

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

PRINTED: 09/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2011
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	<i>Rivers Edge Nursing & Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.</i>	
F 164 SS=D	<p>A standard health survey was conducted 09/13/11 - 09/15/11. A Life Safety Code survey was conducted on 09/13/11. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>This was a nursing home initiative survey initiated on 09/13/11 at 6:00 AM.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when</p>	F 164	<p><i>Rivers Edge response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Rivers Edge reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.</i></p> <p>F 164 483.10(e), 483.75 (1) (4) PERSONAL PRIVACY/ CONFIDENTIALITY OF RECORDS</p> <p>1. During the annual survey on 9/13/11 it was determined by the surveyor that LPN failed to provide privacy by not closing the blinds prior to completing a dressing change for resident #2.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Zettie M. Parker Turner

Administrator

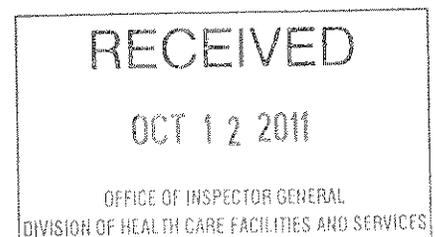
9/12/11

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

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F 164	Continued From page 1 release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of the facility's policy for Clean Dressing Changes and Residents' Rights, it was determined the facility failed to provide privacy for one (1) of twenty-two (22) sampled residents. Staff did not close the window blinds before providing wound care for Resident #2 who's bed was directly in front of the window. The findings include: Review of the Residents' Rights packet provided by the facility revealed each resident shall be treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs. Review of Resident #2's clinical record revealed the facility admitted the resident on 01/21/11 with the following diagnoses: Multiple Sclerosis; Post Laminectomy Syndrome; Decubitus Ulcer; Contractures; and Quadriplegia. Observation of a dressing change, on 09/13/11 at 2:00 PM, for Resident #2 revealed Licensed Practical Nurse (LPN) #1 did not close the privacy blinds on the resident's window before beginning the dressing change. The resident's window looked out directly into the main dining area. The resident's was turned to his/her left side,	F 164	F 164 Continued 2. Starting 09/16/11, the NHA has non-clinical department heads completing two rounds daily to insure staff is following facility policy. DON has administrative nurses completing daily rounds of all residents at different intervals to include all shifts to ensure staff is providing privacy, maintaining dignity, and respect at all times. Rounds sheets are returned to the DON daily for review and/or follow up. All staff to correct any concerns immediately and will provide education as needed. 3. Reeducation completed with LPN #1 identified in the concern on 9/15/11 by the DON. An all staff in-service was initiated on 9/15/11 and completed on 10/6/11 regarding providing privacy, dignity, and respect of all residents by the SDC & DON. The in-service included Q&A interviews with different disciplines to identify knowledge of information being taught. 100% of individual interviews did not reveal knowledge deficit of staff on privacy, dignity, and respect of all residents.	



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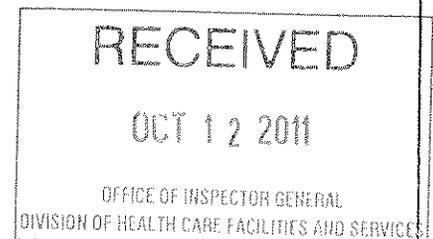
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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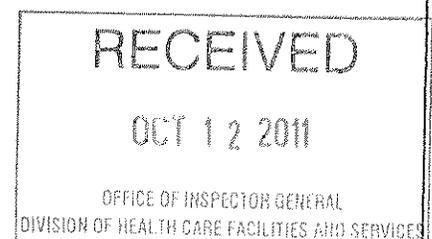
F 164	Continued From page 2 exposing the per1 area, while LPN #1 completed a dressing change to the left gluteal fold. Interview with LPN #1, on 09/15/11 at 2:45 PM, revealed the nurse was not aware the blinds were open. The LPN stated she was aware of the windows proximity to the dining area. She further revealed leaving the blinds open did not provide the resident with privacy. Interview with the Director of Nursing, on 09/15/11 at 5:30 PM, revealed the facility finds it unacceptable to leave a resident exposed. She further stated all staff need to make sure window blinds and curtains are closed before providing care.	F 164	<i>F 164 Continued</i> 4. DON/NHA will complete daily rounds of all four resident care areas beginning 9/15/11 x30days. Then 3x's per week x90days. Then weekly x8weeks. The results of these rounds will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during the QA process, the committee will reconvene for additional recommendations until sustained compliance. 5. Completion date 10/10/11	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to promote care with dignity and respect for residents individually for three (3) of twenty-two (22) sampled residents. Resident #14 was not approached or assisted to the table in the dining room for lunch in a respectful and dignified way. Resident # 22 was not responded to in a respectful way when the resident voiced dissatisfaction of getting to the	F 241	<i>F 241</i> F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 1. During the annual survey on 9/13/11 it was determined by the surveyor that resident #21 complained of staff not providing assistance with care as desired. It was also determined by the surveyor that on 9/14/11 the DON yelled across the dining room to get the attention of a resident #14 and did not give resident a choice prior to providing a clothing protector. It was also determined by the surveyor on 9/13/11 that nursing assistant #6 failed to follow up with resident #15 request for more cereal. It was also determined by the surveyor on 9/13/11 that certified nursing assistant #6 was pushing	10/10/11



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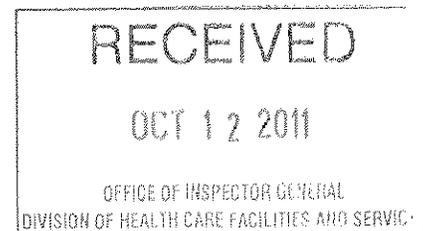
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F 241	Continued From page 3 bathroom and Resident #15 was not responded to when the resident asked for dry cereal. The findings include: Review of the facility policy for Abuse, Neglect, and Misappropriation of Residents Property, Prevention, revised 02/2009 revealed, the facility will provide supervision to staff to identify inappropriate behaviors, such as using derogatory language....ignoring residents while giving care..... Interview, on 09/13/11 at 1:00 PM, with the Resident Council revealed Resident #21 voiced a request for care was made of a staff member, the staff member responded by stating another resident required assistance. Resident #21 said staff members would say they would be with you in a minute, but they do not follow-up by honoring the request for care. Resident #21 stated when a staff member was reminded of an earlier request for care, the staff members responded saying, "I forgot." Resident #21 said staff say this all the time. Resident #21 reported being physically unable to put stockings on and take them off without staff assistance, and complained of being forced by staff to ask repeatedly for assistance with the stockings. Resident #21 said when the staff member was reminded of a request, the staff remarked they "forgot" about the request for assistance with the stockings. 1. Observation of the meal service, on 09/14/11 at 12:15 PM, in the Dining Room revealed the Director of Nursing (DON) standing across the room by the kitchen beverage counter. Resident #14 walked into the dining area and began	F 241	<i>F 241 Continued</i> resident #22 while asking resident #22 how he/she was feeling and resident #22 responded "not to good, I have been waiting to go to the bathroom for the last two hours". Certified nursing assistant #6 stated, "Well that's the way life is, I have to go to the bathroom too". 2. Starting 09/16/11 NHA has non-clinical department heads completing two rounds daily to insure staff is following facility policy. Starting 09/16/11 DON has administrative nurses completing daily rounds of all residents at different intervals to include all shifts to ensure staff is maintaining dignity, and respect of all residents at all times. Rounds sheets are returned to the DON/NHA daily for review and/or follow up. All staff to correct any concerns immediately and provides education as needed. 3. NHA completed retraining/education with DON on 9/28/11 regarding dignity, respect and all resident rights. DON has administrative nurses assigned to the dining room during all three meals daily for 6 months starting 09/16/11 for oversight and supervision to ensure resident needs are met. Education completed with certified nursing assistant #5 identified in the concern on 9/16/11 by the DON. An all staff in-service was initiated on 9/15/11 and completed on 10/6/11 by the DON &	



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F 241	Continued From page 4 speaking to other residents in greeting. The DON was observed yelling Resident #14's name repeatedly from across the room. When the resident did not respond, the DON walked across the room, took the residents hand and lead him/her to a table without explanation. Once the resident sat down in the chair, the DON then poked the resident in the shoulder and said "here" as she applied a clothing protector without asking the resident if they would like to wear the clothing protector. This observation was witnessed by two other surveyors. Interview with DON, on 09/15/11 at 5:30 PM, revealed all staff should call residents by their name and not poke them to get their attention. The DON revealed she should have asked the resident if he/she would like to have a clothing protector to give him/her the option. She further revealed she would not want anyone treating her in that manner and would want a choice in wearing the clothing protector. The DON revealed she did not feel the resident was treated with disrespect or that the incident lacked dignity. She stated it was not acceptable to rush someone and revealed she tries to watch her tone of voice, but "some of us are louder then others". The DON revealed she wanted the residents to be as comfortable as possible because the facility is their home. She further revealed she has instructed the staff to stop and think about their approach and its perception. 2) Observation, on 09/13/11 at 2:10 PM, revealed Certified Nursing Assistant #6 pushing Resident #22 in the wheelchair from the dining room down the hallway to the resident's room. CNA #6 asked	F 241	<i>F 241 Continued</i> SDC regarding providing privacy, dignity, and respect of all residents. An all staff in-service was completed by the Ombudsman on residents rights on 10/6/11. The in-service included Q&A interviews with different disciplines to identify knowledge of information being taught. 100% of individual interviews did not reveal knowledge deficit of staff on privacy, dignity, respect and all resident rights of all residents. 4. DON will complete daily rounds of at least one meal care beginning 9/15/11 x30days. Then 3x's per week x90days. Then weekly x8weeks. The results of these rounds will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during the QA process, the committee will reconvene for additional recommendations until sustained compliance. 5. Completion date: 10/10/11	10/10/11	



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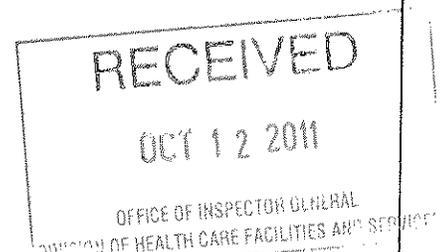
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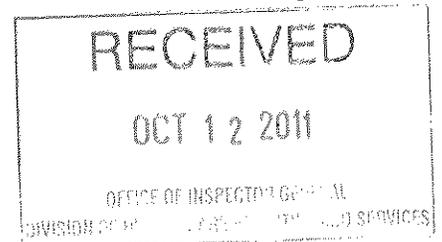
F 241	Continued From page 5	F 241		
	<p>the resident how they were feeling. The resident stated "not too good, I been having to go to the bathroom for the last two (2) hours. CNA #6 stated "well that's the way life is, I have to go to the bathroom too". CNA #6 proceeded to take the resident to their room, then left the room.</p> <p>Interview with Resident #22, on 0/14/11 at 12:05 PM, revealed the resident did recall the conversation and the comment by CNA #6 "well that's the way life is, I have to go to the bathroom too", and stated that is was upsetting but an isolated event.</p> <p>An Interview was attempted, on 09/15/11 at 10:20 AM and 5:15 PM, when a call was placed to CNA #6 and a phone message was left with no return phone call.</p> <p>Interview with the Director of Nursing, on 09/15/11 at 5:25 PM, regarding the comment made by CNA #6 revealed the DON stated that was "totally unacceptable".</p> <p>3. Observation, on 09/13/11 at 7:55 AM, in the Dining Room revealed Resident #15 had finished eating the food which was served, and requested an additional box of Rice Crispies from CNA #5. CNA #5 told Resident #15 she would be with them in a "minute", as she needed to assist another resident to be seated. CNA #5 spoke with another staff member about the request of Resident #15, and returned to her duties in the Dining Room. No follow-up was provided to Resident #15 about the request for Rice Crispies.</p> <p>Observation, on 09/13/11 at 8:05 AM, in the</p>			



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F 241	Continued From page 6	F 241		
F 248 SS=E	<p>Dining Room revealed Resident #15 stood up unassisted from the table, and ambulated out of the Dining Room with a rolling walker. Resident #15 was not provided a box of Rice Crispies or an explanation why the cereal was not provided.</p> <p>Interview, on 09/13/11 at 8:10 AM, with CNA #5, revealed when Resident #15 requested the Rice Crispies, she conferred with another staff member who said Resident #15 was on a fluid restricted diet, and because additional milk would be needed, Resident #15 could not have another box of Rice Crispies. CNA #5 said she was busy in the Dining Room and she "forgot" to explain this to Resident #15. When CNA #5 was asked how Resident #15 would feel after no response was received to the request, CNA #5 stated, "I just forgot."</p> <p>Interview, on 09/15/11 at 5:30 PM, with the Director of Nursing (DON) revealed she had attended recent Resident Council meetings and had heard residents complain of staff responses to repeated requests for assistance by saying, "I forgot." The DON said it was unacceptable for CNA #5 to neglect to communicate with Resident #15, and should have followed up in a timely manner, but did not think this was a resident dignity concern. The DON stated in response to concerns by the Resident Council, discussion of this issue had been included in new employee orientation.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and</p>	F 248	- F 248 Start Next page	



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F 248	Continued From page 7 the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy for the Activity Program and the Activity Calendar, it was determined the facility failed to develop and implement an Activity Program designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. Activity programming offered to the residents was limited on evenings and weekends, and activities were scheduled at the same starting time, which challenged residents to choose between a religious/worship service or a recreational activity as voiced by 13 Resident Council members and two (2) unsampled residents. In addition, the facility allowed uncomfortable high sound levels in the Activity Room during a Sensory Group Activity which lead to resident complaints. The findings include: Record review of the Activity Program Policy Manual revealed the purpose of the Activity Program was to provide residents with an individualized activity program to enhance resident's quality of life through involvement in recreational activities. Objectives included provision of regularly scheduled programs in the evenings and on weekends, and coordination of religious services or arrangements to meet the religious preferences and needs of residents.	F 248	F 248 F 248 483.15(f) (1) Activities meet interest/needs of each resident. 1). Unsampled resident was not identified. Facility had already self identified concerns with the activities department to include the calendar as things were added after the calendar was printed, guidelines, time frames, activity staff hours, variety, changes/updates, Restorative calendar and approval. 2). 100% survey was conducted with all alert and oriented residents beginning on 09/14/11 through 10/14/11 to determine activity interest. Surveys were also sent out to responsible parties for all other residents on September 12, 2011. 3. Activity staff was reeducated on September 8 th and again on September 14, 2011 by the administrator regarding activities, calendar, guidelines, time frames, activity staff hours, variety, changes/updates, Restorative calendar and approval.	

Continuation sheet Page 8 of 28
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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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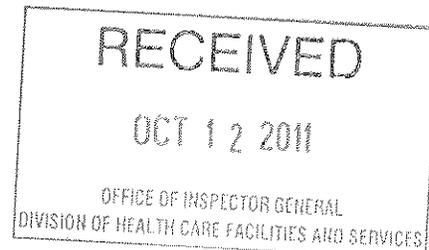
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F 248	Continued From page 8	F 248	<i>F-248 Continued</i>	
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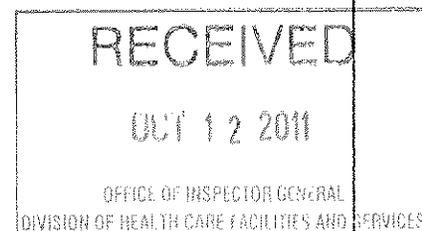
	<p>Record review of the facility Activity Calendar for August, 2011, revealed no activity programs were offered after 2:30 PM, with the exception of a movie offered on Friday nights at 7:00 PM, during the month of August, 2011. No activity programs were scheduled after 10:30 AM on Saturday or Sunday during the month of August, 2011. On five (5) days during the month of August, 2011, two (2) activity programs (one was a religious program), were scheduled to begin at 10:30 AM and run concurrently.</p> <p>Record review of the facility Activity Calendar for September, 2011, revealed no activity programs were offered after 4:00 PM with the exception of one (1) activity on three (3) Friday nights at 7:00 PM, during the month of September, 2011. No activity programs were scheduled on Saturday after 1:30 PM, during the month of September, 2011. No activity programs were scheduled on Sunday after 3:00 PM, during the month of September, 2011. On three (3) days during September, 2011 two (2) activity programs (one was a religious program), were scheduled to begin at 10:30 AM and run concurrently.</p> <p>Interview, on 09/13/11 at 1:00 PM, with thirteen (13) members of the Resident Council revealed the Activity Program did not offer enough variety. Resident #21 said only Bingo and religious services are offered on the weekends. Resident #8 said more activities should be offered in the evenings. Resident #21 said the Activities Director was new, and recently one Activity Assistant resigned and left the facility, and the other Activity Assistant had resigned to leave employment at the end of September. Resident #21 said the facility did not have enough activity</p>		<p>4). The Activities Director will monitor activities daily for two weeks, weekly for four weeks then monthly for two months to assess the level of participation and enjoyability exhibited by residents involved. Resident surveys will be conducted quarterly. Results of the monitoring will be forwarded to the QA committee at least quarterly. The QA committee will address any concerns and will recommend revisions and additions as deemed appropriate.</p> <p>Completion: 10/14/11</p>	10/14/11
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/15/2011
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
(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 248	Continued From page 9 staff available to effectively manage current programs, or offer more programs that are needed on the weekends. Observation, on 09/14/11 at 10:30 AM, revealed six (6) residents were seated in a circle with three (3) staff members in the Activities Room. Loud, popular/oldies music played as staff provided therapeutic touch including hand rubs with lotion. An Unsampled Resident requested the staff to turn the music down, and another Unsampled Resident requested the music be turned off. A staff member lowered the volume and continued the program. Interview, on 09/14/11 at 10:35 AM, with an Unsampled Resident in the Activity Room reported they did not enjoy the current program with the loud music. The Unsampled Resident wanted staff to turn the music off because it was so loud it caused their left leg to throb with pain. The Unsampled Resident said they suffered Polio as a child, and frequently had pain in the left leg as a result. The Unsampled Resident requested pain medication for the left leg pain during the program. Observation, on 09/14/11 at 10:40 AM, in the Dining Room revealed a live piano performance including show tunes and Big Band music. The program was titled, "Apples, Apples, Apples." Sixteen (16) residents were sitting at tables with two (2) staff members who served apple juice and cinnamon apples or applesauce to the residents. Music books with lyrics were provided at some tables, but residents were not observed to sing-along.	F 248			



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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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F 248	Continued From page 10	F 248		
	<p>Interview, on 09/14/11 at 10:50 AM, in the Dining Room with an Unsampled Resident revealed the Activity Program was not adequate to meet the needs of the residents. The Unsampled Resident stated the "Apples, Apples, Apples" program was "dull." The Unsampled Resident stated, "This is not a happy place." The Unsampled Resident said, "A person is supposed to enjoy their retirement, I am not enjoying this. We all still have feelings and need to be involved and do something interesting." The Unsampled Resident said the facility does not have enough activities which are interesting to the residents and said, "There is no Activity Program here, it is null and void."</p> <p>Interview, on 09/14/11 at 10:55 AM, with the Quality Improvement (QI) Coordinator revealed the facility considers resident preferences and suggestions for activity programs, and said the activity staff members brainstorm and search for new programming ideas on the Internet.</p> <p>Interview, on 09/14/11 at 3:15 AM, with the Activity Director revealed he has been in the position for one (1) month. The Activity Director stated activities were not offered after 4:00 PM because there was no activity staff available to provide activities in the evenings. The Activity Director said Bingo was offered on Saturday and church services were offered on Sunday and said this was sufficient because residents had visits from families on the weekends. On 09/15/11, when two activities were offered at 10:30 AM, the Activity Director said residents who attend Mass at 10:30 AM, could join 'Name that Tune' upon the conclusion of Mass. The Activity Director said residents were not forced to choose when two</p>			

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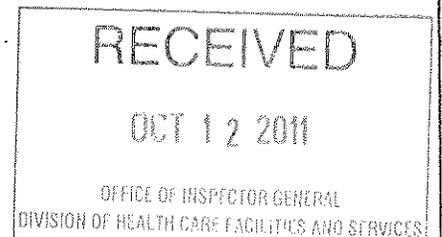
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 OFFICE OF INSPECTOR GENERAL
 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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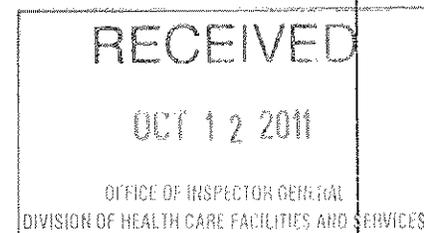
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059	
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F 248	Continued From page 11 activities were scheduled concurrently. Observation, on 09/15/11 at 9:35 AM, of an announcement heard on the facility public address system revealed that Mass and 'Name that Tune' was cancelled for Wednesday, 09/15/11, and 'Corn Hole' would be held at 10:30 AM instead. Mass was rescheduled for next Wednesday. Interview, on 09/15/11 at 1:50 PM, with the Activity Director revealed he met with the Administrator on 09/14/11 to discuss the Activity Calendar and some changes to the Activity Program. The Activity Director said the person who presided at weekly Mass could not be present, and the morning program was changed as a result. The Activity Director said the comments from the Unsampled Residents who reported they did not enjoy the activity programming concerned him. The Activity Director did not think the loud popular/oldies music played on 09/14/11 was appropriate for the residents in the Activity Room, and was told by staff of the resident requests to turn the music down or off. Interview, on 09/15/11 at 6:50 PM, with the Administrator revealed a consultation with the Activity Director was held to discuss activity programming and the Activity Schedule. The Administrator said residents should not be forced to choose between two activities which were scheduled at the same time. The Administrator said some activity programs were not reflected on the schedule, such as 1:1 visits, sensory groups, and restorative programs. The Administrator said the previous Activity Director "did not do a	F 248		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/15/2011
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
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F 248	Continued From page 12 good job," regarding the lack of evening and weekend activities prior to September, 2011. Interview, on 09/13/11 at 1:00 PM, with thirteen (13) Resident Council Members revealed the facility had not maintained comfortable sound levels for the residents. Resident #21 voiced the noise level after 10:00 PM is unacceptable and said staff "yell and scream" the length of the hall during the night. An Unsampled Resident stated staff play personal music devices loudly and did not think residents should have to "endure" the staff members music choices. Resident #20 said some residents who were sleeping at night kept the televisions playing loudly, and staff were unwilling to turn the television volume down or off. Resident #20 said staff members had been observed to watch television in resident's rooms as the resident slept. Resident #21 said the noise concerns were reported to the facility Administrator and Director of Nursing (DON), without any improvement in the sound levels. Observation, on 09/14/11 at 10:25 AM, revealed loud pop/oldies music which was played in the Activity Room, and was audible from the South hallway near room #1, which became progressively louder upon approach of the Activity Room. Observation, on 09/14/11 at 10:30 AM, of the Activity Room revealed six (6) residents were sitting in a circle with three (3) staff members present during a Sensory Group Activity. The loud music was played while staff provided therapeutic touch and lotion rubs. Residents were not observed to speak, sing, or react to the	F 248			



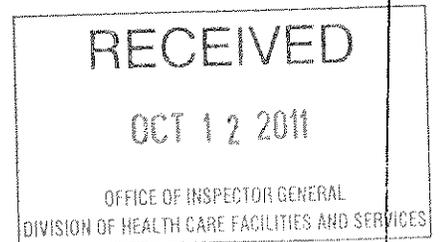
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40069
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F 248	Continued From page 13.	F 248		
F 371 SS=E	<p>music. One Unsampled Resident asked staff to turn the volume down, and another Unsampled Resident asked for the music to be turned off. Staff turned the volume down and the group activity continued.</p> <p>Interview, on 09/14/11 at 10:35 AM, with an Unsampled Resident revealed they did not enjoy the music played during the Sensory Group Activity because the loud music made their left leg hurt. The Unsampled Resident said he/she had Polio as a child, and suffered chronic left leg pain as a result. The Unsampled Resident requested pain medication for leg pain during the Sensory Group Activity.</p> <p>Interview, on 09/15/11 at 1:50 PM, with the Activity Director revealed he was not aware of the volume of the music played during the Sensory Group Activity on 09/14/11 at 10:30 AM, but he said he was told by staff that residents requested the music be turned down or off.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 371	<p>F 371</p> <p>F 371 483.35 (i) FOOD PROCEDURE, STORE/PREPARE/SERVE-SANITARY</p> <p>1. During the annual survey on 9/13/11 it was determined by the surveyor that three different staff member s was observed handling a resident's food with bare hands.</p>	



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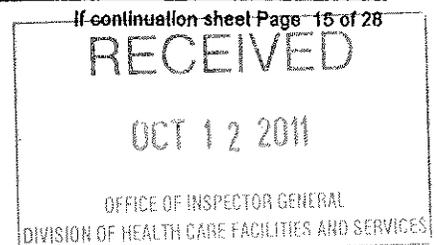
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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F 371	Continued From page 14 Based on observation and interview it was determined the facility failed to prepare and serve food under sanitary conditions as observed in the main dining room. Observation of the meal service revealed three (3) different staff members handling the residents food with bare hands. The findings include: The facility did not provide a policy on employee bare hand contact with food. Observation of the meal service, on 09/13/11 at 7:12 AM, revealed Certified Nursing Assistant (CNA) #1 touching a resident's piece of toast with her bare hands to spread butter and jelly. She then picked up the toast and placed it in the palm of her hand, spooned the resident's scrambled eggs onto the toast, and folded it closed with both of her hands. She then handed the sandwich to the resident to eat. Observation of another CNA #5, on 09/13/11 at 7:30 AM, revealed the CNA assisted a resident with their toast. The CNA held the toast in her bare hands while applying butter and jelly. The CNA then assisted two other residents with their toast in the same manner consecutively without washing her hands in between. Observation of CNA #2 during meal service, on 09/13/11 at 7:35 AM, revealed the CNA using her bare hands to hold a piece of toast while spreading butter and jelly. Interview with CNA #1, on 09/15/11 at 12:55 PM, revealed she was trained by the facility it was acceptable to touch the residents' food with their	F 371	<i>F 371 Continued</i> 2. In-service initiated on 9/15/11 and completed on 10/6/11 by the DON & SDC with the certified nursing assistants identified in the concern and with all clinical staff regarding meal service and setting up resident meal trays with clean hands, and continue to encourage independence of the resident with eating. 3. New hire employees will receive training during the orientation process regarding meal tray set up and utilizing clean hands during this process effective 10/10/11. DON/SDC will complete clean hands in-service quarterly with all clinical staff x4quarters. Licensed nurse/SDC will provide any reeducation as needed. 4. DON/Weekend supervisor will complete daily rounds of at least one meal beginning 9/15/11 x30days. Then 3x's per week x90days. Then weekly x8weeks. The results of these rounds will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during the QA process, the committee will reconvene for additional recommendations until sustained compliance. 5. Completion date: 10/10/11	10/10/11
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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F 371	Continued From page 15	F 371		
F 372 SS=D	<p>bare hands as long as they used hand sanitizer. The CNA revealed the last in-service was sometime in the past year. The CNA stated she would not want people touching her food.</p> <p>Interview with CNA #2, on 09/15/11 at 1:15 PM, revealed she was aware she was not supposed to use her bare hands when handling the residents' food. The CNA stated she should have used a knife and fork, but didn't even realize she had touched the residents food with her bare hands.</p> <p>Interview with the Director of Nursing (DON), on 09/15/11 at 5:30 PM, revealed the staff had been told not to use gloves. The DON revealed the staff had been taught to wash their hand or use hand sanitizer before assisting someone with their food.</p> <p>Interview with the Administrator, on 09/15/11 at 3:10 PM, revealed she was not aware of a facility policy on bare hand contact with food. The administrator revealed it was acceptable for the staff to touch a resident's food as long as the staff member washed their hands or used hand sanitizer between residents.</p> <p>483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review it was determined the facility failed to</p>	F 372	F 372 Next page	

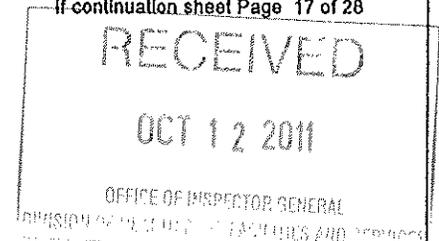
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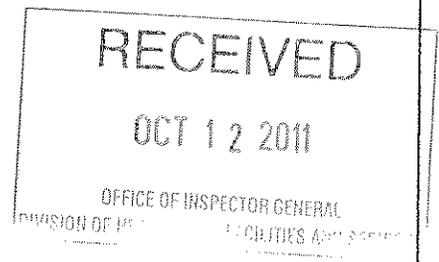
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F 372	Continued From page 16 dispose of garbage and refuse properly for two (2) of two (2) dumpster's. The dumpster doors were left open, trash was hanging outside of the dumpster's, and trash was on the ground around the dumpsters. The findings include: Review of the facility's policy on Trash & Biohazard Waste, undated, revealed the doors to the dumpsters should be closed immediately after garbage is placed in the dumpster, broken glass should be containerized before putting in the dumpsters. The Dumpster should be monitored three (3) times per day during the week. Observation, on 09/14/11 at 03:10 PM, revealed the dumpster doors partially opened with plastic hanging out. The ground area around the dumpster had several discarded disposable gloves, thirteen (13) wooden pallets, one (1) green plastic container, five (5) pieces of wood debris with rusty nails exposed, one (1) broken white ceramic plate, and scattered cigarette butts and gum wrappers. Interview with the Maintenance Director (MD), on 09/15/11 at 10:50 AM, revealed he was aware the door to the dumpster should be closed and the area around the dumpster should be clear of debris. The MD said Environmental Services was responsible for the maintenance of the dumpsters. Interview with the Environmental Service Director (ESD), on 09/15/11 at 5:30 PM, revealed he was responsible for overseeing the maintenance of the dumpsters. The doors to the dumpster	F 372	F 372 F 372 483.35(i) (3) Dispose Garbage & refuse properly. 1. All trash was picked up from off the ground around the dumpsters and doors closed during the next monitoring rounds on 9/15/11. 2. All dumpsters have been checked three times a day seven days a week since 09/16/11 by Environmental services supervisor. Corrective action ongoing after trash pickup twice per week by the vendor. 3. Environmental services supervisor reeducated by the administrator on proper trash/refuse disposal and reporting on 09/15/11. 4. Environmental Services Supervisor or floor tech will monitor the dumpster area(s) three times per day, seven days a week for two weeks then five times per week for four weeks then three times per week for six weeks. Results of the monitoring will be forwarded to the QA committee monthly x 3 months. The QA committee will address any concerns and will have revisions and additions as deemed appropriate. 4. Completion date: 09/16/11	9/16/11



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F 372	Continued From page 17	F 372		
F 431 SS=F	<p>should be closed and there should not be debris on the ground around the dumpsters.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<p>F 431</p> <p>483.60 (b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <ol style="list-style-type: none"> During the annual survey on 9/15/11 it was determined by the surveyor that the facility failed to monitor expired medications and treatment supplies. All expired medication and treatment supplies were discarded immediately. 100% audit by the DON, SDC & Unit Manager was completed from 09/15/11-09/22/11 for all medication carts, refrigerators containing medications, treatment supplies carts, all clinical supply closets, and detached storage garage to ensure no expired supplies is being stored for use. DON/SDC in-serviced all licensed nurses on 10/6/11 on the facility policy/protocol for disposing of expired medications and treatment supplies. Treatment nurse educated by the DON and action plan put into place on 9/16/11. SDC/central supply clerk/ward clerk weekly audit began on 9/23/11 to audit supply carts, supply closets, and garage. DON/unit manager will audit supply carts, supply closets, and garage beginning on 9/30/11. All expired medication will be sent back to the pharmacy at the end of each month but will be removed from the medication 	



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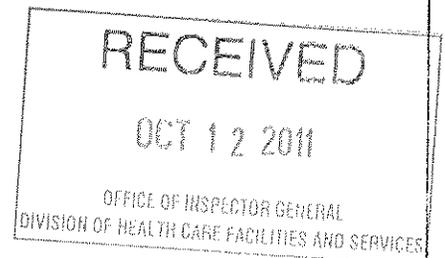
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 431	Continued From page 18	F 431	<i>F 431 Continued</i>	
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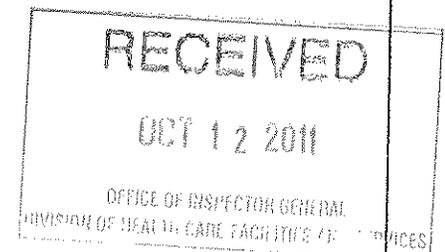
	<p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy Expiration Dating of Unit Dose Packaged Medications, it was determined the facility failed to ensure drugs and biologicals used in the facility were monitored for expiration dates in one (1) of one (1) medication room, one (1) of one (1) treatment cart, and the treatment storage room.</p> <p>The findings include:</p> <p>Review of the facility's policy Expiration Dating of Unit Dose Packaged Medications Addendum, not dated, revealed all medication not being used will be sent back to the pharmacy at the end of each month. This includes but is not limited to the following: All expired medication; Discontinued medication; Medications that had direction changed per physician's orders; Licensed staff will check expiration date on all medications and treatment supplies prior to administering and/or use.</p> <p>Observation of the medication room, on 09/15/11 at 6:30 AM, revealed five (5) expired intravenous piggyback doses of Gentamycin 120 mg in 100 cc of Normal Saline, two expired 09/05/2011 and three expired 09/08/2011.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 09/15/11 at 6:30 AM, revealed the medication should not be used. The LPN stated the resident could have a reaction or it would not be effective. The LPN revealed the medication had been discontinued in August, 2011.</p>		<p>carts and/or refrigerator when discontinued or expired.</p> <p>4. SDC/central supply clerk/ward clerk will complete the specified audit weekly x12weeks, then monthly indefinitely to ensure there are no expired supplies and/or medications being stored for use. The results of these rounds will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during the QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion date: 10/11/11</p>	10/11/11
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/15/2011
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
(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 431	Continued From page 19	F 431			
	<p>Observation of the treatment cart, on 09/15/11 at 7:30 AM, revealed six (6) packages of steri strips which expired 05/2009, one package of steri strips which expired 12/2010, seven (7) packages of Curafil Hydrogel 4x4 which expired 08/2009, two (2) bottles of Nugauze which expired 11/2004, twelve (12) packages of Vaseline gauze which expired 06/2005, three (3) packages of Xeroform which expired 05/2010, three packages of Xeroform which expired 07/2008, nine (9) packages of Tegaderm which expired 05/2009, six (6) packages of Curasalt which expired 07/2011, three (3) packages of Tegasorb which expired 07/2009, and one package of Telfa 3x4 dressing which expired 04/02/10.</p> <p>Observation of the treatment storage room, on 09/15/11 at 8:00 AM, revealed four (4) packages of Tegaderm foam adhesive dressing which expired 08/2009, twenty-two (22) packages of Hydrogel 2x3 dressings which expired 08/2009, nine (9) bottles of Nugauze which expired 11/2004, forty-five (45) packages of Hydrogel 11x4 dressings which expired 06/2010, one hundred fifty (150) packages of Xerofoam dressings which expired 07/2008, one hundred forty-four (144) packages of Curasalt dressing which expired 07/2011, one hundred (100) Silver Nitrate sticks which expired 11/2008, and twenty (20) Curly ABD pads which expired 03/2009.</p> <p>Interview with LPN #1, on 09/15/11 at 2:45 PM, revealed someone checked the treatment cart once a month for expired medication but did not know who was responsible. The LPN revealed she was aware that some of the treatment supplies had expiration dates but did not know</p>				



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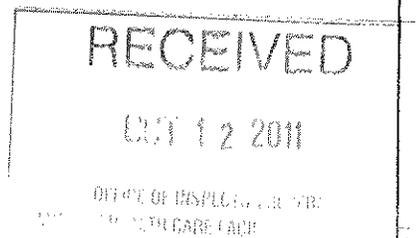
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F 431	Continued From page 20	F 431		
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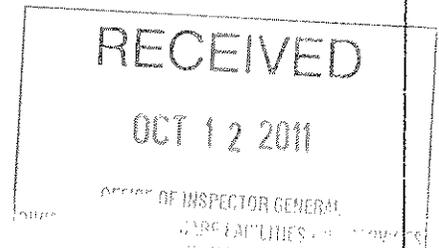
F 441 SS=F	<p>they had expired. The LPN revealed using expired treatment supplies could lead to infection or not be effective.</p> <p>Interview with the Director of Nursing (DON), on 09/15/11 at 5:30 PM, revealed all nurses should be checking expiration dates. The DON revealed there was a monthly audit performed on all the medication carts, but the audit did not include the treatment cart. The DON further revealed the unit manager or herself did a quarterly audit of all carts, but this audit did not include checking for expiration dates.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a</p>	F 441	<p>F 441</p> <p>F 441 483.65 INJECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>1. During the annual survey on 9/15/11 it was determined by the surveyor that the facility failed to maintain a sanitary environment for a resident #19 noted with an indwelling catheters that touched the floor; staff adjusted the bed of resident #2 with soiled gloves on; and staff placed the ice scoop in the ice chest while passing ice on the hallway. Resident #19 catheter was immediately changed per MD orders. Resident #2 bed cleaned and disinfected immediately. Ice chest was emptied and cleaned before put back in use.</p> <p>2. 100% of all residents with catheters audited on 09/16/11 by DON to ensure that leg bags are worn when residents are out of bed. 100% audit completed on 09/16/11 by DON to ensure coil clips are in place on all resident drainage bags. Interviews completed with 10 certified nursing assistants, 10 nurses to include all 3 shifts to determine the knowledge of each staff member regarding infection control specific to indwelling catheters, passing ice, and hand washing protocol. 100% of staff interviews completed by 10/05/11 by the DON did not reveal</p>	
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40069	
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F 441	Continued From page 21	F 441	<i>F 441 Continued</i>	
	<p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to maintain a sanitary environment for two (2) of twenty-two (22) sampled residents. Resident #19 had an indwelling catheter with the tubing laying on the floor. During a dressing change for Resident #2, staff adjusting the bed control with contaminated gloves. In addition, staff were observed placing the ice scoop in the ice chest while passing ice on the hallway.</p> <p>The findings include:</p> <p>Review of the facility's policy on Handwashing, revised 08/2005, revealed handwashing should be done after touching inanimate sources that are likely to be contaminated. The facility did not provide a policy regarding changing gloves.</p> <p>1. Observation, on 09/13/11 at 11:00 AM,</p>		<p>knowledge deficit regarding infection control policy/protocol.</p> <p>3. Education/in-service initiated on 9/16/11 and completed on 10/6/11 with all clinical staff by DON/SDC regarding facility policy and protocol for infection control specific to indwelling catheters, passing ice, and hand washing protocol.</p> <p>4. Unit manager/Weekend supervisor will complete daily monitoring of all residents with catheters beginning 9/16/11 x30days. Then 3x's per week x90days. Then weekly x8weeks. Administrative nurses will complete daily rounds of assigned resident hallways and care areas to observe staff and ensure no infection control issues are present. The results of these rounds will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during the QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion date: 10/10/11</p>	10/10/11



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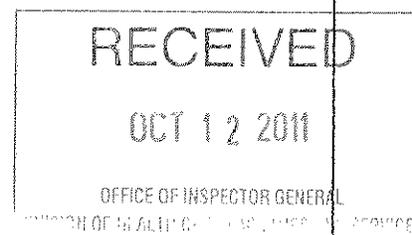
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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F 441	Continued From page 22 revealed Certified Nursing Assistant (CNA) #1 passed ice on the hall. The CNA went into the resident rooms, removed the lids off the ice pitcher, dumped the water, came out to the ice chest in the hallway, filled the pitcher with ice, then placed the ice scoop in the ice between each pitcher. CNA #1 continued in this manor for seven (7) rooms and then began to place the ice scoop in the holder on the front of the ice cart. Interview with the Director of Nursing (DON), on 09/15/11 at 5:25 PM, revealed the ice scoop should be stored in the protective sleeve for infection control purposes. Observation of Incontinence care, on 09/14/11 at 9:45 AM, revealed Licensed Practical Nurse (LPN) #1 provided incontinence care for Resident #1 after a bowel movement and before a dressing change. The LPN cleaned the resident's peri area, then reached down to hyperinflate the resident's low air loss (LAL) mattress with the same dirty gloved hands. Interview with LPN #1, on 09/15/11 at 2:45 PM, revealed the LPN did not realize she had used her dirty gloved hands to hit the hyperinflate button on the LAL mattress. The LPN stated this was an infection control issue. Interview with the infection control nurse/staff development coordinator, on 09/15/11 at 6:50 PM, revealed external urinary collection bag tubing dragging on the floor is an infection control problem and could potentially cause contamination to the closed system and the resident. She revealed ice should be served with the scoop being contained in the holder and not	F 441		
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059	
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F 441	Continued From page 23 stored in the ice chest due to potential harborage of bacteria. She stated using a dirty gloved hand to hyperinflate a LAL mattress could contaminate the surface of the machine and anything that happens to touch the machine. She was unable to recall when last in-service was provided to the staff on infection control and no in-service information was provided upon request. Interview with the Director of Nursing (DON), on 09/15/11 at 5:30 PM, revealed staff should be washing hands and never touching equipment with soiled gloves.	F 441		
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation, interview, it was determined the facility failed to provide privacy curtains for three (3) of eighty-eight (88) residents. Resident #19, who resided in room twenty-two (22) bed one (1), and two (2) unsampled residents, who resided in rooms fourteen (14) and fifteen (15) did not have privacy curtains in their rooms. The findings include:	F 460	F 460 F 460 483.70 (d) (1) (iv)-(v) Bedrooms assure Full visual privacy. 1. Privacy curtains were provided for all three residents on 09/15/11. 2. 100% of rooms were checked by the environmental services supervisor and department heads assigned on 09/15/11 no other rooms were noted to have a missing privacy curtains. 3 Environmental Services supervisor re-educated on 09/15/11 by NHA. All staff has been in serviced on privacy curtains and the need to report missing curtains immediately to their supervisor from 09/15/11 through 10/06/11 by DON/SDC.	

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F 460

Continued From page 24

F 460

F 460 Continued

Observation, on 09/15/11 at 7:30 AM, revealed Resident #19 sitting up in the wheelchair beside the bed. The resident resided in bed one that was closest to the door. There was no privacy curtain to go around the resident's bed.

Interview with Certified Nursing Assistant (CNA) #4, on 09/15/11 at 7:30 AM, revealed he normally had this group of residents. The CNA stated the privacy curtain had been missing since Monday 09/12/11. He stated it was probably in laundry. CNA #4 stated if they needed to provide care for Resident #19, they would just close the door. He stated he did not know what he would do if someone knocked on the door to provide care for the resident in bed two (2).

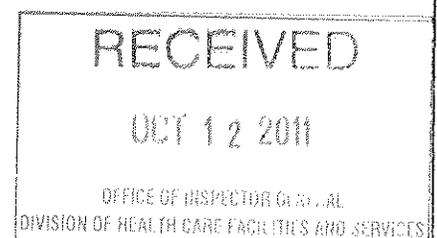
Observation, on 09/15/11 at 9:00 AM, revealed Housekeeper #1 stood on a ladder in private room #14, and installed a privacy curtain, as an Unsampled Resident watched. Housekeeper #1 stated the privacy curtain had been taken down the day before for cleaning. Three decorative personal items were hanging from the privacy curtain hooks where the housekeeper was replacing the curtain. Housekeeper #1 removed the personal items from the hooks so the privacy curtain could be replaced. Housekeeper #1 said he thought the resident's family placed the items on the hooks during a visit on the previous day. The Unsampled Resident said the family had not visited for a long time, and the personal items had been hanging there for a long time.

Observation, on 09/15/11 at 9:10 AM, revealed no privacy curtain was available for use in private

4. Department heads assigned room checks will monitor rooms twice daily to ensure curtains remain intact. The Environmental Services Supervisor will monitor rooms daily for two weeks then weekly for eight weeks to ensure compliance. Results of the monitoring will be forwarded to the QA committee monthly x 3 months. The QA committee will address any concerns and will have revisions and additions as deemed appropriate.

Completion 10/06/11

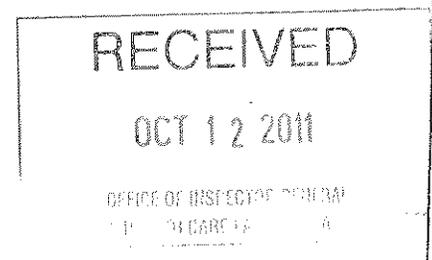
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 460	Continued From page 25 room #15. Housekeeper #1 said he was going to hang a privacy curtain in room #15.	F 460		
F 465 SS=F	Interview with the Staff Development Coordinator (SDC), on 09/15/11 at 7:45 AM, revealed she did not notice the privacy curtain was missing. She stated if they were providing care for Resident #19 they would just close the door, and if someone needed to come in they would put a sheet over the resident to provide privacy. The SDC stated they took down the privacy curtain today. Interview with the Director of Nursing (DON), on 09/15/11 at 5:25 PM, revealed it was unacceptable for residents to not have privacy curtains. 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to provide effective maintenance services to ensure fourteen (14) residents had accessible pull cords for over the bed lighting, the Third Street Shower Room had damage to the baseboard and wall and one (1) room had holes in the wall over the bed. The findings include:	F 465 F 465	F 465 483.70 (h) Safe functional sanitary comfortable environment. 1. The pull cords on the overbed lights were replaced on 09/13/11. The three one inch tiles on the baseboard and the scratches on the wall were replaced and painted on 09/15/11. The hole in the wall was repaired on 09/16/11. 2. 100% of rooms were checked by the maintenance supervisor and administrator on 09/16/11, only one other room was noted to have damage and it was repaired on 09/19/11.	



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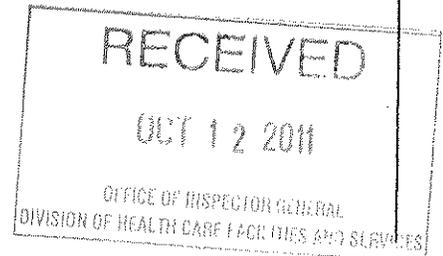
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F 465	Continued From page 26	F 465	<i>F 465 Continued</i>	
	<p>Review of the facility's policy on Maintenance revealed light bulbs are to be checked monthly. The facility was unable to produce a policy on the maintenance of string cords for over the bed lighting. The facility's policy revealed the Maintenance Supervisor was responsible to find time to complete his assigned preventative maintenance work orders.</p> <p>Observations made on the initial tour, on 09/13/11 at 7:00 AM, revealed rooms 15, 31B, 36, 37A, 37B, 40, 42A, 43B, 48A, 48B, 49, 51A, 51B, & 53A did not have pull cords for the over bed lights.</p> <p>Observation during the initial tour, on 09/13/11 at 7:45 AM, in room 9B revealed a hole in the drywall 4"x12"x1/2" exposing raw drywall and several small scrapes on the wall behind the resident's bed.</p> <p>Observation, on 09/15/11 at 9:05 AM, revealed several missing ceramic tiles on the baseboard and the wall above the baseboard was scuffed with unpainted drywall exposed.</p> <p>Interview with the Maintenance Director (MD), on 09/15/11 at 5:00 PM, revealed he was aware of the damage to the wall in Room 9B and that it was difficult for two men to keep up with the maintenance for the entire facility. The MD revealed he had asked management for more help, but was told there was not money for more maintenance staff. The MD stated light cords are checked once monthly when light bulbs are checked.</p>		<p>3. Maintenance Director and maintenance assistant have been in serviced how to look for damage to walls and baseboards, missing tiles and missing pull cords on 09/15/11 by the NHA.</p> <p>4. Maintenance Supervisor will monitor rooms weekly for 12 weeks then monthly to ensure damage is repaired timely. Results of the monitoring will be forwarded to the QA committee monthly x 3 months. The QA committee will address any concerns and will have revisions and additions as deemed appropriate.</p> <p>Completion date: 09/19/11</p>	9/19/11



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F 465	Continued From page 27 Interview with the MD, on 09/15/11 at 5:30 PM, revealed he was not aware of the damage to the wall and baseboard in the Third Street Shower Room. Observation of the shower room with the surveyor at this time, the MD stated he just did not see the damage because the waste container was in front of the damaged wall. The MD revealed it should have been repaired last week when the wall in the adjoining shower was repaired.	F 465			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/13/2011
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1973</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system</p> <p>GENERATOR: Type II generator installed in 2010, fuel source is diesel</p> <p>A standard Life Safety Code survey was conducted on 09/13/11. Rivers Edge was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred (100) beds and the census was eighty eight (88) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p><i>Rivers Edge Nursing & Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance. Rivers Edge response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Rivers Edge reserves the right to submit documentation to refute any of the stated deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.</i></p> <p>K 050</p> <p>K 050 NFPA 101 Life Safety Code Standard-Fire drills conducted at unexpected times under varied conditions.</p> <p>1. During the life safety tour on 09/13/11 it was determined by the surveyor that fire drills were held at predictable times on first and second shifts.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Gettie M. Parker-June* TITLE: *Administrator* (X6) DATE: *10/11/11*

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

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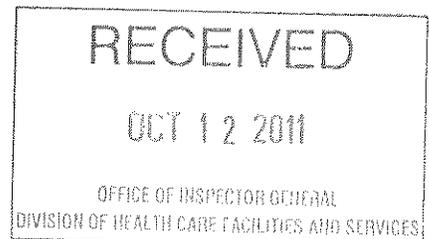
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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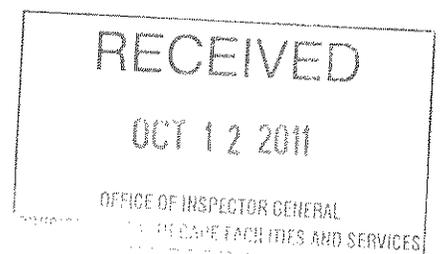
K 000	Continued From page 1	K 000	<p>K050 Continued</p> <p>2. The nursing center administrator and the maintenance director completed 100% interviews with all staff. None of the staff could verify that drills were predictable; most stated the drills were always at an inconvenient time regardless of when they are conducted.</p> <p>3. The Nursing center administrator reeducated the maintenance director on 09/13/09 regarding fire drills being held at various times for all shifts.</p> <p>4. The maintenance director will institute a monitoring form to show the times of each fire drill per shift by 10/10/11. The times will serve as a side by side quick glance when planning/conducting future drills. Results will be forwarded to the Performance Improvement Quality Assurance committee at least quarterly for review and recommendations. If concerns are identified during the QA process the team will reconvene for additional recommendations until sustained compliance is achieved.</p> <p>Completion: 10/10/11</p>	
K 050 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of eighty eight (88) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 09/13/11 at 3:00 PM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions.</p> <p>Interview, on 09/13/11 at 3:00 PM, with the</p>	K 050		10/10/11



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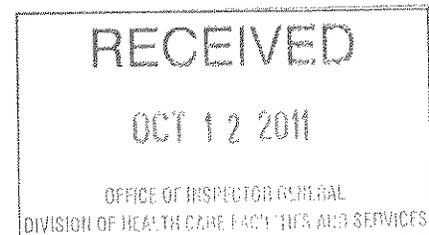
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059	
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K 050	Continued From page 2 Maintenance Director revealed he was unaware the fire drills were not being conducted as required.	K 050	<p>K056</p> <p><i>K 056 NFPA 101 Life Safety Code Standard-sprinkler system for the entire building</i></p> <ol style="list-style-type: none"> 1. During the life safety tour on 09/13/11 it was revealed that one (1) Front porch, and two (2) air locks (located between the Medical records office and the MDS office) had no sprinkler protection. The sprinkler protection will be installed by 10/28/11. 2. The Nursing Center administrator and the maintenance director completed a 100% audit on the entire building and covered areas on 09/16/11. There were no other areas without or requiring sprinkler protection. 3. The Nursing Center administrator reeducated the maintenance director on 09/13/09 regarding areas requiring sprinkler heads. Estimates were received and the sprinklers will be installed by 10/28/11 over all three areas identified. 4. The maintenance director will institute visual monitoring of sprinkler heads in potential areas into the weekly rounds starting 09/19/11 for 12 weeks then monthly to ensure compliance is maintained. Results of the rounds will be forwarded to the 	
K 056 SS=E	<p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of eighty eight (88) on</p>	K 056		



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K 056	Continued From page 3 the day of the survey. The findings include: Observation, on 09/13/11 between 11:00 AM and 2:00 PM, with the Maintenance Director revealed one (1) Front porch, and two (2) air locks that did not have sprinkler protection. The first airlock was located next to the Medical Records Office, and the second was located next to the MDS Office. Interview, on 09/13/11 between 11:00 AM and 2:00 PM, with the Maintenance Director revealed he was not aware of the airlocks not having sprinkler protection, and was not aware the front porch was required to be sprinkler protected. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	K056 Continued Performance Improvement Quality Assurance committee at least quarterly for further review and recommendations. The Performance Improvement Quality Assurance committee reporting will continue monthly times three months. If concerns are identified during the QA process the team will reconvene for additional recommendations until sustained compliance is achieved. Completion: 10/28/11	10/28/11
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was	K 062	K062 K 062 NFPA 101 Life Safety Code Standard- sprinkler head wrench. 1. During the life safety tour inspection on 09/13/09 it was revealed that no special sprinkler head wrench was provided for the removal or installation of sprinklers. The sprinkler wrench was delivered on 09/14/11. 2. The maintenance director contacted the vendor maintaining the facility sprinkler system on 09/13/11. 3. The facility administrator reeducated the maintenance	



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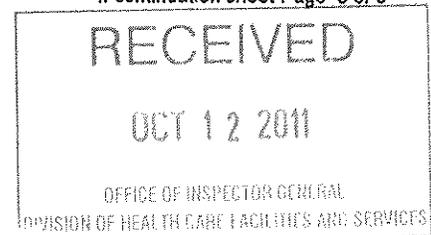
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K 062	Continued From page 4 determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of eighty eight (88) on the day of the survey. The Findings Include: Observation, on 09/13/11 at 11:35 AM, with the Maintenance Director revealed the facility failed to provide a sprinkler head wrench per NFPA requirements. Interview, on 09/13/11 at 11:35 PM, with the Maintenance Director revealed that he was unaware the wrench was missing, and that it was there before last sprinkler inspection. Reference: NFPA 13 (1999 edition) 6.2.9.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed.	K 062	director on 09/13/09 regarding the need of a sprinkler head wrench. 4. The maintenance director will institute weekly visual monitoring of the sprinkler head wrench weekly for twelve weeks then monthly to ensure it remains in place. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee monthly. If concerns are identified during the QA process additional recommendations will be discussed until sustained compliance is achieved. Completion Date: 09/14/11	9/14/11
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072	<i>K 072 NFPA 101</i> Life Safety Code Standard- Means of egress are continuously maintained free of all obstructions or impediments. 1. During the life safety tour inspection on 09/13/09 it was revealed that wheelchairs, linen carts and lifts were being stored in the corridors. All wheelchairs, linen carts and lifts were removed on 09/13/11. 2. Starting 09/13/11 multiple daily rounds by department heads, admin nurses, DON and NHA ensures the means of egress is maintained. 3. The facility administrator reeducated the maintenance & director & maintenance assistant on	



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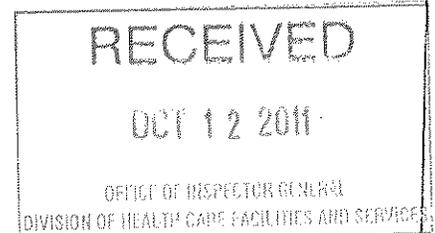
K 072	Continued From page 5 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access according to NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of eighty eight (88) on the day of the survey. The findings include: Observations, on 09/13/11 at 2:00 PM, with the Maintenance Director revealed that wheelchairs, linen carts, and lifts, were being stored in the corridors. Interview, on 09/13/11 at 2:00 PM, with the Maintenance Director revealed the facility was lacking in storage space. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	K072 Continued 09/13/09 regarding the means of egress to continuously be maintained free of all obstructions or impediments. All clinical, housekeeping, dietary & therapy staff was reeducated by 10/6/2011 by the DON/SDC. 4. The maintenance director will institute random daily visual monitoring of egresses for four weeks then weekly for eight weeks then monthly to ensure wheelchairs, linen carts and lifts are not being stored in the corridors. In addition the facility department heads, nurse admin staff, DON and NHA will continue rounds with immediate corrective action if warranted. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee monthly. If concerns are identified during the QA process additional recommendations will be discussed until sustained compliance is achieved. Completion Date: 10/06/11	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K 147 NFPA 101 Life Safety Code Standard- Electrical wiring maintained. 1. During the life safety tour inspection on 09/13/09 it was revealed that 1). A microwave was	10/6/11

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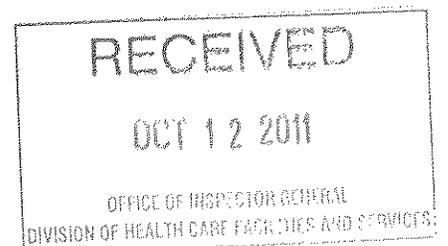
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K 147	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of eighty eight (88) on the day of the survey. The findings include: Observation, on 09/13/11 between 11:00 AM and 2:00 PM, with the Maintenance Director revealed: 1) A microwave and refrigerator plugged into power strip that was plugged into an extension cord located in the Copy Room. 2) Electrical panels were unlocked in each of the four (4) corridors. 3) Two (2) refrigerators plugged into a power strip located in the Medicine Room. 4) An extension cord in use located in the Staff Development Office. 5) A refrigerator plugged into a power strip located in the Director of Nursing Office. 6) An oxygen nebulizer plugged into a power strip located in resident room #45. 7) A refrigerator plugged into a power strip located in resident room # 47. 8) An open electrical junction box located above the drop ceiling by the smoke barrier doors, located at the First Street corridor.	K 147	<i>K147 Continued</i> plugged into a power strip that was plugged into an extension cord in the copy room. 2). Electrical panels were unlocked on each of the four corridors. 3). Two refrigerators plugged into a power strip located in the medicine room. 4). An extension cord in use located in the staff development office. 5). A refrigerator plugged into a power strip located in the Director of nursing office. 6). An oxygen nebulizer plugged into a power strip located in room 45. 7). A refrigerator plugged into a power strip in resident room # 47. 8). An open electrical box located above the drop ceiling by the smoke barrier doors, located at the First street corridor. All the above corrected on /by 09/14/11. 2. The maintenance director removed all the extension cords and power strips as well as replaced the cover on the junction box on 09/13/11. Locks were placed on all electrical panel boxes on 09/14/11. 3. The facility administrator reeducated the maintenance director on 09/13/09 regarding electrical maintenance standards to include regarding extension cord and surge protector/power strip use & non use, electrical panel locks & junction box covers. All clinical, housekeeping, dietary & therapy staff was reeducated by 10/6/2011 by the maintenance director/DON/SDC	



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K 147	Continued From page 7 Interview, on 09/13/11 between 11:00 AM and 2:00 PM, with the Maintenance Director revealed they were unaware of the extension cords and power strips being misused. He was also unaware of the open junction box, and that the electrical panels had to be locked in resident areas. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147	<i>R147 Continued</i> regarding extension cord and surge protector/power strip use & non use. 4. The maintenance director will institute weekly visual monitoring for twelve weeks of the electrical panel boxes for all four corridors to ensure continued compliance. The maintenance director will also conduct weekly rounds for twelve weeks then monthly rounds to ensure extension cords/surge protectors are not used out of compliance of the NFPA 70, National electric code. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee monthly. If concerns are identified during the QA process additional recommendations will be discussed until sustained compliance is achieved. Completion Date: 10/06/11	10/6/11



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{F 000}	INITIAL COMMENTS Amended SOD 12/01/11 A standard health survey was conducted 09/13/11 - 09/15/11. A Life Safety Code survey was conducted on 09/13/11. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. This was a nursing home Initiative survey initiated on 09/13/11 at 6:00 AM. A follow-up visit was conducted on 11/23/11 and found the facility to not meet minimum requirements for 42 CFR 483.65 (F441) Infection Control. A statement of deficiencies was re-issued.	{F 000}	Plan of Correction Disclaimer for Rivers Edge Nursing and Rehabilitation Center Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) ten days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed of considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
{F 441} SS=E	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.	{F 441}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

X Bettie M. Parker Turner

Administrator

X 12/3/11

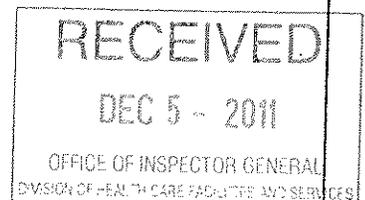
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

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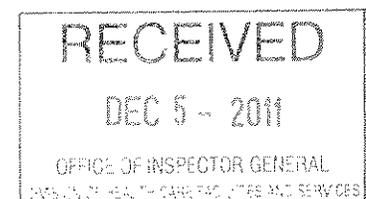
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/23/2011
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059	
(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 1 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and facility policies, it was determined the facility continued to fail to establish and maintain an Infection Control Program to provide a safe and sanitary environment to prevent the spread of infection and disease for one (1) of six (6) sampled residents (Resident #23) and three (3) of five (5) unsampled residents (Residents A, B, and E). Resident #23 had a CPAP mask (used to force air into the lungs) uncovered and intravenous (IV) tubing undated. Resident A had oxygen tubing in contact with the floor, the mini-nebulizer mask was on the bedside table uncovered and a floor mat with numerous rips and tears. Resident B	Start (F 441)	F-441 F 441 483.65 INECTION CONTROL, PREVENT SPREAD, LINENS 1. During the follow up survey conducted on 11/23/11 it was determined by the surveyor that the facility continued to fail to establish and maintain an Infection Control Program to provide a safe and sanitary environment to prevent the spread of infection and disease for one (1) of six (6) sampled (resident # 23) and three (3) of five (5) unsampled residents (residents A, B, and E). Resident# 23 had a CPAP mask (used to force air into the lungs) uncovered and intravenous (IV) tubing undated and IV pump also in resident room with clear sticky spots of the exterior and brown particles on the bottom of the pole. Resident A had oxygen tubing in contact with the floor; the mini-nebulizer mask was on the bedside table uncovered and a floor mat with numerous rips & tears. Resident B catheter tubing was in direct contact with the floor. Resident E was noted to have the indwelling catheter drainage bag tubing in contact with the floor. Resident E was placed at risk for urinary tract infection related to staff removing urinary drainage bags and saving them for reuse on another day. In addition, room 53-A had boxes, bags of personal items and empty and full soda cans littering the floor around the bed.	



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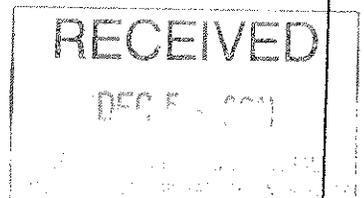
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{F 441}	<p>Continued From page 2</p> <p>catheter tubing was in direct contact with the floor. Resident E was noted to have the indwelling catheter drainage bag tubing in contact with the floor. Resident E was placed at risk for a urinary tract infection related to staff removing urinary drainage bags and saving them for reuse on another day. In addition, Room 53-A had boxes of opened food boxes, bags of personal items and empty and full soda cans littering the floor around the bed.</p> <p>The findings include:</p> <p>Review of the facility's standard survey plan of correction, revealed nursing staff were in-serviced on infection control by the Director of Nursing (DON) and the Staff Development Coordinator (SDC) on 09/16/11. This in-service included the facility's policy and procedure for indwelling catheters, handwashing and passing ice to residents. Unit Managers and Supervisors were to monitor compliance daily for thirty (30) days, then three (3) times a week for ninety (90) days, then weekly for eight (8) weeks. The facility's administrative nurses were to monitor staff to ensure infection control practices were followed. These results were reviewed by the Quality Assurance Committee. The facility's compliance date for infection control was 10/10/11.</p> <p>Observation of Room 53-A, on 11/23/11 at 8:25 AM, revealed the room's floor was cluttered with open soda cans on the bedside table and stored on the floor. In addition, there were bags of personal items and boxes of crackers and other items stored on the floor all around the bed.</p>	{F 441}	<p>F 441 Continued</p> <p>2. Resident A fall mat removed and replaced. 100% of all fall mats in facility audited and replaced if needed. One other mat was replaced. Resident A's oxygen tubing was immediately discarded and replaced. Resident #23 CPAP mask replaced and covered immediately. Resident #23 IV tubing discarded immediately. IV tubing not replaced for resident #23 due to treatment was complete. Resident B catheter replaced and new drainage bag secured per clamp. Resident E catheter replaced and new drainage bag secured per clamp. 100% of all residents with catheters reviewed to ensure no infection control concerns noted. 100% of all residents with respiratory equipment reviewed for proper placement and storage of tubing and devices. 100% of all IV poles and pumps in facility were cleaned immediately. All equipment will be cleaned weekly per the nursing supply clerk and as-needed-per-nursing staff. Facility will not allow nurse aides to apply or remove catheter drainage bags for any resident. Resident in room 53-A was in the process of leaving the facility for a home leave for the holiday but his floor was cleaned and all items removed from the floor immediately.</p>	



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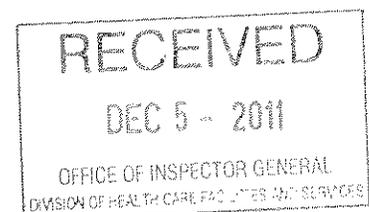
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{F 441}	Continued From page 3 Interview with Housekeeper #1, on 11/23/11 at 2:30 PM, revealed, the clutter on the floor made mopping and cleaning difficult on a daily basis. She stated room floors were mopped daily. Observations of Resident #23, on 11/23/11 at 8:45 AM, 10:00 AM, 11:00 AM, 1:10 PM, 1:40 PM, and 2:30 PM, revealed the resident's CPAP mask stored on top of the dresser uncovered. In addition, an IV pump with a bag of fluids containing antibiotics was not dated and the IV pump had dried clear sticky spots on the exterior. The bottom of the IV pole had brown particles. The resident was observed outside the room at the nursing station in a wheelchair at these times. Review of the clinical record for Resident #23, revealed the facility admitted the resident on 10/29/11 with diagnoses of Sleep Apnea, Morbid Obesity and Chronic Obstructive Pulmonary Disease. The facility completed an admission Minimum Data Set (MDS) assessment on 11/04/11 which revealed the resident had no cognitive deficits, was not able to ambulate, and required limited assistance for activities of daily living (ADL) except for bathing which required maximum assistance. Interview with Resident #23, on 11/23/11 at 10:30 AM, revealed the resident, on occasion, used the CPAP machine during the day. The resident indicated the CPAP mask stayed on top of the machine and staff had not mentioned covering the mask when not in use. Interview with Licensed Practical Nurse (LPN) #1, on 11/23/11 at 2:00 PM, revealed oxygen /CPAP	{F 441}	F 441 Continued 3. Re-education and in-services initiated on 11/23/11 and completed on 12/3/11 by the DON for all clinical staff regarding facility policy and procedure for infection control specific to removal or application of catheter drainage bags, covering respiratory equipment and storage of oxygen tubing, clutter in resident rooms and items on the floors, equipment cleaning, and discarding of defective fall mats. DON initiated on 11/23/11 and completed on 12/3/11 re-education of procedure for catheterization and applying drainage bags to residents with catheters with all license nurses to ensure staff is able to complete the skill correctly. Re-education conducted by the DON 11/23/11 through 12/3/11 also included catheter drainage bags will be changed by the licensed nurse only. Re-education and in-services initiated on 11/23/11 and completed on 12/3/11 by the NHA for all non clinical staff regarding infection control preventative measures, clutter in resident rooms, items on the floors and worn/torn floor mats.		



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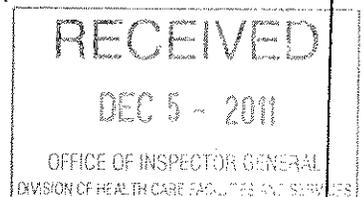
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{F 441}	<p>Continued From page 4</p> <p>masks should be covered when not in use. She stated she did not know if there was a policy regarding this. She stated IV tubing required date and time in order to dispose of the tubing daily. She stated IV tubing should be changed daily and the IV pump and pole should be cleaned as needed.</p> <p>Observations of Unsampled Resident A, on 11/23/11 at 8:55 AM, 9:40 AM, 1:10 PM, and 4:00 PM, revealed the resident supine in bed with nasal oxygen via cannula. The oxygen tubing was in direct contact with the floor. The resident's mini-nebulizer was on the bedside table uncovered.</p> <p>Interview with LPN #1, on 11/23/11 at 2:00 PM, revealed oxygen tubing should not be in contact with the floor. She stated staff had been trained to ensure oxygen tubing was not in contact with the floor. She stated the CPAP and mini-nebulizer masks should be covered when not in use.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 11/23/11 at 2:45 PM, revealed she had received training on preventing oxygen tubing off the floor. She stated frequent monitoring was needed to ensure the tubing did not slip to the floor.</p> <p>Review of the facility's policy for Indwelling Urinary Catheters, dated April 2007, revealed the policy contained no directions on management of the drainage bag or the tubing.</p> <p>Observations of Unsampled Resident B, on 11/23/11 at 10:00 AM, revealed the resident in bed with a indwelling catheter to bedside</p>	{F 441}	<p><i>F-441 Continued</i></p> <p>4. DON/Unit Manager/Weekend supervisor will monitor all residents with catheters, oxygen tubing/CPAP mask, and IV equipment, daily x30days, then weekly x16weeks, then monthly x3months. Administrative nurses will continue daily rounds to resident care areas to ensure no infection control issues are noted. Starting 11/28/11 assigned Department heads will monitor assigned resident rooms & common areas daily for three months to ensure facility infection control practices are being followed. The results of these rounds will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion date <i>12/3/11</i> <i>12-4-11 per Adm Zettie Parker</i> <i>12-6-11 PB</i></p>		



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{F 441}	Continued From page 5 drainage. The catheter tubing was in direct contact with the floor. Interview with LPN #2, on 11/23/11 at 2:00 PM, revealed there was no policy on catheter tubing management to prevent contamination; however, tubing should not be in contact with the floor to prevent infection. She stated staff were trained to keep tubing off the floor. Interview with CNA #3, on 11/23/11 at 4:00 PM, revealed Resident B used a catheter drainage bag and the tubing should not be in contact with the floor. She stated she had been trained to keep the tubing off the floor to prevent infection. Review of the facility's policy on Indwelling Urinary Catheters, dated April 2007, revealed there were no guidelines on changing leg bags and drainage bags. Interview with the DON, on 11/23/11 at 5:50PM, revealed the facility had no policy on changing from drainage bags to leg bags.	{F 441}			
	Review of the Centers for Disease Control and Prevention (CDC), Guidelines for Prevention of Catheter-associated Urinary Tract Infections, 2009, (CAUTI), revealed the revised guidelines reviewed available evidence on CAUTI prevention for residents requiring long-term catheter use. The guidelines include specific recommendations for implementation, performance measurement, and surveillance. The document is intended for use by infection prevention staff, administrators, nurses, and for those developing, implementing, and evaluating infection control programs in the healthcare setting. It is important to know that all				



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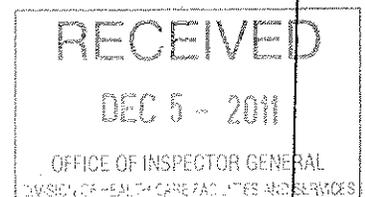
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{F 441}	<p>Continued From page 6</p> <p>Category I recommendations are considered strong recommendations and should be equally implemented. It is only the quality of the evidence underlying the recommendation that distinguishes between levels A and B.</p> <p>Category 1A is a strong recommendation supported by high to moderate quality evidence suggesting net clinical benefits or harms.</p> <p>Category 1B is a strong recommendation supported by low quality evidence suggesting net clinical benefits or harms or an accepted practice supported by low to very low quality evidence.</p> <p>(Category 1B) Following aseptic insertion of the urinary catheter, maintain a closed drainage system. If breaks in aseptic technique, disconnection, or leakage occurs, replace the catheter and collecting system using aseptic technique and sterile equipment.</p> <p>Interview with CNA #1, on 11/23/11 at 5:15 PM, revealed Unsamped Resident E wore a urinary leg bag during the day and a drainage bag at night. The CNA indicated caring for the resident often. He stated he removed the resident's urinary leg bag at bed time and placed the leg bag in a plastic bag to keep it clean for use the next day and stored it in the bathroom. He stated he then gloved and connected the catheter to a drainage bag. He stated he was trained on this procedure during CNA schooling.</p> <p>Interview with CNA #2, on 11/23/11 at 5:25 PM, revealed Unsamped Resident E wore a urinary leg bag during the day and a drainage bag at night. She stated the leg bag was removed at</p>	{F 441}		
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{F 441}	<p>Continued From page 7</p> <p>bedtime then stored in a plastic bag to protect the bag from infection. She indicated she then connected the down drain bag for the night. She stated she was trained on this procedure in CNA school.</p> <p>Interview with LPN #1, on 11/23/11 at 3:25 PM, revealed she taught the CNAs to change urinary drainage systems. She stated she was not sure about what a closed system was, however, she ensured the drainage bag connector to the indwelling catheter was protected from contamination by wrapping the end in plastic. She stated the bag was then ready for use the next time the resident needed it. She stated the leg bag was used on male residents.</p> <p>Interview with the DON, on 11/23/11 at 5:50 PM, revealed urinary drainage bags were not for reuse and anytime a urinary drainage bag was removed, it was discarded. She stated she had no indication some nursing staff disconnected drainage bags and did not discard them.</p>	{F 441}		

