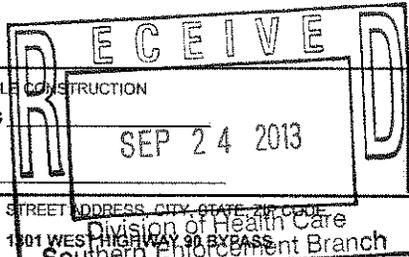


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/06/2013  
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  08/22/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HICKS GOLDEN YEARS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1301 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633 Division of Health Care Southern Enforcement Branch
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A standard health survey was conducted on 08/20-22/13. Deficient practice was identified with the highest scope and severity at "G" level, with an opportunity to correct.	F 000		
F 272 SS=G	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	Please see attachment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael Luckee Rn</i>	TITLE DON	(X8) DATE 9-24-13
---	--------------	----------------------

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



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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 272	<p>Continued From page 2</p> <p>physical functioning of being up in the wheelchair and moving about the facility. (Refer to F279 and F315.)</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Foley Catheter Care," not dated, revealed a resident's catheter tubing should be secured to the bottom bed linens and staff was not to pull or tug on the catheter.</p> <p>Review of a facility policy with no title or date noted, revealed staff was to conduct skin assessments upon admission and then weekly. Staff was to assess for red areas, pain, or swelling. If abnormalities were identified, staff was to assess the resident's needs at that time. Further review of the policy revealed it was the responsibility of the treatment nurse to monitor all skin problems to include abrasions, redness, and tears.</p> <p>Review of the Resident Assessment Instrument (RAI) User Manual Version 3.0 revealed, "The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter...and consideration of complications resulting from the use of an indwelling catheter (e.g., urethral erosion, pain, discomfort, and bleeding)."</p> <p>1. Review of the medical record for Resident #9 revealed the facility admitted the resident on 02/12/13. The resident's admitting diagnoses included Multiple Sclerosis, Enlarged Prostate, and a History of Urinary Tract Infections. A review of the resident's admission comprehensive (RAI) assessment dated 02/18/13 revealed facility</p>	F 272			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 272	<p>Continued From page 3</p> <p>staff identified that the resident had a urinary catheter. However, the resident's assessment provided no evidence the facility assessed Resident #9 and considered the risk factors of the indwelling urinary catheter (urethral erosion, pain, and discomfort). According to the 02/18/13 assessment, Resident #9 did not have a penile tear/erosion. Review of the quarterly Minimum Data Set (MDS) assessment dated 06/27/13, revealed Resident #9 continued to utilize a urinary catheter; however, there was no evidence Resident #9 had a penile tear/erosion. Further review of the MDS assessment revealed the resident required extensive assistance with bed mobility, bathing, and incontinence care, and was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.</p> <p>A review on 08/22/13, of Resident #9's medical record revealed licensed staff had conducted a head-to-toe skin assessment when the facility admitted the resident on 02/12/13. The resident's admission skin assessment provided no evidence the resident had a penile tear or penile edema. Further review of the record revealed staff had conducted Resident #9's skin assessments weekly since admission, with the last skin assessment conducted on 08/22/13. According to the weekly skin assessments, Resident #9 did not have any torn/split areas to the penis. Staff documented on 08/22/13 at 12:01 PM, that the resident had "no areas noted."</p> <p>Observations conducted of urinary catheter care for Resident #9 on 08/22/13 at 10:40 AM, revealed the resident's penis was torn/split from the urinary meatus (the opening in the penis from which urine flows) and down the shaft of the</p>	F 272			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 272	<p>Continued From page 4</p> <p>resident's penis. The resident was observed to have facial grimacing while care was provided by facility staff and when the resident was turned onto his side. There was no evidence Resident #9's catheter was secured to prevent pulling/relieve pressure of the catheter tubing.</p> <p>Interview with Resident #9 on 08/22/13 at 12:40 PM, revealed the resident's penis was not torn when the facility admitted the resident (was unable to recall when the tear occurred after admission). The resident stated, "They [staff] have ripped and pulled on my catheter so much here." The resident stated his genitals burned and were painful when facility staff provided care. The resident continued to state that he told staff that it hurt when staff provided care; however, the resident stated, "They won't do anything to keep it from pulling."</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 08/22/13 at 1:15 PM, revealed she had conducted the skin assessment for Resident #9 at 12:01 PM on 08/22/13 (same day observations of catheter care were conducted), and documented that the resident had no skin problems. The LPN acknowledged the resident had swelling and a penile tear; however, she stated she had not documented the abnormalities because this was not a change for this resident. She continued to state that she should have documented an accurate assessment of the resident's skin integrity. Continued interview with the LPN revealed she had conducted the admission assessment for Resident #9 on 02/18/13. LPN #1 stated the resident's penis was torn and swollen upon admission; however, the LPN stated she had not documented an accurate assessment at the time of admission.</p>	F 272			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 272	<p>Continued From page 5</p> <p>An interview with the Director of Nursing on 08/22/13 at 5:30 PM, revealed staff was required to conduct and document an accurate skin assessment upon admission and weekly for facility residents. The DON stated she was not aware of the edema and penile tear to Resident #9. She continued to state staff should have documented an accurate, thorough assessment of Resident #9's skin.</p> <p>An interview with the MDS Coordinator on 08/22/13 at 4:50 PM, revealed she did not conduct a skin assessment of residents when completing an MDS assessment, but coded the assessment information based on facility staff documentation. The MDS Coordinator stated she was not aware of the edema or penile tear to Resident #9's penis. She acknowledged staff should have documented that the resident's penis was torn/split when staff conducted the weekly skin assessments. She stated Resident #9 had not had a comprehensive, accurate MDS assessment due to the facility failure to ensure skin assessments were accurate.</p> <p>2. Record review conducted for Resident #4 revealed the facility admitted the resident on 01/16/13, with diagnoses of Dementia, Urinary Retention, and Benign Prostrate Hypertrophy (BPH). Review of the new admission information and the admission assessment completed on 01/16/13 revealed the facility admitted Resident #4 with a urinary catheter. According to the assessment there was no evidence the resident had any tears or problems of the penis related to the urinary catheter.</p> <p>Further record review revealed Resident #4</p>	F 272			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 272	<p>Continued From page 6</p> <p>exhibited behaviors and had pulled out the urinary catheter with the bulb inflated on 01/17/13. According to the record, staff reinserted the urinary catheter the same day. Review of the nurse's notes dated 01/20/13 at 2:10 PM, and 01/23/13 at 4:47 AM, revealed Resident #4 was agitated and pulling at his urinary catheter. Additional record review revealed the resident had a small, red tear to the urethral opening with a small, reddened area around the urinary catheter on 02/24/13; however, according to the treatment sheets, the area had resolved on 03/07/13.</p> <p>Review of the comprehensive admission MDS completed for Resident #4, dated 01/24/13, revealed staff assessed the resident to have behaviors (not directed toward others) and to have a urinary catheter. There was no evidence the facility assessed the resident's behavior of pulling out the catheter or attempting to pull out the catheter. Additional review of the quarterly Minimum Data Set assessments completed for Resident #4 on 04/18/13 and 07/12/13 revealed the resident continued to utilize an indwelling urinary catheter; however, there was no evidence the resident had tears to the penis. In addition, review of weekly skin assessments completed for Resident #4 since admission revealed no documented evidence the resident had a tear/split to the penis.</p> <p>Observation of urinary catheter care conducted for Resident #4 on 08/22/13 at 9:50 AM, revealed the resident had an old tear/split of the penis through the urethra to the underside of the penis extending from the end of the penis down the length of the shaft of the penis 4 centimeters long. The resident's urinary catheter was not</p>	F 272		

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 272	Continued From page 7 secure and was observed protruding from the bottom of the tear/split.  Interview with LPN #1 on 08/22/13 at 10:45 PM, revealed the resident's penis had always been torn. LPN #1 stated the resident's catheter was not secured to the resident's leg because the resident was allergic to tape.  Interview conducted with the facility's Treatment Nurse on 08/22/13, at 4:40 PM, revealed the Treatment Nurse was aware the resident had a tear to the penis in the past, but was not aware the resident's penis had torn to a length of 4 centimeters. According to the treatment nurse, she would not monitor the skin tear to the penis unless the tear was new.  Interview conducted with the MDS Nurse on 08/22/13 at 5:00 PM, revealed the MDS assessment was completed by the fourteenth day after a resident was admitted to the facility and then at least quarterly as required. Further interview with the MDS Nurse revealed she had not identified behaviors of Resident #4 pulling at the catheter, nor had she identified the resident's tear/split to the penis.	F 272			
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 279	<p>Continued From page 8</p> <p>needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policies, it was determined the facility failed to assess and consider risk factors of an indwelling urinary catheter (erosion, pain, and discomfort) and develop a care plan based on the assessment for two of fourteen sampled residents (Residents #9 and #4). In addition, the facility failed to develop a care plan that addressed securing residents' indwelling urinary catheter tubing to prevent pulling/pressure per the facility's policy. Observations conducted of urinary catheter care for Resident #9 revealed the resident's penis was swollen and torn/split from the urinary meatus (the opening in the penis from which urine flows) and down the shaft of the resident's penis. Resident #9's catheter tubing was not anchored/secured to prevent pulling. Interviews with Resident #9 revealed the injury to his penis resulted from the catheter tubing being pulled. In addition, the facility admitted Resident #4 with no evidence of any tears/damage to the penis on 01/16/13. The resident exhibited behaviors of pulling and dislodging the urinary</p>	F 279			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 279	<p>Continued From page 9</p> <p>catheter and was noted to have a tear to the penis on 02/24/13. The facility failed to implement interventions to secure the urinary catheter to prevent further damage to the resident's penis. Observation of the resident's penis on 08/22/13 revealed a tear/split from the urinary meatus (the opening in the penis from which urine flows) and down the shaft of the resident's penis. (Refer to F272 and F315.)</p> <p>The findings include:</p> <p>An interview conducted with the Director of Nursing on 08/22/13 at 5:35 PM, revealed the facility did not have a specific policy related to completion of the care plans. However, it was facility practice to develop an initial care plan when the resident was admitted. Then the required MDS assessment and care planning process was utilized to develop a comprehensive care plan as required.</p> <p>Review of the facility's policy entitled "Foley Catheter Care," not dated, revealed a resident's catheter tubing should be secured to the bottom bed linens and staff was not to pull or tug on the catheter.</p> <p>Review of the Resident Assessment Instrument (RAI) User Manual Version 3.0 revealed, "The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter...and consideration of complications resulting from the use of an indwelling catheter (e.g., urethral erosion, pain, discomfort, and bleeding). The next step is to develop an individualized care plan based directly on these conclusions."</p>	F 279			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 279	<p>Continued From page 10</p> <p>1. A review of Resident #9's medical record revealed the facility admitted the resident on 02/12/13, with diagnoses including Enlarged Prostate and Multiple Sclerosis.</p> <p>A review of Resident #9's admission comprehensive Resident Assessment Instrument (RAI) assessment dated 02/18/13, revealed facility staff had identified the resident had a urinary catheter. Review of Resident #9's most recent Minimum Data Set (MDS) assessment dated 06/27/13, revealed the resident had no cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 15 and utilized an indwelling urinary catheter. There was no evidence the facility assessed and considered the risk factors and complications of having the urinary catheter.</p> <p>Review of Resident #9's care plan initially dated 02/12/13, and updated on 07/02/13, revealed staff was required to provide routine urinary catheter care. However, staff failed to develop individualized care plan interventions that addressed risk factors of an indwelling urinary catheter (urethral erosion, pain, and discomfort). In addition, the facility failed to develop a care plan with interventions to address pulling/pressure of the resident's indwelling urinary catheter tubing per the facility's policy.</p> <p>Observations conducted on 08/22/13 at 10:40 AM, of Foley catheter care for Resident #9 revealed the resident's penis was torn/split from the urinary meatus (the opening in the penis from which urine flows) and down the shaft of the resident's penis (measured 3.5 centimeters). Resident #9 was observed to have facial grimacing while facility staff provided care.</p>	F 279			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 279	<p>Continued From page 11</p> <p>Observations revealed the resident's catheter was not secured.</p> <p>An interview with Resident #9 on 08/22/13 at 12:40 PM, revealed the resident's penis was torn after he was admitted to the facility (was unable to recall when the tear occurred after admission). The resident stated staff had "ripped it by pulling it so much." Resident #9 stated his genitals burned and it was painful when staff provided care. The resident stated staff had been told that it hurt when care was provided; however, nothing had been done to keep the catheter from "pulling" when care was provided.</p> <p>An interview with the MDS Coordinator on 08/22/13 at 4:50 PM, confirmed she failed to implement interventions to prevent Resident #9's indwelling urinary catheter tubing from being pulled. She acknowledged a care plan should have been developed to prevent the catheter tubing from being pulled.</p> <p>An interview with the Director of Nursing (DON) on 08/22/13 at 5:30 PM, revealed staff should have developed interventions to prevent Resident #9's indwelling urinary catheter tubing from being pulled.</p> <p>2. A medical record review conducted for Resident #4 revealed the facility admitted the resident on 01/16/13, with diagnoses including Urinary Retention, Benign Prostrate Hypertrophy (BPH), and Dementia. According to the record, the resident had a urinary catheter upon admission. Review of the admission assessment, the comprehensive MDS admission assessment dated 01/24/13, quarterly MDS assessments dated 04/18/13 and 07/12/13, and</p>	F 279			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 279	<p>Continued From page 12</p> <p>the Care Area Assessment (CAA) Summary dated 01/29/13, revealed the resident was assessed to have a urinary catheter. There was no evidence on the assessments that the resident had any tears or problems of the penis related to the urinary catheter.</p> <p>According to nurse's notes, Resident #4 exhibited behaviors and pulled out the urinary catheter on 01/17/13. Additional review revealed on 01/20/13 at 2:10 PM, and 01/23/13 at 4:47 AM, the resident was agitated and pulling at the urinary catheter. Additional record review revealed the resident had a small red tear to the urethral opening with a small spot of red around the urinary catheter on 02/24/13, and according to the treatment sheets the area had resolved on 03/07/13.</p> <p>Review of Resident 4's Admission Care Plan, Comprehensive Care Plan, and updates to the plan of care from 01/16/13 to 08/22/13 revealed no evidence of interventions developed to prevent the resident from pulling the urinary catheter, or to secure the urinary catheter to prevent pulling and tearing of the penis.</p> <p>Interview conducted with Certified Nursing Assistant (CNA) #2 on 08/22/13 at 9:50 AM, revealed the CNA was not aware of any interventions to stabilize the catheter for Resident #4. According to CNA #2, the resident had a history of pulling at the catheter and the resident's penis had been torn since admission to the facility.</p> <p>Interview with the MDS Coordinator on 08/22/13 at 5:00 PM, revealed the MDS Nurse had not assessed the resident's behavior related to pulling at the catheter nor had identified that the</p>	F 279			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 279	Continued From page 13 resident had a tear/split of the penis. Further interview revealed the MDS Nurse had not developed care plan interventions related to the pulling of the catheter or the torn/split penis because she was not aware of the resident's problems related to the catheter and had not considered problems related to the catheter tears or erosion of the penis. In addition, the MDS Coordinator stated she relied on weekly skin assessments to identify problems; however, she did not look at the resident's skin when completing the MDS and care plan unless the resident had a pressure sore.  According to interview conducted with the DON on 08/22/13 at 5:35 PM, the care team reviewed the resident prior to admission to identify care needs and an admission nursing assessment was completed the day the resident was admitted. Based on the initial review and the admission nursing assessment, an initial care plan was put in place to address the resident's immediate care needs. Further interview revealed the MDS Nurse then completed the admission MDS assessment and developed a comprehensive care plan to address needs based on the assessment. Further interview revealed if a resident had a change or a new concern developed, it was discussed in the department head meeting and the MDS Nurse would update the care plan. According to the DON, the resident's torn/split penis should have been monitored and the care plan should have had interventions to prevent further injury.	F 279			
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive	F 315			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 315	<p>Continued From page 14</p> <p>assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure two of fourteen sampled residents (Residents #9 and #4) with indwelling urinary catheters received care to prevent complications. A review of Resident #9 and Resident #4's admission and quarterly Minimum Data Set (MDS) assessments revealed staff failed to assess risk factors associated with urinary catheter usage and failed to assess the skin condition of the residents' penis. In addition, the facility failed to develop a care plan with interventions that addressed complications/risk factors related to the resident's urinary catheter and failed to develop interventions to ensure the urinary catheter tubing was secured to prevent pulling/pressure as required per the facility's policy. In addition, the facility failed to assess Resident #4's behavior of pulling at/pulling out his urinary catheter and failed to develop interventions to address this behavior. A review of Resident #9's medical record, including the care plan, revealed the resident had the urinary catheter at the time of admission (02/12/13). Observations conducted on 08/22/13 of urinary catheter care revealed Resident #9's penis was</p>	F 315			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 315	<p>Continued From page 15</p> <p>swollen and torn/split from the urinary meatus (the opening in the penis from which urine flows) and down the shaft of the resident's penis, approximately 3.5 centimeters. Review of Resident #9's medical record, including the care plan, revealed the resident had the urinary catheter at the time of admission (02/12/13). Observations conducted on 08/22/13 of urinary catheter care revealed Resident #4's penis was torn/split from the urinary meatus (the opening in the penis from which urine flows) and down the underside of the shaft of the resident's penis, approximately 4 centimeters. (Refer to F272 and F279.)</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Foley Catheter Care," not dated, revealed a resident's catheter tubing should be secured to the bottom bed linens. Further review of the policy revealed staff was not to pull or tug on the catheter. However, the policy failed to address how the indwelling urinary catheters were to be secured to prevent excessive tension on the catheter, which could lead to urethral tears or dislodging of the catheter.</p> <p>Review of Resident Assessment Instrument (RAI) User Manual Version 3.0 revealed, "The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter...and consideration of complications resulting from the use of an indwelling catheter (e.g., urethral erosion, pain, discomfort, and bleeding). The next step is to develop an individualized care plan based directly on these conclusions."</p>	F 315			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 315	<p>Continued From page 16</p> <p>1. Review of Resident #9's medical record revealed the facility admitted the resident on 02/12/13, with diagnoses including Multiple Sclerosis and Enlarged Prostate.</p> <p>Review of Resident #9's most recent Minimum Data Set (MDS) assessment dated 06/27/13, and the admission MDS assessment dated 02/18/13, revealed the facility assessed the resident as being alert and oriented, with a BIMS (Brief Interview for Mental Status) score of 15, which indicated no cognitive impairment. According to the MDS assessments, Resident #9 had a urinary catheter and required extensive assistance from staff with transferring, dressing, hygiene/bathing, and toilet use (which includes managing a catheter).</p> <p>Review of Resident #9's care plan initially dated 02/12/13, and updated on 07/02/13, revealed staff was required to provide routine catheter care for Resident #9. However, the care plan failed to address interventions to prevent complications from the urinary catheter and failed to develop interventions to direct staff to secure the resident's indwelling urinary catheter tubing to prevent pulling.</p> <p>Observations conducted on 08/22/13 at 10:40 AM, of Foley catheter care for Resident #9 revealed the resident's penis was torn/split from the urinary meatus (the opening in the penis from which urine flows) and down the shaft of the resident's penis (measured 3.5 centimeters). The resident was turned onto his side and facility staff failed to secure the resident's Foley catheter while care was provided. The resident was observed to have facial grimacing while staff provided care to the resident.</p>	F 315			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 315	Continued From page 17  Interview with Certified Nurse Aide (CNA) #1 on 08/22/13 at 11:00 AM, revealed the CNA acknowledged she had not secured the resident's catheter when care was provided and stated she had never been trained to secure urinary catheters since employed at the facility. However, the CNA stated it would decrease the resident's discomfort if the catheter was secured.  An interview with Resident #9 on 08/22/13 at 12:40 PM, revealed the resident stated, "My penis was not torn when I came here." The resident stated staff had "ripped it by pulling it so much." The resident stated his genitals burned and were painful when care was provided by facility staff. The resident stated staff had been told that it hurt when care was provided, but nothing had been done to keep the catheter from being pulled when care was provided.  An interview with Licensed Practical Nurse (LPN) #1 on 08/22/13 at 2:40 PM, revealed she was assigned to provide care to Resident #9 on 08/22/13. According to LPN #1, the resident's penis had been swollen and split/torn since admission to the facility. However, she stated interventions had not been implemented to prevent the resident's indwelling Foley catheter tubing from being pulled. The LPN stated a thorough assessment should have been conducted and interventions should have been implemented to prevent the resident's Foley catheter from being pulled.  An interview with the MDS Coordinator on 08/22/13 at 4:50 PM, revealed she acknowledged an assessment, which included consideration of the risks and benefits of an indwelling catheter	F 315			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 315	<p>Continued From page 18</p> <p>and consideration of complications which could result from the use of an indwelling catheter (e.g., urethral erosion, pain, discomfort, and bleeding), had not been conducted for Resident #9. The MDS Coordinator stated a thorough assessment and interventions should have been implemented for the resident related to the indwelling catheter.</p> <p>An interview with the Director of Nursing (DON) on 08/22/13 at 5:30 PM, confirmed the facility policy failed to address how indwelling urinary catheters were to be secured to prevent excessive tension on the catheter, which could lead to urethral tears or dislodging of the catheter. Further interview revealed Resident #9 should have been accurately assessed and interventions should have been implemented related to the resident's indwelling urinary catheter.</p> <p>2. Observation of urinary catheter care for Resident #4 on 08/22/13 at 9:50 AM, conducted by CNA #2, revealed Resident #4's penis was torn/split from the urinary meatus (the opening in the penis from which urine flows) and down the shaft of the resident's penis (measured 4 centimeters). Further observation revealed the resident's urinary catheter was not secured and the catheter tubing was routed out the leg of the resident's pants. The resident was transferred to a wheelchair and the catheter bag was covered and attached to the frame of the wheelchair under the seat.</p> <p>An interview conducted with CNA #2 on 08/22/13 at 9:50 AM, revealed the CNA had not been trained to secure the resident's catheter and did not have a means of securing the resident's catheter to prevent pulling or further tearing of the penis. In addition, CNA #2 stated the resident's</p>	F 315			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 315	<p>Continued From page 19</p> <p>penis was torn when the resident was admitted to the facility.</p> <p>A review of the medical record for Resident #4 revealed the facility admitted the resident on 01/16/13, with diagnoses of Dementia, Urinary Retention, and Benign Prostrate Hypertrophy (BPH). A review of the admission assessment, admission MDS assessment completed on 01/16/13, and quarterly MDS assessments completed on 04/18/13 and 07/12/13, revealed Resident #4 utilized a urinary catheter; however, according to the assessments, there was no evidence the resident had any tears or damage to the penis. Further record review revealed Resident #4 exhibited behaviors and pulled out the urinary catheter on 01/17/13. According to the record, the urinary catheter was reinserted the same day with no evidence of tears or damage to the penis documented. According to the nurse's notes, the resident was noted to have a small, red tear to the urethral opening with a small spot of red around the urinary catheter on 02/24/13. Review of the treatment sheets revealed the area had resolved on 03/07/13. Additional review of weekly skin assessments and nurse's notes for Resident #4 since admission revealed no evidence of any other additional tears/damage to the resident's penis. A review of the plan of care developed when the facility admitted Resident #4 on 01/16/13 and updated on 4/23/13 and 7/12/13, revealed no interventions to secure the resident's catheter to prevent pulling of the catheter tubing to prevent or reduce the risk of injury to the penis.</p> <p>An interview conducted with LPN #1 on 08/22/13 at 10:47 PM, revealed the facility did secure some residents' urinary catheters but not</p>	F 315			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 315	Continued From page 20 Resident #4's because the resident was allergic to tape. According to LPN #1, the resident's penis was torn before the resident was admitted to the facility.  An interview with the MDS Nurse conducted on 8/22/13 at 5:00 PM, revealed the MDS Nurse was not aware of the tear/damage to the resident's penis and had not developed care plan interventions to secure the catheter for Resident #4 to prevent additional tears/damage and was not aware of behavior of pulling and did not assess risk factors or consider risks when developing the care plan.	F 315			
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 (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 441	<p>Continued From page 21</p> <p>(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.</p> <p>(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, interview, record review, and facility policy review, it was determined the facility failed to 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. Facility staff failed to perform handwashing procedures appropriately when providing incontinence care for one of fourteen sampled residents (Resident #9). In addition, the facility failed to ensure an employee was free from communicable disease. Certified Nurse Aide #3, with a hire date of 08/13/13, received a Tuberculosis screening (PPD) on 08/13/13. However, the CNA's PPD was never read to ensure she was free from Tuberculosis, and she continued to provide direct care to facility residents.</p> <p>The findings include:</p>	F 441			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 441	<p>Continued From page 22</p> <p>1. The facility's policy entitled "Universal Precautions," not dated, revealed blood and body fluids which included saliva, urine, and feces, can contain viruses and bacteria that can be passed on to another person through direct contact. The policy directed staff to wear disposable gloves and use hand gel or foam disinfectant when caring for facility residents. The policy further stated handwashing was the number one way to fight infection from employee to resident.</p> <p>A review of Resident #9's medical record revealed the facility admitted the resident on 02/12/13, with diagnoses including Multiple Sclerosis and Enlarged Prostate.</p> <p>Review of Resident #9's most recent Minimum Data Set (MDS) assessment dated 06/27/13, and the admission MDS assessment dated 02/18/13, revealed the facility assessed the resident to be incontinent of bowel functions. Further review revealed Resident #9 required extensive assistance from staff with hygiene/bathing and toilet use.</p> <p>Observations conducted on 08/22/13 at 10:40 AM, of incontinence care for Resident #9 revealed the resident had been incontinent of stool. Certified Nurse Aide (CNA) #1 was observed to clean the resident's stool from his/her peri-area with gloved hands. Further observations revealed the CNA, without changing her soiled gloves, placed her right gloved hand into a container of "house cream," and applied the cream to the resident's coccyx. The CNA then continued, with soiled gloves, to apply a clean attends to Resident #9, adjust his/her gown and bed linens, and raise the resident's head of the bed with the same gloves by touching the</p>	F 441			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 441	<p>Continued From page 23</p> <p>resident's bed controls.</p> <p>An interview with CNA #1 on 08/22/13 at 11:00 AM, revealed the CNA acknowledged she had not changed her gloves and washed her hands as required. The CNA stated she should have changed her gloves and washed her hands after she had cleaned stool from the resident.</p> <p>An interview with the Director of Nursing (DON) on 08/22/13 at 5:30 PM, revealed staff had been trained to change their gloves and wash their hands after coming in contact with blood/body fluids. The DON continued to state CNA #1 should have changed her gloves "after cleaning stool" when incontinence care was provided to Resident #9.</p> <p>2. The policy entitled "Policy on TB skin testing," not dated, revealed all new employees would be tested for Tuberculosis (TB) when hired, and the information would be retained in their employee files. However, the policy failed to address when the TB test results were required to be read, and what actions would be taken if the employees failed to have their tests read as required.</p> <p>A review of employee files on 08/21/13 revealed CNA #3 was hired, and received TB skin testing on 08/13/13. No evidence was identified in the CNA's employee file that staff had read the TB skin test.</p> <p>An interview with the Human Resources (HR) Manager on 08/21/13 at 5:00 PM, revealed she was responsible to ensure all new employees received a TB skin test and was also responsible to ensure all TB skin tests were read within 48 to 72 hours. The HR Manager confirmed CNA #3 received a TB skin test on 08/13/13 and failed to have the test read as required. The HR Manager further stated she should have notified the DON,</p>	F 441			

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

PRINTED: 09/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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 441	Continued From page 24 and the CNA should not have provided direct patient care until the TB skin test was read. Continued interview revealed CNA #3 provided direct patient care on 08/17/13 and 08/18/13.  The DON stated in interview on 08/22/13 at 9:20 AM, that she was responsible for the Infection Control program in the facility. The DON stated the HR Manager should have notified her when CNA #3 failed to obtain a reading of the TB skin test. The DON further stated CNA#3 should not have provided patient care until the skin test had been read.	F 441			

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

PRINTED: 12/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185298</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/21/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKS GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633</b>		
(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>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (200)</p> <p>SMOKE COMPARTMENTS: 5</p> <p>FIRE ALARM: Complete automatic fire alarm system.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II propane generator.</p> <p>A life safety code survey was initiated and concluded on 08/21/13, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be 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.