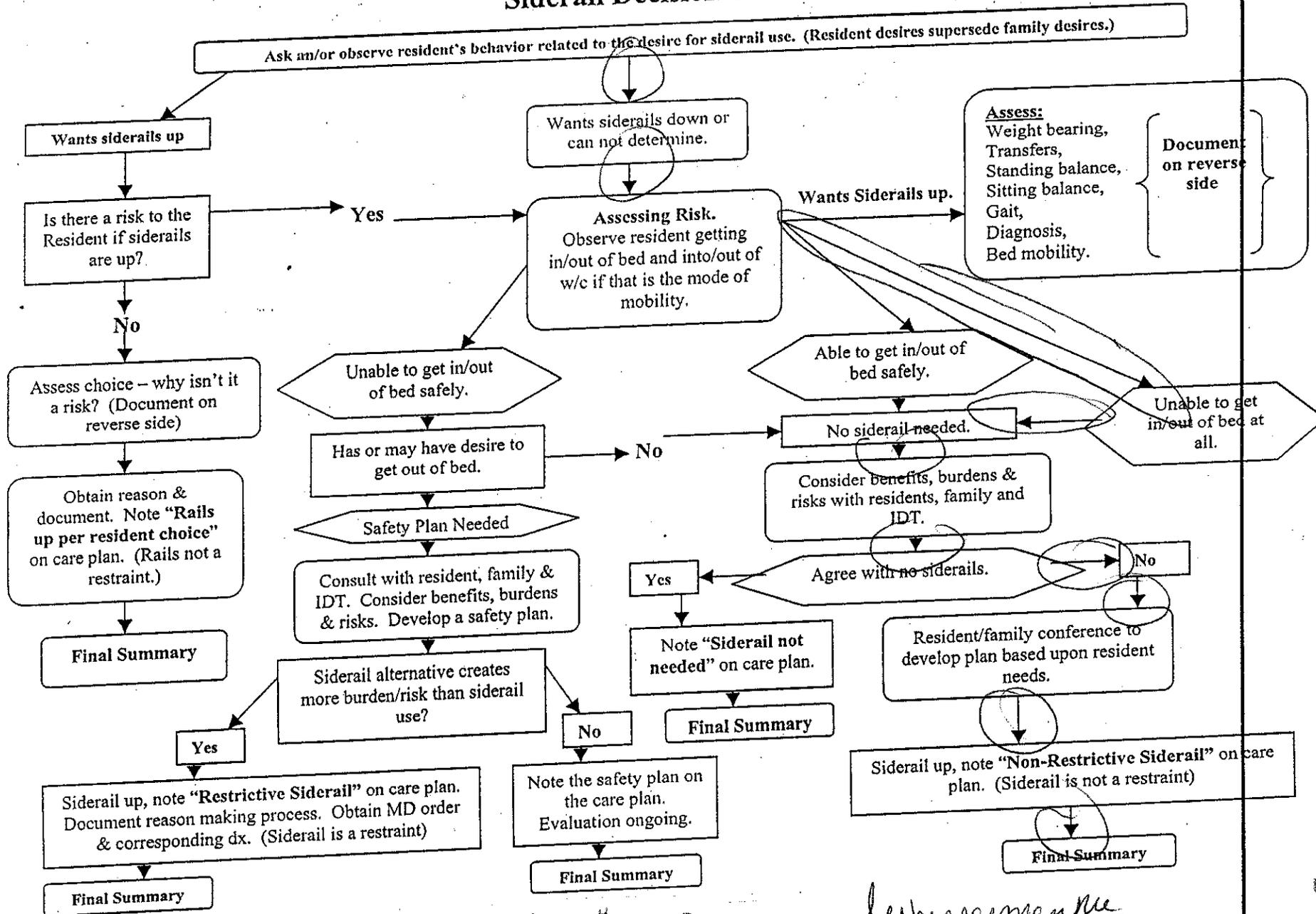
Resident #23

Room #151-2

* Moved from 156-1

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
6/20/09	Side Rails Up Per Residents Choice	Cont	cont	NSG	SW	9/20/09	
9/1/09	REV Cont	Cont	Cont	NSG	SW	12/09	
12/1/09	REV 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	
Rev 9/10	cont 5R x 2 per chair	cont	cont	NSG	SW	12/10	

Siderail Decision Tree



Resident # 3

Attachment

25

Resident Name: Room #152-2
 Date: 11/30/10

Nurse sign: *[Signature]*

Turns and helps position man on side rails, SRT #2,
educated at risk family and resident per requested
A x 2.

Resident #3
Attachment #25
Room # 152-2

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

Attachment #25

Resident # 3

Room # 152-2

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
2/1/10	NON-RESTRICTIVE SIDE RAILS <i>Requests SR ↑ x 2. educate d L/R risks cont to 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	5/10	

FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT



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

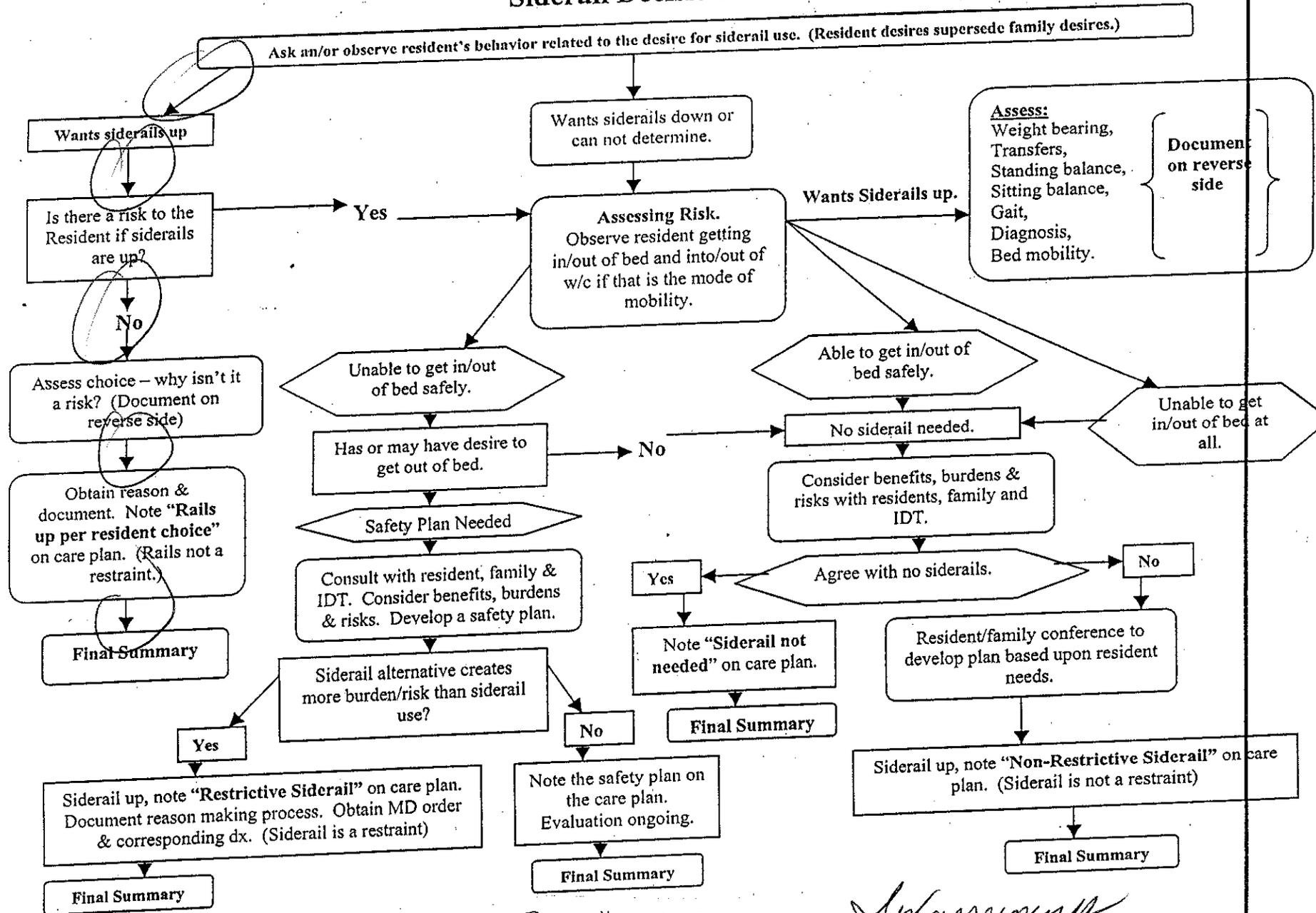
Attachment #25

Resident #3

Room #152-2

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
5/10 Rev	Nonrestrictive tx 2	cont	cont	NSG	SW	8/10	
	Siderails-cont						
Rev 8/10	cont	cont	cont	NSG	SW	11/10	
Rev 11/10	cont	cont	cont	NSG	SW	2/10	

Siderail Decision Tree



Resident # 24

Attachment # 210

Resident Name: Room # 153-2
 Date: 11/30/10

Nurse sign: *[Signature]*

SRP x 2 per resident request used for transfers and
repositioning. Educated on risk will monitor, cont to
request SRP x 2

Resident #24
Attachment #24
Room #153-2

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

Attachment # 26

Resident # 24

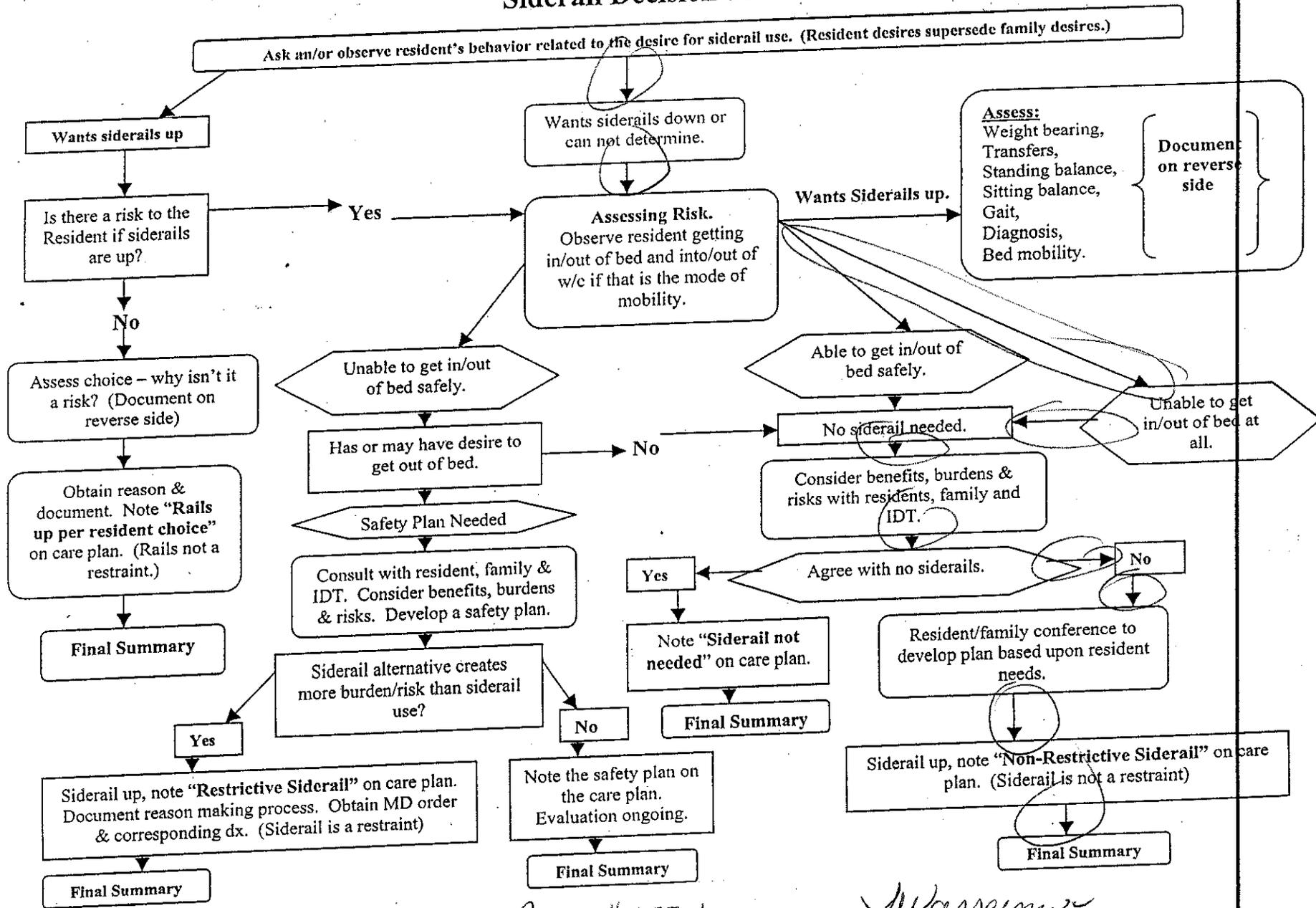
Room # 153-2

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
11/19/10	SIDE RAILS UP PER RESIDENTS CHOICE <i>SR ↑ x 2 per choice uses for bed mobility and transfers</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	EW	2/11	



Siderail Decision Tree



Resident # 35

Attachment # 27

Resident Name: Room #155-1

Nurse sign: *Wasserman*

Date: 11/30/10

SR ↑ x2 R/H spastic upper body movements, does
not attempt OOB by self.

Resident # 25
Attachment # 27
Room # 155-1

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

Attachment # 27

Resident # 25

Room # 155-1

Problem Number _____

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
<i>12/08/08</i>	<p>NON-RESTRICTIVE SIDE RAILS</p> <p><i>Resident is non mobile - dependant on staff for bed mobility + transfers</i></p> <p><i>Resident's family educated on rules of side rails vu still request use of siderails.</i></p>	<p>No decrease in ROM or injury X 90 Days</p>	<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>mm</i>	<i>3/09</i>	

FREQUENTLY FOR ANY PROBLEMS OR INJURIES AND DOCUMENT



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

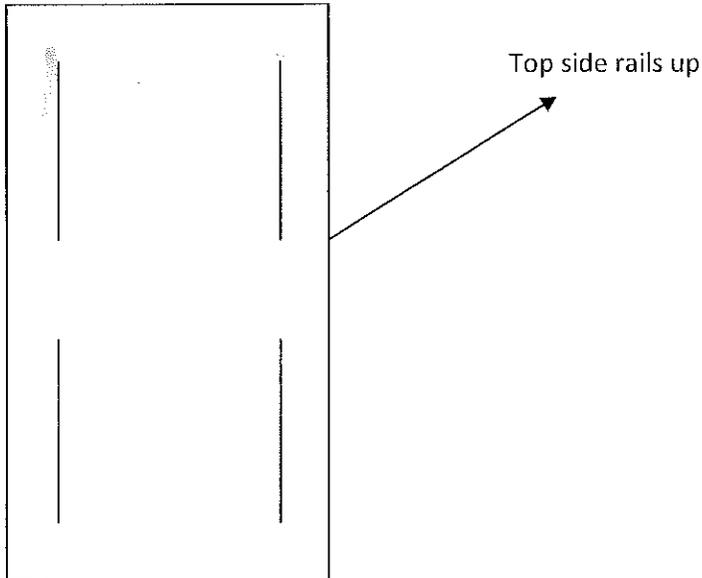
Attachment # 27

Resident # 25

Room # 155-1

DATE	PATIENT PROBLEM	GOAL	INTERVENTIONS	DISCIPLINE INTERVENING	INITIALS	GOAL DATE	DATE RESOLVED
Rev. 3/09	Continue	Cont	Continue	NSG	mm	6/09	
Rev 6/09	Cont	cont	cont	NSG	sw	9/09	
Rev 9/09	Cont	cont	cont	NSO	sw	12/09	
Rev 12/09	Cont	cont	cont	NSU	sw	3/10	
Rev 3/10	cont	cont	cont	NSG	sw	6/10	
Rev 6/10	cont	cont	cont	NSG	sw	9/10	
Rev 9/10	cont	cont	cont	NSG	sw	12/10	
	↑X2 R/H upper body specific movement does not attempt OOB by self						

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).

QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: 1/2011

MONITORING PERIOD: 10/10-12/10 SAMPLE: all

DATA SOURCES: Side rails will up according to care planed and assessed needs per side rail decision tree CATEGORY:

METHODOLOGY: Spot checks PREPARED BY: Sonya Wasserman RN, BSN

ASPECT OF CARE: Resident Safety

1. INDICATOR/THRESHOLD FOR EVALUATION:

The side rails in use will be what is care planned according the the decision side rail tree 100% of the time.

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

2. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

3. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

4. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: 1/2011

MONITORING PERIOD: 10/10-12/10 SAMPLE: all

DATA SOURCES: All medications/
ointments / and
cleansers will be
secured CATEGORY:

METHODOLOGY: Spot checks PREPARED BY: Sonya Wasserman RN, BSN

ASPECT OF CARE: Resident Safety

1. INDICATOR/THRESHOLD FOR EVALUATION:

Medications (ointments, topical meds ect) and cleansers will be seruced and not left in patient care areas 100% of the time.

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

2. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

3. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

4. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: Jan 2011

MONITORING PERIOD: 10/10-12/10 SAMPLE: all

DATA SOURCES: Meal trays will meet holding and delivery temps for residents in SNF as outlined for acceptable ranges for specific items cold and hot CATEGORY:

METHODOLOGY: Spot checks of Holding area and delivery of first and last tray to SNF residents PREPARED BY: Patty Stroud

ASPECT OF CARE: Resident Safety

1. INDICATOR/THRESHOLD FOR EVALUATION:

The tray temps will kept at acceptable temps per guidelines for holding temps and delivery of first and last trays 100% of the time.

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

2. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

3. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

4. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

Attachment # 32

Quality Improvements
Page 3

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

**Policy and Procedure
Conducting Test Trays**

**SUBJECT: CONDUCTING TEST TRAYS TO ASSESS RATE OF TRAY
DELIVERY AND FOOD TEMPERATURES UPON DELIVERY**

POLICY (222-A): Test trays will be completed at least once monthly at breakfast, lunch, and dinner meal service. Additional test trays will be completed as needed based on patient complaints about cold food.

PURPOSE: To assure meal trays are delivered to residents in a timely manner, assuring food is at the proper temperature and quality when it is served to the patient.

DATE REVISED: 11/25/2010

PROCEDURE (222.1):

1. CDM (Certified Dietary Manager) or designee will inform dietary staff when a test tray in to be added to meal cart.
2. Food temperature will be obtained prior to meal service and recorded on the "Tray Audit Form".
3. CDM or designee will place a meal card for test tray on the tray. Kitchen will prepare a regular meal tray as part of routine meal service and place on cart to be delivered to dining room or unit.
4. The test tray should remain on the food delivery cart until all other patient trays have been delivered.
5. CDM or designee use "Test Tray Form" to record the time of tray delivery.
6. CDM or designee will record food and beverage temperatures at delivery on the "Test Tray Form" using a calibrated bimetallic stem thermometer or a digital thermometer.
7. If delivery time is excessive, a corrective action plan should be developed to assure those who deliver trays will deliver all patient trays within a timely manner.
8. If food temperatures are inappropriate, a corrective action plan for better holding procedures and/or more timely delivery should be implemented.
9. A follow-up test tray should be conducted in one week to evaluate effectiveness of the corrective action plan.
10. Tray audit forms will be kept on file in the Dietary Office for at least one year.

Test Tray

Date: _____ Meal: _____ Wing/Hall # _____

Time cart left kitchen: _____

Time cart arrived on hall : _____

Time tray delivered: _____

Holding Temperature (Steam-table/warming cabinet)	Menu Day: Menu Item	First Tray Temperature after Delivery to floor	Last Tray Temperature after Deliver to floor	Acceptable Temperature Range of Palatable Food
Entrée (Hot)				115 degree Fahrenheit to 130 degree Fahrenheit
Starch (Hot)				115 degree Fahrenheit to 130 degree Fahrenheit
Vegetable (Hot)				115 degree Fahrenheit to 130 degree Fahrenheit
Beverage (Hot)				120 degree Fahrenheit to 130 degree Fahrenheit
Beverage (Cold)				40-50
Soup (Hot)				120 degree Fahrenheit to 130 degree Fahrenheit
Salad (cold)				40-50
Dessert				40-50
Hot Cereal				115 degree Fahrenheit to 130 degree Fahrenheit

Acceptable refrigeration temperature range for holding food (Federal 2005 Food Code section 3 articles 3-501.16) Cold Food 45 degree and below Fahrenheit (refrigeration units)

Acceptable Temperature for Hot Food holding (Federal 2005 Food Code section 3 article 3-501) 135 degree Fahrenheit and above (warming units)

Corrective action needed? Yes _____ No _____

Notes:

Completed by _____ Date _____

Revised 11/25/2010

Test Tray

Date: 11-25-10 Meal: Breakfast Wing/Hall # _____

Time cart left kitchen: 7:25 AM

Time cart arrived on hall: 7:30 AM

Time tray delivered: 8:10 AM completed

Holding Temperature (Steam-table/warming cabinet)	Menu Day: <u>18</u> Menu Item <u>Regular Purseed</u>	First Tray Temperature after Delivery to floor	Last Tray Temperature after Deliver to floor	Acceptable Temperature Range of Palatable Food
Entrée (Hot) <u>145°</u>	<u>scrambled eggs</u>	<u>130°</u>	<u>130°</u>	115 degree Fahrenheit to 130 degree Fahrenheit
Starch (Hot) <u>130°</u>	<u>Oatmeal</u>	<u>130°</u>	<u>116°</u>	115 degree Fahrenheit to 130 degree Fahrenheit
Vegetable (Hot)	<u>N/A</u>			115 degree Fahrenheit to 130 degree Fahrenheit
Beverage (Hot) <u>136°</u>	<u>coffee</u>	<u>135°</u>	<u>130°</u>	120 degree Fahrenheit to 130 degree Fahrenheit
Beverage (Cold) <u>39°</u>	<u>Milk</u>	<u>40°</u>	<u>45°</u>	40-50
Soup (Hot)	<u>N/A</u>	<u>-</u>	<u>-</u>	120 degree Fahrenheit to 130 degree Fahrenheit
Salad (cold)	<u>N/A</u>	<u>-</u>	<u>-</u>	40-50
Dessert <u>145°</u>	<u>Hot Apples</u>	<u>130°</u>	<u>124°</u>	40-50
Hot Cereal				115 degree Fahrenheit to 130 degree Fahrenheit

Acceptable refrigeration temperature range for holding food (Federal 2005 Food Code section 3 articles 3-501.16) Cold Food 45 degree and below Fahrenheit (refrigeration units)

Acceptable Temperature for Hot Food holding (Federal 2005 Food Code section 3 article 3-501) 135 degree Fahrenheit and above (warming units)

Corrective action needed? Yes _____ No

Notes:

Completed by [Signature] DTK, CDM

Date 11-25-2010
Revised 11/25/2010

Test Tray

Date: 12/2/10 Meal: Supper Wing/Hall # _____Time cart left kitchen: 4:54 pm
Time cart arrived on hall: 4:58 pm
Time tray delivered: 5:14 pm

Holding Temperature (Steam-table/warming cabinet)	Menu Day: 4 Menu Item <i>Regular Pureed</i>	First Tray Temperature after Delivery to floor	Last Tray Temperature after Deliver to floor	Acceptable Temperature Range of Palatable Food
Entrée (Hot) 158°	meatloaf	130°	118°	115 degree Fahrenheit to 130 degree Fahrenheit
Starch (Hot) 160°	mashed Potato	135°	120°	115 degree Fahrenheit to 130 degree Fahrenheit
Vegetable (Hot) 152°	Greens	130°	120°	115 degree Fahrenheit to 130 degree Fahrenheit
Beverage (Hot)	coffee	125°	120°	120 degree Fahrenheit to 130 degree Fahrenheit
Beverage (Cold) 36°	milk	38°	40°	40-50
Soup (Hot) 125°	Soup	110°	100°	120 degree Fahrenheit to 130 degree Fahrenheit
Salad (cold)				40-50
Dessert	Peach Sauce	40°	45°	40-50
Hot Cereal				115 degree Fahrenheit to 130 degree Fahrenheit

Acceptable refrigeration temperature range for holding food (Federal 2005 Food Code section 3 articles 3-501.16) Cold Food 45 degree and below Fahrenheit (refrigeration units)

Acceptable Temperature for Hot Food holding (Federal 2005 Food Code section 3 article 3-501) 135 degree Fahrenheit and above (warming units)

Corrective action needed? Yes No

Notes:

Soup will remain in warmer until staff starts serving
SNF Floor

Completed by Patty L. Howard DTK, CDM Date 12-2-10
Revised 11/25/2010

Test Tray

Date: 12/9/10 Meal: Lunch Wing/Hall # _____Time cart left kitchen: 11:25 AM
Time cart arrived on hall: 11:28 AM
Time tray delivered: 11:29 AM to 11:44 AM

Holding Temperature (Steam-table/warming cabinet)	Menu Day: Menu Item	First Tray Temperature after Delivery to floor	Last Tray Temperature after Deliver to floor	Acceptable Temperature Range of Palatable Food
Entrée (Hot) 150°	Pureed Beef tips	130°	120°	115 degree Fahrenheit to 130 degree Fahrenheit
Starch (Hot)	mashed Potato	130°	121°	115 degree Fahrenheit to 130 degree Fahrenheit
Vegetable (Hot)	Green Beans	132°	130°	115 degree Fahrenheit to 130 degree Fahrenheit
Beverage (Hot)	Coffee	138°	138°	120 degree Fahrenheit to 130 degree Fahrenheit
Beverage (Cold)	Milk	41°	48°	40-50
Soup (Hot) 132°	Tomato Soup	123°	118°	120 degree Fahrenheit to 130 degree Fahrenheit
Salad (cold)	_____	_____	_____	40-50
Dessert	Ice Cream	3°	18°	40-50
Hot Cereal	_____	_____	_____	115 degree Fahrenheit to 130 degree Fahrenheit

Acceptable refrigeration temperature range for holding food (Federal 2005 Food Code section 3 articles 3-501.16) Cold Food 45 degree and below Fahrenheit (refrigeration units)

Acceptable Temperature for Hot Food holding (Federal 2005 Food Code section 3 article 3-501) 135 degree Fahrenheit and above (warming units).

Corrective action needed? Yes _____ No

Notes:

Completed by Patty Howard DTR, CDM Date 12/9/10
Revised 11/25/2010

QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: 2/2011

MONITORING PERIOD: 10/10-12/10 SAMPLE: all

DATA SOURCES: Meal cart doors will be closed when not getting a tray out CATEGORY:

METHODOLOGY: Spot checks PREPARED BY: Sonya Wasserman RN, BSN

ASPECT OF CARE: Resident Safety

1. INDICATOR/THRESHOLD FOR EVALUATION:

Meal cart doors will be closed when not getting a tray out 100% of the time during meal tray passes.

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

2. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

3. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

4. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

Hand washing: Do's and don'ts

Hand washing is an easy way to prevent infection. Understand when to wash your hands, how to properly use hand sanitizer and how to get your children into the habit.

By Mayo Clinic staff

Frequent hand washing is one of the best ways to avoid getting sick and spreading illness. Hand washing requires only soap and water or an alcohol-based hand sanitizer — a cleanser that doesn't require water. Find out when and how to wash your hands properly.

When to wash your hands

As you touch people, surfaces and objects throughout the day, you accumulate germs on your hands. In turn, you can infect yourself with these germs by touching your eyes, nose or mouth. Although it's impossible to keep your hands germ-free, washing your hands frequently can help limit the transfer of bacteria, viruses and other microbes.

Always wash your hands before:

- Preparing food
- Eating
- Treating wounds or giving medicine
- Touching a sick or injured person
- Inserting or removing contact lenses

Always wash your hands after:

- Preparing food, especially raw meat or poultry
- Using the toilet
- Changing a diaper
- Touching an animal or animal toys, leashes or waste
- Blowing your nose, coughing or sneezing into your hands
- Treating wounds
- Touching a sick or injured person, *Touching your face*
- Handling garbage or something that could be contaminated, such as a cleaning cloth or soiled shoes

Of course, it's also important to wash your hands whenever they look dirty.

How to wash your hands

It's generally best to wash your hands with soap and water. Follow these simple steps:

- Wet your hands with running water.
- Apply liquid, bar or powder soap.
- Lather well.
- Rub your hands vigorously for at least 20 seconds. Remember to scrub all surfaces, including the backs of your hands, wrists, between your fingers and under your fingernails.
- Rinse well.
- Dry your hands with a clean or disposable towel or air dryer.
- If possible, use your towel to turn off the faucet.

Keep in mind that antibacterial soap is no more effective at killing germs than is regular soap. Using antibacterial soap may even lead to the development of bacteria that are resistant to the product's antimicrobial agents — making it harder to kill these germs in the future.

{ Wash hand between }
{ Glove changes }

{ Change Gloves }
{ Between retrieve food carts from floors }

CH-20 Dietary

	11/8	11/9	11/10	11/11	11/12	11/13	11/14	11/15	11/16	11/17	11/18	11/19	11/20	11/21	11/22	11/23	11/24	11/25	11/26	11/27	11/28	11/29	11/30	12/1	12/2	12/3	12/4	12/5	
	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	
JOANN	5	Z	/	/	Z	Z	Z	5	5	5	5	/	/	5	5	5	5	5-1:30	5	/	/	/	/	5	5	5	5	5	
Tama	11	11	11	11	11	/	/	/	/	11	11	11	11	11	11	/	/	10:30-7	11	11	11	11	11	11-clean	/	/	11	11	
BELINDA	/	/	5	5	5	5-1:30	5-1:30	11	11	/	/	5	5	11	11	11	11	H	/	5	5	5	5	11	11	V	/	/	
	11/8	11/9	11/10	11/11	11/12	11/13	11/14	11/15	11/16	11/17	11/18	11/19	11/20	11/21	11/22	11/23	11/24	11/25	11/26	11/27	11/28	11/29	11/30	12/1	12/2	12/3	12/4	12/5	
	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	
Kaye	6	6	6	6	/	/	5:30-2:00	6	6	6	6	6	n/a	n/a	V	V	SP	H	BD	/	/	/	/	6	6	5:30	5:30	5:30	
SAMANTHA	sick	/	/	F	F	6-2:30	6-2:30	6	6	6	/	/	6	6	6	6	6	H	V	/	/	/	/	6	6	6	6	6	
Clara	/	/	6	6	6	5:30-2:00	10:3	6	6	/	/	5:30	5:30	5:30	6	/	/	5:30-1:30	5:30	5:30	5:30	6	6	9-5	9-5	K	/	/	
	11/8	11/9	11/10	11/11	11/12	11/13	11/14	11/15	11/16	11/17	11/18	11/19	11/20	11/21	11/22	11/23	11/24	11/25	11/26	11/27	11/28	11/29	11/30	12/1	12/2	12/3	12/4	12/5	
	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	
Pauline	/	/	K	V	6	10:3 cook	10:3 cook	11	11	V	/	/	9-5	9-5	11	11	11	H	/	11	11	11	11	11	11	11	11-cook	/	/
Mary	6	9-5	11-train	/	/	10:3	10:3	11	11	11-train	11	11	/	/	/	/	6	H	6	6	6	5-train	5-train	/	/	9-5	9-5	9-5	
Sandra	6	6	9-5	9-5	/	10:3	/	11	11	11	11	11	/	/	/	/	11	6	9	9	9	6	6	/	/	11	11	11	
Rachelle	11	11	11	11	11	/	/	/	/	6-2 hood	6	6	11	11	6	6	/	10:30-7	11	/	11	11	11	11	11	11	11	/	/
Nora	11-train	11	11	11	11	/	/	/	/	9-5	9-5	11-hood	11	11	/	11	11	10:30-7	11	11	/	11	11	11	/	/	11	11	

SUBJECT TO CHANGE!

Revised November 12th 2010

Attachment #36

IN - SERVICE REPORT

Program Title or Topic: Infection Control (Handwashing) Date: 12-1-10
Audience: Dietary Length of instruction: 20 minutes Presenter: J. Hall RNCNM
Learning Need (Why is program needed): _____

The following information must be provided: (Objective (s), content in outline form, method (s) of presentation, validation of learning)

OB Section: Effects of Proper Handwashing Technique + Prevention of Spread of Infection

- 1.) Importance of correct handwashing procedures.
- 2.) Importance of washing before & after donning gloves.
- 3.) Rational presentation for proper technique use in good handwashing.

J. Hall RNCNM
Infection Control Assistant

Program Evaluation: _____ Yes _____ No

Written Test

Average Test Score _____ %

Return Demonstration

Satisfactory _____ %

Unsatisfactory _____ %

Expected outcomes (Behavioral Changes) of employees:

SIGNATURE OF PERSON SUBMITTING REPORT

IN - SERVICE REPORT

Program Title or

Topic: Infection Control (Handwashing) Date: 12-3-10

Audience: _____ Length of Instruction: 20 minute Presenter: [Signature]

Learning Need (Why is program needed): _____

The following information must be provided: (Objective (s), content in outline form, method (s) of presentation, validation of learning)

- Objective: Effects of Proper Handwashing Technique and Prevention of Spread of Infection
- 1) Importance of correct handwashing procedure
 - 2) Importance of washing before & after changing gloves
 - 3) Rational prevention for proper technique use in good handwashing

Program Evaluation: _____ Yes _____ No

Written Test

Average Test Score _____ %

Return Demonstration

Satisfactory _____ %

Unsatisfactory _____ %

Expected outcomes (Behavioral Changes) of employees:

[Signature]
SIGNATURE OF PERSON SUBMITTING REPORT

QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: 1/2011

MONITORING PERIOD: 10/10-12/10 SAMPLE: all

DATA SOURCES: Hand washing or sanitizer will be done between contact with food prep and before putting on gloves and when taking off per CDC guidelines

CATEGORY:

METHODOLOGY: Spot checks PREPARED BY: Patty Stroud

ASPECT OF CARE: Resident Safety

1. INDICATOR/THRESHOLD FOR EVALUATION:

Staff will wash hands or use sanitizer per CDC guidelines before contact with any food prep or putting on or taking off gloves contact 100% of the time.

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

2. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

3. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

4. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: Jan 2011

MONITORING PERIOD: 10/10-12/10 SAMPLE: all

DATA SOURCES: There will be a coffee urn provided for each meal cart for SNF CATEGORY:

METHODOLOGY: Spot checks of meal carts PREPARED BY: Patty Stroud

ASPECT OF CARE: Resident Safety

1. INDICATOR/THRESHOLD FOR EVALUATION:

There will be a coffee urn on each meal cart 100% of the time

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

2. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

3. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

4. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: 1/2011
MONITORING PERIOD: 10/10-12/10 SAMPLE: all
DATA SOURCES: Medication Cart will be locked and secure when out of site of medication nurse CATEGORY:
METHODOLOGY: Spot checks PREPARED BY: Sonya Wasserman RN, BSN

ASPECT OF CARE: Resident Safety

1. INDICATOR/THRESHOLD FOR EVALUATION:

Medication carts will be locked and secured 100% of the time when medication nurse does not have in their site.

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

2. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

3. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

4. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: 1/2011

MONITORING PERIOD: 10/10-12/10 SAMPLE: all

DATA SOURCES: Hand washing will be done between contact with patients per CDC guidelines CATEGORY:

METHODOLOGY: Spot checks PREPARED BY: Sonya Wasserman RN, BSN

ASPECT OF CARE: Resident Safety

1. INDICATOR/THRESHOLD FOR EVALUATION:

Staff will wash hands or use sanitizer per CDC guidelines before and after patient contact 100% of the time.

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

2. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

3. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

4. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

Hand Hygiene Direct Observation Data Collection Tool

Williamson ARH

Month: November 2011 **Unit:** 604

Directions:

1. This form applies to ALL Units / Departments / Physicians that have any patient contact.
2. The purpose of this tool is to provide regular observational feedback and education to patient care staff, and to prevent healthcare-associated infections.
3. Please make **10** HAND HYGIENE observations per month, evenly spaced throughout the month, of different staff members on all shifts.
4. At the end of each month, please forward this completed form via email to kdotson@arh.org, or leave it in the IC's office or mail box.
- 5. For EACH recorded observation, please observe the practitioner's hand hygiene practices **BEFORE** and **AFTER** patient contact. **THANK YOU !!**

Obs #	Name of Observer	Date	Shift (D, E, or N)	Job Position of the staff member being observed (RN, CNA, RT, MD, etc.)	Hand Hygiene Performed Before & After Patient Contact (or after contact with bodily fluids or soiled linen) AND PRIOR TO contact with any other patient, surface or item (charts, equip., etc.)? (Y or N)		Mark the Cleaning Method(s) Used		Was the Cleaning Method Properly Done? * ** (Y or N)	Evidence of Artificial Nails? (Y or N) (tips, wraps, rhinestones, overlays, appliques, etc.)	Comments
					Y	N	Soap & Water * (for at least 15 sec. using friction)	Alcohol Hand Sanitizer ** (Foam, Gel, or Lotion) (for 15-20 sec. over all surfaces)			
1	SW	11/9/10	D	RN	(Y)	N	✓		(Y) N	Y (N)	
2	SW	11/9/10	D	CNA	(Y)	N		✓	(Y) N	Y (N)	
3	SW	11/10/10	D	LPN	(Y)	N		✓	(Y) N	Y (N)	
4	SW	11/10/10	E	LPN	(Y)	N		✓	(Y) N	Y (N)	
5	SW	11/17/10	D	LPN	(Y)	N		✓	(Y) N	Y (N)	
6	SW	11/22/10	D	CNA	(Y)	N		✓	(Y) N	Y (N)	
7	SW	11/24/10	E	LPN	(Y)	N		✓	(Y) N	Y (N)	
8	SW	11/29/10	D	LPN	(Y)	N		✓	(Y) N	Y (N)	
9	SW	11/29/10	D	CENP	(Y)	N		✓	(Y) N	Y (N)	
10	SW	11/30/10	D	CNA	(Y)	N	✓		(Y) N	Y (N)	

*** Soap and Water:**

Use soap & water whenever there has been any contact with protein material (bodily fluids, soil, etc.), OR if there is an odor (like urine) even though nothing can be seen on the hands.

Proper Method:

- Soap applied after wetting hands and good lather achieved.
- Back & front of hands, between fingers, and wrists scrubbed.
- Scrubbing lasts for at least 15 seconds.
- Rinse hands with fingers pointed down and thoroughly pat dry with paper towel.
- Faucet turned off with dry paper towel and hands not re-contaminated.

**** Alcohol-Based Hand Sanitizer (foam, gel or lotion):**

You may use an alcohol-based hand sanitizer before applying and after removing gloves IF there is no soil on the hands.

Proper Method:

- Uses golf ball size of foam OR a full pump of gel or lotion.
- Covers entire surface of hands, fingers and wrists.
- Rubs hands until dry (approximately 15 - 20 seconds)

C-Diff:

If known or suspected use Soap and Water technique for cleansing hands.

NOTE: The CDC recommends washing with soap & water after every 5 times of using alcohol-based hand sanitizers due to build-up of moisturizers and bonding agents.

Attachment #41

Hand Hygiene Direct Observation Data Collection Tool

Williamson ARH

Month: December 2010 **Unit:** CH-64

Directions:

1. This form applies to ALL Units / Departments / Physicians that have any patient contact.
2. The purpose of this tool is to provide regular observational feedback and education to patient care staff, and to prevent healthcare-associated infections.
3. Please make **10** HAND HYGIENE observations per month, evenly spaced throughout the month, of different staff members on all shifts.
4. At the end of each month, please forward this completed form via email to kdotson@arh.org, or leave it in the IC's office or mail box.
- 5. For EACH recorded observation, please observe the practitioner's hand hygiene practices **BEFORE** and **AFTER** patient contact. **THANK YOU !!**

Obs #	Name of Observer	Date	Shift (D, E, or N)	Job Position of the staff member being observed (RN, CNA, RT, MD, etc.)	Hand Hygiene Performed Before & After Patient Contact (or after contact with bodily fluids or soiled linen) AND PRIOR TO contact with any other patient, surface or item (charts, equip., etc.)? (Y or N)		Mark the Cleaning Method(s) Used		Was the Cleaning Method Properly Done? * ** (Y or N)	Evidence of Artificial Nails? (Y or N) (tips, wraps, rhinestones, overlays, appliques, etc.)	Comments
					Y	N	Soap & Water * (for at least 15 sec. using friction)	Alcohol Hand Sanitizer ** (Foam, Gel, or Lotion) (for 15-20 sec. over all surfaces)			
1	SW	12/6/10	D	CNA	<input checked="" type="radio"/>	N	<input checked="" type="checkbox"/>		<input checked="" type="radio"/> Y <input type="radio"/> N	Y <input checked="" type="radio"/> N	
2	SW	12/7/10	D	CNA	<input checked="" type="radio"/>	N		<input checked="" type="checkbox"/>	<input checked="" type="radio"/> Y <input type="radio"/> N	Y <input checked="" type="radio"/> N	
3	SW	12/7/10	D	CNA	<input checked="" type="radio"/>	N		<input checked="" type="checkbox"/>	<input checked="" type="radio"/> Y <input type="radio"/> N	Y <input checked="" type="radio"/> N	
4	SW	12/8/10	D	LPN	<input checked="" type="radio"/>	N		<input checked="" type="checkbox"/>	<input checked="" type="radio"/> Y <input type="radio"/> N	Y <input checked="" type="radio"/> N	
5	SW	12/8/10	D	CNA	<input checked="" type="radio"/>	N		<input checked="" type="checkbox"/>	<input checked="" type="radio"/> Y <input type="radio"/> N	Y <input checked="" type="radio"/> N	
6	SW	12/9/10	D	CFNP	<input checked="" type="radio"/>	N	<input checked="" type="checkbox"/>		<input checked="" type="radio"/> Y <input type="radio"/> N	Y <input checked="" type="radio"/> N	
7	SW	12/9/10	D	LPN	<input checked="" type="radio"/>	N		<input checked="" type="checkbox"/>	<input checked="" type="radio"/> Y <input type="radio"/> N	Y <input checked="" type="radio"/> N	
8					Y	N			Y N	Y N	
9					Y	N			Y N	Y N	
10					Y	N			Y N	Y N	

*** Soap and Water:**

Use soap & water whenever there has been any contact with protein material (bodily fluids, soil, etc.), OR if there is an odor (like urine) even though nothing can be seen on the hands.

Proper Method:

- Soap applied after wetting hands and good lather achieved.
- Back & front of hands, between fingers, and wrists scrubbed.
- Scrubbing lasts for at least 15 seconds.
- Rinse hands with fingers pointed down and thoroughly pat dry with paper towel.
- Faucet turned off with dry paper towel and hands not re-contaminated.

**** Alcohol-Based Hand Sanitizer (foam, gel or lotion):**

You may use an alcohol-based hand sanitizer before applying and after removing gloves IF there is no soil on the hands.

Proper Method:

- Uses golf ball size of foam OR a full pump of gel or lotion.
- Covers entire surface of hands, fingers and wrists.
- Rubs hands until dry (approximately 15 - 20 seconds)

C-Diff:

If known or suspected use Soap and Water technique for cleansing hands.

NOTE: The CDC recommends washing with soap & water after every 5 times of using alcohol-based hand sanitizers due to build-up of moisturizers and bonding agents.

A Hechmeit #411

QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: April 2011
MONITORING PERIOD: Dec 10-March 11 SAMPLE: Enitre SNF
DATA SOURCES: Tour of Facility CATEGORY: Low Risk, High Volume
METHODOLOGY: Tour of Facility PREPARED BY: Sonya Wasserman, CNM

ASPECT OF CARE: Environemnt of Care - Safety

1. INDICATOR/THRESHOLD FOR EVALUATION:

100% of time a monthly tour of the facility will be conducted to check cabinet doors, clean tracking, mineral deposits on faucets, pull cords in bathrooms and overbed light cords, broken tile, marred or chipped paint, and missing or chipped Formica. Work requests will be sent to Maintenance and follow up monthly until repairs are completed.

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

2. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

PERFORMANCE IMPROVEMENT APPRAISAL

Results of indicator data collection: EOC – SNF – Safety, Sanitation

Indicator :100% of time monthly EOC tour to check for cabinet needs, dirty tracks, mineral deposits on faucets, pull cords, overbed cords, broken tile, chipped or marred paint. Repair requests sent and FU completed			Indicator 100% of time monthly EOC tour to check for cabinet needs, dirty tracks, mineral deposits on faucets, pull cords, overbed cords, broken tile, chipped or marred paint. Repair requests sent and FU completed			Indicator 100% of time monthly EOC tour to check for cabinet needs, dirty tracks, mineral deposits on faucets, pull cords, overbed cords, broken tile, chipped or marred paint. Repair requests sent and FU completed			Indicator 100% of time monthly EOC tour to check for cabinet needs, dirty tracks, mineral deposits on faucets, pull cords, overbed cords, broken tile, chipped or marred paint. Repair requests sent and FU completed		
Monitoring Period DATE	Initial Jan – 2011	Most Current	Monitoring Period DATE	Initial	Most Current Feb 2011	Monitoring Period DATE	Initial	Most Current March 2011	Monitoring Period DATE	Initial	Most Current 1 st quarter
numerator			numerator			numerator			numerator		
denominator			denominator			denominator			denominator		
% of compliance			% of compliance			% of compliance			% of compliance		

• Did assessment of measurement identify opportunity for improvement for this aspect of care? Yes _____ No _____

• What actions were taken to improve this aspect of care?

• Was aspect of care improved? Yes _____ No _____

• If no, identify areas for improvement that continue to be unresolved.

• Your plan to resolve issues:

X Education Policy/Proc. Change
Other:

Form Revision
Process Change

Continue Data Collection

Additional Comments:

QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: April 2011
MONITORING PERIOD: Dec 10-March 11 SAMPLE: Resident/Facility Equipment
DATA SOURCES: Tour of Facility CATEGORY: High Risk/High Volume
METHODOLOGY: Tour of Facility PREPARED BY: Kathy Mullins, SS Caseworker

ASPECT OF CARE: Patient Equipment e.g. wheelchairs, etc

1. INDICATOR/THRESHOLD FOR EVALUATION:

100% of time a monthly tour of the facility will be conducted to monitor if resident and facility equipment used by residents e.g. wheelchairs are in safe condition. Equipment will be taken out of use until repairs are made.

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

FOLLOW-UP DATE:

2. INDICATOR/THRESHOLD FOR EVALUATION:

FINDINGS/EVALUATION:

CONCLUSIONS:

RECOMMENDATIONS/ACTIONS:

EFFECT OF PREVIOUS ACTIONS:

Area Cleaned	Sharp Containers Checked		Floors Cleaned & Buffed		Corners Cleaned		Mirror/Window Cleaned		Furniture Cleaned		Damp/Mop Floors		Sinks Cleaned		Empty/Clean Trash Cans		Vents/TV's Cleaned		Lights Cleaned & Working		Commodos/ Shower Cleaned		
	Yes/Time	No	Yes/Time	No	Yes/Time	No	Yes/Time	No	Yes/Time	No	Yes/Time	No	Yes/Time	No	Yes/Time	No	Yes/Time	No	Yes/Time	No	Yes/Time	No	
Room 147																							
Room 148																							
Room 149																							
Room 150																							
Room 151																							
Room 152																							
Room 153																							
Room 154																							
Room 155																							
Room 156																							
Nurses Station																							
Restrooms																							
Dietary																							
Comments:																							
Percentage																							



CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744
Phone: 606-330-2030
Fax: 606-330-2054
<http://chfs.ky.gov/os/oig/>

Janie Miller
Secretary

Mary Reinle Begley
Inspector General

March 25, 2011

Ms. Karen Reed
Williamson ARH
260 Hospital Drive
South Williamson, Kentucky 41503

Dear Ms. Reed:

Thank you for submitting your proposed plan of correction regarding the deficiencies noted during our survey completed on November 18, 2010.

We are accepting your allegation of compliance and presume that substantial compliance was achieved by December 20, 2010, as alleged in your plan of correction. Therefore, we are not recommending the remedies referred to in the initial notice dated December 6, 2010, to the Centers for Medicare and Medicaid Services Regional Office at this time. Based on implementation of your plan of correction, we will recommend that your nursing facility be relicensed and recertified for continued participation in the Title XVIII/XIX program(s) contingent upon approval from the appropriate agencies.

Your cooperation is appreciated. If you should have questions regarding this information, please contact our office.

Sincerely,

A handwritten signature in cursive that reads "Sandy Goins /SG".

Sandy Goins
Regional Program Manager

SG:st.lk



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744
Phone: 606-330-2030
Fax: 606-330-2054
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Janie Miller
Secretary

Mary Reinle Begley
Inspector General

December 6, 2010

ELECTRONIC MAIL

Ms. Karen Reed
Williamson ARH
260 Hospital Drive
South Williamson, Kentucky 41503

Dear Ms. Reed:

On November 18, 2010, a standard survey was completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This visit found that your facility was not in substantial compliance with the participation requirements. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567, whereby corrections are required (E).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (POC)

A POC for the deficiencies must be submitted no later than ten (10) days from receipt of this letter. Failure to submit an acceptable POC may result in a recommendation that remedies be imposed immediately upon notification requirements being met. Your POC, as fully implemented, will serve as your allegation of compliance.

Ms. Karen Reed
December 6, 2010
Page Two

Your POC must:

- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and
- **Include dates when corrective action will be completed. In the right column with the heading 'completion date,' include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

You are required to record your plan of correction in the appropriate column on the enclosed Form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided at the bottom of page one.**

Recommended Remedies

As a result of our finding that your facility was not in compliance with participation requirements, the following remedies will be recommended to the Centers for Medicare and Medicaid Services (CMS) Regional Office if substantial compliance has not been achieved by January 2, 2011.

- A civil money penalty of \$ _____ beginning November 18, 2010, and continuing until substantial compliance is achieved or your provider agreement is terminated.
- Denial of payment for new admissions as soon as notification requirements can be met.

A change in the seriousness of the noncompliance at the time of a revisit may result in a change in the remedy(ies). If this occurs, you will be notified.

If you do not achieve substantial compliance **within three (3) months** from the last day of the survey identifying noncompliance, the CMS Regional Office must deny payments for new admissions.

Ms. Karen Reed
December 6, 2010
Page Three

Your provider agreement must be terminated if substantial compliance is not achieved **within six (6) months** from the last day of the survey identifying noncompliance.

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare and Medicaid Services determine that termination or any other sanction is warranted, it will provide you with a separate formal notification of that determination.

Informal Dispute Resolution

In accordance with 42 CFR 488.331 and 906 KAR 1:120, a provider shall have one informal opportunity to dispute a cited deficiency, or scope and severity assessment that constitutes Substandard Quality of Care or Immediate Jeopardy. You are required to send your request in writing to IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621. Your request shall specify the format for the informal dispute resolution, specify the deficiency in dispute, explain the dispute, and provide a detailed basis for the dispute. Documentation in support of the dispute shall be attached to the request. The request and attachments shall be delivered **on or before the tenth calendar day after receipt of the Statement of Deficiencies**. A request for informal dispute resolution shall not delay an enforcement action.

If you should have questions regarding this information, please contact our office.

Sincerely,



Sandy Goins
Regional Program Manager

SG:st:lk

Enclosures



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744
Phone: 606-330-2030
Fax: 606-330-2054
<http://chfs.ky.gov/os/oig/>

Janie Miller
Secretary

Mary Reinle Begley
Inspector General

December 6, 2010

Ms. Karen Reed
Williamson ARH
260 Hospital Drive
South Williamson, Kentucky 41503

Dear Ms. Reed:

The Division of Health Care completed a relicensure survey at your facility on November 18, 2010. This survey was conducted to determine compliance with state licensure requirements. The survey found that your facility failed to meet minimum state licensure requirements for operation of a nursing facility. The deficiencies cited are listed on the enclosed Statement of Deficiencies/Plan of Correction document.

As part of the licensure process, each facility is required to submit a written plan for the correction of all deficiencies noted during the survey. The Plan of Correction shall specify:

- The date by which the violation shall be corrected,
- The specific measures utilized to correct the violation, and
- The specific measures utilized to ensure the violation will not recur.

Ms. Karen Reed
December 6, 2010
Page Two

902 KAR 20:008 Section 2.(5)(b) requires that a plan of correction for licensure deficiencies be submitted to this agency within ten (10) days from receipt of this letter. The plan, outlining methods of correction and proposed completion dates for each deficiency, should be incorporated in the column provided on the enclosed form. The form should be signed by you or an authorized representative and received in this office within ten (10) days of receipt of this letter. You should make a copy of the form for your records and/or posting requirements. Continued failure to meet minimum state licensure requirements will result in a recommendation for revocation of a license to operate a nursing facility.

KRS 216.547 requires that all long-term care facilities shall retain, for public inspection in the office of the administrator and in the lobby of the facility, a complete copy of every inspection report of the facility received from the cabinet during the past three (3) years, including the most recent inspection report.

Informal Dispute Resolution (IDR): In accordance with 906 KAR 1:120, a long-term care facility shall have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send a written request which specifies the deficiency in dispute; explain the dispute and provide a detailed basis for the dispute; specify the format desired (refer to the enclosure) and attach the documentation in support of your position to the request. This written request and attachments shall be delivered to IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621 on or before the mandated return date for the plan of correction. Informal Dispute Resolution will be accomplished in accordance with 906 KAR 1:120. This process will not delay the effective date of any enforcement action.

IDR in no way is to be construed as a formal evidentiary hearing. It is an informal process to discuss deficiencies. If you will be accompanied by counsel, you must indicate this in your request for IDR so that we may also have counsel present. You will be advised verbally of your decision relative to the informal dispute, with written confirmation to follow.

If you should have questions regarding this information, please contact our office.

Sincerely,

Handwritten signature of Sandy Goins in cursive script.

Sandy Goins
Regional Program Manager

SG:st:lk

Enclosure

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

PRINTED: 08/03/2011
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2010
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	
K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on November 19, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.