

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

PRINTED: 12/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/13/2013
NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055		
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F 000	INITIAL COMMENTS  A Recertification Survey was conducted on 12/10/13 through 12/13/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification, with the highest S/S of an "F", with Substandard Quality of Care, Identified at 483.15 Quality of Life, F-253 and F-257. on 12/12/13. A Life Safety Code survey was conducted on 12/10/13, with the highest deficiency cited at a S/S of "F".  The facility failed to have an effective system to ensure water temperatures were maintained at 100-110 degrees Fahrenheit (F) and room temperatures were maintained at 71-81 degrees F. Resident #1 was observed sitting in the wheelchair shivering in his/her room after receiving a shower and stated "he/she was freezing". Water temperatures in the showers ranged between 82-98 degrees F and the shower room air temperatures ranged between 63-84 degrees F.	F 000			
F 241 SS=D	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 facility policy review it was determined the facility failed to promote care for one (1) of ten (10) sampled residents (Resident #7), in a	F 241			

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

*[Handwritten Signature]*

TITLE

Administrator

(X6) DATE

1/31/2014

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 241	<p>Continued From page 1</p> <p>manner that maintained and enhanced a resident's dignity and respect. Resident #7 was requesting assistance to go to his/her room from the dining room because other residents' wheelchairs were blocking his/or her way and staff told the resident he/she would have to wait.</p> <p>The findings include:</p> <p>Review of the facility's policy on "Resident Rights", (no date), revealed the facility "will uphold the resident's bill of rights and treat each resident with dignity and respect". The section titled, "Resident Bill of Rights", revealed the residents had "The right to be treated with dignity". Record review revealed the facility admitted Resident #7 on 09/27/12 with diagnoses which included Stroke, Dysarthria, Weakness, Confusion, and Depression. Review of an annual Minimum Data Set (MDS) assessment, dated 09/04/13, revealed the facility assessed Resident #7 to have cognitive impairment, was non-ambulatory, and required extensive assistance for all activities of daily living.</p> <p>Observation, on 12/11/2013 at 7:58 AM in the main dining room, revealed Resident #7 requested to go back to his/her room. Certified Nurse Aide (CNA) #5 responded to Resident #7 and stated, "You will have to wait, I can't take you right now, you have to wait until these other residents get done, I can't pick you up and carry you over them." Further observation revealed a Certified Medication Technician (CMT) on the opposite side of the dining room yell to CNA #5, "I would like to see you try". Resident #7 requested to be taken to his/her room again at 8:05 AM, 8:14 AM, 8:26 AM, 8:27 AM and 8:28 AM. At 8:28 AM, the resident attempted to wheel</p>	F 241	<p><b>Disclaimer; Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</b></p> <p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b> <b>F 241</b></p> <p><b>Criteria 1</b> – The DON and/or designee will in-service all the nursing staff on dignity and respect of individuality at the mandatory staff meeting on January 15, 2014.</p> <p><b>Criteria 2</b> – The facility acknowledges that all residents have the potential to be affected by this deficient practice. The Dietary Manager completed dining/seating chart audits on 12/16/2013, 12/18/2013, 12/23/2013, 12/30/2013, 1/1/2014 and 1/6/2014 that addressed dignity and respect of the residents. No concerns were noted.</p> <p><b>Criteria 3</b> – The Administrator and/or designee will adopt a new policy related to the dining room operations. The dining room seating chart will be reviewed quarterly or PRN by the Dietary Manager and/or designee to ensure that all residents are able to move freely in and out of the dining room. Dining room/seating chart audits will be completed 2x/week for 4 weeks and monthly thereafter. As part of the new hire orientation and annual staff training, employees will be in-serviced on dignity</p>		

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F 241	<p>Continued From page 2</p> <p>him/herself into other residents, who were also in wheelchairs and yelled, "please come and help me". CNA #6 moved the resident out of Resident #7's way and the resident wheeled self into the hallway.</p> <p>Observation of Resident #7, on 12/11/2013 at 8:38 AM, revealed the resident was sitting in the wheelchair in the hallway crying loudly, "I want to go home".</p> <p>Interview with Resident #7, on 12/12/13 at 10:10 AM, revealed he/she likes to go to his/her room when he/she gets done eating to rest. The resident stated when the staff told him/her "You will have to wait, I can't take you right now, you have to wait until these other residents get done, I can't pick you up and carry you over them", he/she felt irritated and it made him/her feel bad.</p> <p>Interview with CMT #1, on 12/11/13 at 1:00 PM, revealed she had heard CNA #5 state, I can't pick you up and carry you over them. The CMT stated she said, "I would love to see you try" in a joking manner and stated she should not have said that. The CMT further stated the staff should have moved the residents out of Resident # 7's way so the resident could have exited the dining room when she requested and she should not have had to wait. The CMT revealed Resident #7 gets upset very easily.</p> <p>Interview with CNA #5, on 12/11/13 at 1:07 PM, revealed she told Resident #7 "I can't pick you up and carry you over them" when the resident requested to leave the dining room. The CNA stated she should not have said that to a resident and she should have moved the other residents out of Resident # 7's way when she requested to</p>	F 241	<p>and respect of individuality of residents. The Social Service Director and/or designee will also ask each interviewable resident during the MDS process if he/she has any issues/concerns with the staff or facility as well as question each resident if he/she has any unresolved problems that need to be addressed. The Social Service Director will provide a written report to the QA committee addressing all concerns discovered upon MDS interviews and action taken.</p> <p><b>Criteria 4</b> – The Administrator and/or designee will ensure that all staff is in-serviced and that the new systems are put in place to ensure ongoing compliance. The seating chart and dining room/seating chart audit will be reviewed by the QA committee during the QA regularly scheduled meeting. During the QA meeting the Social Service Director will provide a written report to the QA committee addressing all concerns discovered during the MDS interview process and action taken to correct those issues.</p> <p><b>Criteria 5</b> – Target Date:</p>	1/20/2014	

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F 241	Continued From page 3 leave the dining room. The CNA stated the resident should not have had to wait and the resident gets upset and agitated easily.  Interview with the Director of Nursing (DON), on 12/11/13 at 1:19 PM, revealed she expected for the staff to treat all residents with dignity. She stated the staff should have immediately moved this resident from the dining room as soon as the resident requested.	F 241	<b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b> <b>F 253</b>  1. <b>Criteria 1</b> – On 12/10/2013 the shower rooms were shut down and have remained closed at this time. Residents are receiving bed baths in their private restrooms or resident room. The Maintenance Director has received a bid from a plumber to install an instant hot water heater for the short hall and long hall shower rooms. Once installed, a consistent water temperature will be disbursed. The instant water heater will be installed on 1/29/2014. The Maintenance Director has received a bid and accepted it to install two 7.5 KW electric inline duct heaters for the short hall and long hall shower rooms. The inline duct heaters will be installed on 1/29/2014. The temperature in room 201 has been corrected by the Maintenance Director. The Maintenance Director has installed a locking cover over the thermostat to prevent staff and visitors from changing the thermostat without the resident's permission. The Maintenance Director has installed an individual HVAC unit in resident room 201. This will ensure the resident has complete control over his/her room temperature. Room 204 is equipped with an individual HVAC unit and the resident has the right to set the temperature at the desired temperature. <b>Criteria 2</b> – The facility acknowledges that all residents have the potential to be affected by this deficient practice. The facility immediately closed both shower rooms on 12/10/2013 to prevent any		
F 253 SS=F	<b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b>  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for one (1) of ten (10) sampled residents (Resident #10). Maintenance failed to monitor and ensure water temperatures were between 100-110 degrees Fahrenheit (F) and failed to ensure room temperatures were between 71 -81 degrees F. Resident #1 was observed after a shower in his/her room shivering and complaining the water and shower room were freezing cold. In addition, staff failed to ensure items were stored off the floor and in the appropriate area.  The findings include:	F 253			

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F 253	<p>Continued From page 4</p> <p>1. Review of the facility's policy titled, "Water Temperature Management, (no date), revealed the facility would ensure the water temperatures were at a comfortable level between 100 and 110 degrees throughout the facility. Temperatures were not to exceed 110 degrees.</p> <p>Record review revealed the facility admitted Resident #1 on 09/09/11 with diagnoses which included Pelvic Pain, Dementia, Alzheimer's, Hypothyroid, Depression, Emphysema, Blind, and Anxiety.</p> <p>Observation on 12/10/13 at 4:04 PM revealed Resident #1 was sitting in a wheelchair (w/c) in his/her room just after a shower. The resident's hair was wet and the resident was shivering and complained of being very cold. The resident stated the shower room and water were freezing cold and he/she had told the Certified Nurse Aide (CNA) he/she was cold while in the shower.</p> <p>Observations, on 12/10/13 at 4:12 PM and 4:38 PM; and, on 12/11/13 at 8:50 AM and 10:04 AM with the Director of Maintenance (DOM), revealed the shower room air temperatures (temp) on the long hall ranged from 63 to 84 degrees F; and, the heat vent was closed. The water temperatures ranged from 82 to 98 degrees F.</p> <p>Observations, on 12/10/13 at 4:40 PM; and, on 12/11/13 at 7:16 AM, 8:55 AM and 10:08 AM with the DOM, revealed the shower room air temperatures on the short hall ranged from 69 to 74 degrees F. The water temperature ranged from 95 to 108 degrees F.</p> <p>Observation, on 12/11/13 at 5:08 PM, revealed</p>	F 253	<p>residents from utilizing the shower rooms. The facility immediately initiated bed baths and continued checking the water temperatures by the maintenance department. The Administrator did investigate the issue to determine if it was an ongoing issue, but there was no significant evidence to determine if the issue had been ignored previously. Immediate action was taken to prevent the issue from continuing forward.</p> <p>Criteria 3 – Once the instant hot water heaters have been installed and the inline air duct heaters have been installed, the shower room will be tested for a period of twelve hours by the Maintenance Director and/or designee to ensure consistency. Once deemed acceptable by the Maintenance Director and reviewed by the Administrator and/or designee the shower rooms will be placed back into operational status. At the time they are placed into operational status, the nursing staff will be in-serviced by the Administrator and/or designee on checking the water and room temperatures. Room and water temperatures will be monitored on each shift x14 days by nursing staff. Maintenance staff will also be checking the room and water temperatures at a minimum of 1x/day 5 days/week on an ongoing basis.</p> <p>Criteria 4 – The Maintenance Director and/or designee will monitor the project through completion. The Maintenance Director will bring water and temperature logs to the facility Safety Meeting monthly to be reviewed by the Safety Committee.</p> <p>Criteria 5 – Target Date:</p>	1/13/2014	

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F 253	<p>Continued From page 5</p> <p>the air temperatures in the following resident rooms were as follows: room 201-66 degrees F, room 204-68 degrees F, and the short hall shower room was 66 degrees F.</p> <p>Review of the maintenance water temperature logs for the last six (6) months revealed the domestic water temps were checked in different resident rooms/areas daily and ranged from 107 to 111 degrees F; however, the log did not indicate temperatures were being checked in the shower areas. Furthermore, during the survey, it was determined by the DOM that the digital thermometer he was using appeared not to be working correctly with a variation of temperatures depending on where he placed the light beam.</p> <p>Interviews, on 12/10/13 at 4:12 PM; and, on 12/11/13 at 8:45 AM and 8:49 AM respectively with CNA #3 and CNA #4, revealed the shower rooms on both halls were often cold and the shower water would get cold requiring maintenance to come fix it. The CNAs stated they would have to stop showers and give bed baths. In addition, CNA #3 stated the water on both the long hall and short hall gets cold often so the CNAs have to space the showers out to allow the water to warm back up.</p> <p>Interview, on 12/10/13 at 4:38 PM; and, on 12/11/13 at 4:05 PM with the DOM, revealed he expected the water temperatures to be between 109-110 degrees F. He stated the cold water and cold shower room temperatures occur often and this was not a new issue. The DOM revealed he had checked the temperatures but has not taken any action to address the cold temperatures.</p> <p>Interview, on 12/11/13 at 3:05 PM, with the Acting</p>	F 253			

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F 253	<p>Continued From page 6</p> <p>Director of Nursing (DON) revealed the temperature in the shower room was often cold. She stated she expected the CNAs to alert maintenance when there were water temperature concerns. The Acting DON stated, the CNAs should finish the resident's shower, dry them off and wrap them in a blanket and remove the resident from the cold area.</p> <p>Interview, on 12/10/13 at 5:00 PM with the Administrator and Assistant Director of Nursing (ADON), revealed they expected the water temperatures to be within regulatory guidelines and the residents should be kept safe. The ADON stated she was aware the CNAs had voiced concerns over the water temperatures in the showers in the past.</p> <p>Interview, on 12/11/13 at 12:39 PM with the DOM, revealed a Plumber had visited the facility on this date and indicated that the water line system had been improperly engineered and required re-routing. Further interview, on 12/11/13 at 3:21 PM, revealed the cold water issue had been an ongoing problem.</p> <p>2. Observation of the Long Hall Shower Room, on 12/13/13 at 2:00 PM, revealed there was a folded blue fall mat, boxes of urinals, two (2) pairs of shoes, a raised toilet seat, and an upside down mop bucket, all stored on the floor. Additionally, there was a shower chair with a brown, crusty substance, sitting near the shower.</p> <p>Observation of the Short Hall Shower Room, on 12/13/13 at 2:15 PM, revealed a portable sixteen (16) drawer plastic shelving unit, sitting near the whirlpool, that contained various supplies, to</p>	F 253	<p>2.</p> <p>Criteria 1 -- The portable sixteen (16) drawer plastic shelving unit has been relocated to the facility central supply storage and all items that were improperly stored were either discarded or thoroughly cleaned and stored properly on 12/13/2013 by the Maintenance Director and nursing staff. The Maintenance Director and/or designee will construct elevated storage shelving for miscellaneous items to be stored on to keep them off the floor and out of the shower rooms. The clean linen storage cabinets will continue to remain secured at all times with lock and key.</p> <p>Criteria 2 -- The facility acknowledges that all residents have the potential to be affected by this deficient practice. The Acting DON did a walkthrough on 12/13/2013 of all resident rooms and resident care areas to ensure the facility was within compliance. No concerns were discovered.</p> <p>Criteria 3 -- The DON and/or designee will in-service all nursing staff on January 15, 2014 regarding the proper storage of personal items while on duty. The facility does not allow personal belongings, food or drink to be stored in the resident care areas. DON and/or designee will complete compliance rounds weekly x1 month and monthly thereafter to ensure ongoing infection control compliance. Copies of all compliance rounds will be reviewed in the Quality Assurance Committee meetings held quarterly.</p> <p>Criteria 4 -- DON and/or designee will oversee to ensure ongoing compliance and presenting findings to the QA Committee.</p>		

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F 253	Continued From page 7 include toothbrushes, oral swabs, catheter tubing, leg bags, etc.  Observation of the Short Hall Clean Linen Room, on 12/13/13 at 2:25 PM, revealed five (5) cases of briefs, one (1) box of geri-sleeves, seven (7) boxes of gloves, all stored on the floor and empty drinking cups, soda cans and paper plates, stored on the shelf, over the clean linen supplies.  Interviews with Certified Nurse Aides (CNAs) #1, #2 and #3, on 12/13/13 from 2:40 PM until 2:50 PM, revealed they were aware of the need for products not to be stored on the floor and stated the sixteen (16) drawer storage unit had been in the shower room for approximately one month. Further interview revealed none of the staff members knew anything about the paper cups, plates and soda cans on the shelf.  Interview with the Maintenance Director, on 12/13/13 at 2:30 PM, revealed he had spoken with staff members several times about storing products on the floor.  Interview with the Administrator, on 12/13/13 at 3:00 PM, revealed he had made rounds to look at the shower rooms and storage room, on 12/12/13, and did not identify any concerns at that time. He stated the staff had been trained on these issues and he would have expected compliance.	F 253	Criteria 5 – Target Date:	1/13/2014
F 257 SS=F	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS  The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a	F 257		

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F 257	<p>Continued From page 8 temperature range of 71 - 81° F</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain a comfortable and safe room temperatures of 71-81 degrees Fahrenheit (F) for one (1) of ten (10) sampled residents (Resident #1). Resident #1 was observed shivering after a shower and observations revealed the shower room temperatures and some resident rooms temperatures ranged between 63-84 degrees Fahrenheit (F).</p> <p>The findings include:</p> <p>1. Record review revealed the facility admitted Resident #1 on 09/09/11 with diagnoses which included Pelvic Pain, Dementia, Alzheimer's, Depression, Emphysema, Blind, and Anxiety.</p> <p>Observation on 12/10/13 at 4:04 PM revealed Resident #1 was sitting in a wheelchair (w/c) in his/her room just after a shower. The resident's hair was wet and resident was shivering and complained of being very cold. The resident stated the shower room was freezing cold. The resident stated he/she told the Certified Nurse Aide (CNA) he/she was cold while in the shower.</p> <p>Observation, on 12/10/13 at 4:12 PM and 4:38 PM; and, on 12/11/13 at 8:50 AM and 10:04 AM, with the Director of Maintenance (DOM) revealed the shower room temperature (temp) on the Long Hall ranged from 63 to 84 degrees F. Further interview revealed the heat vent was closed.</p>	F 257	<p><b>483.15(h)(6) COMFORTABLE &amp; SAFE TEMPERATURE LEVELS</b> F 257</p> <p>Criteria 1 – On 12/10/2013 the shower rooms were shut down and have remained closed at this time. Residents are receiving bed baths in their private restrooms or resident room. The Maintenance Director has received a bid and accepted it to install two 7.5 KW electric inline duct heaters for the short hall and long hall shower rooms. The temperature in room 201 has been corrected by the Maintenance Director. The Maintenance Director has installed a locking cover over the thermostat to prevent staff and visitors from changing the thermostat without the resident's permission. The Maintenance Director is going to get a quote from a HVAC technician to install an individual HVAC unit in the room to ensure the resident has complete control over his/her room temperature. Room 204 is equipped with an individual HVAC unit and the resident has the right to set the temperature at the desired temperature.</p> <p>Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. The facility immediately closed both shower rooms on 12/10/2013 to prevent any residents from utilizing the shower rooms. The facility immediately initiated bed baths and continued checking the water temperatures by the maintenance department. The Administrator did investigate the issue to determine if it was an ongoing issue, but there was no significant evidence to determine if the</p>		

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F 257	<p>Continued From page 9</p> <p>Observation on 12/10/13 at 4:40 PM; and, on 12/11/13 at 7:16 AM, 8:55 AM and 10:08 AM with the DOM, revealed the shower room temperatures on the Short Hall ranged from 69 to 74 degrees F.</p> <p>Observation on 12/11/13 at 5:08 PM revealed the air temperatures in the following resident rooms were: room 225-70 degrees F, room 201- 66 degrees F, room 204- 68 degrees, and the Short Hall Shower Room was 66 degrees F.</p> <p>Interview, on 12/11/13 at 8:45 AM and 8:49 AM respectively with CNA #3 and CNA #4, revealed the shower rooms on both halls were often cold.</p> <p>Interview, on 12/11/13 at 4:05 PM with the DOM, revealed the cold shower room temperature occurred often and this was not a new issue. He stated he checked the temperatures but had not taken any action on the concerns. The DOM revealed the air temperature was checked daily and in random locations throughout the facility; however, temperatures were not monitored in the shower areas. He stated the thermostat control for the shower room was located outside the closed door in the hallway inside a locked metal box.</p> <p>Interview, on 12/11/13 at 1:37 PM and 3:05 PM with the Acting ADON, revealed she expected the CNAs to not give showers if the water and room air temperatures were cold; they were to provide bed baths. She stated she expected the CNAs to alert maintenance of temperature concerns. The ADON stated the CNAs should finish the resident's shower, dry them off and wrap them in a blanket and remove the resident from the cold area.</p>	F 257	<p>issue had been ignored previously. Immediate action was taken to prevent the issue from continuing forward.</p> <p><b>Criteria 3</b> – Once the inline air duct heaters have been installed, the shower room temperature will be tested for a period of twelve hours by the Maintenance Director and/or designee to ensure consistency. Once deemed acceptable by the Maintenance Director and reviewed by the Administrator and/or designee the shower rooms will be placed back into operational status. At the time they are placed into operational status, the nursing staff will be in-serviced by the Administrator and/or designee on checking the room temperatures. Room temperatures will be monitored on each shift x14 days by nursing staff. Maintenance staff will also be checking the room and water temperatures at a minimum of 1x/day 5 days/week on an ongoing basis.</p> <p><b>Criteria 4</b> – The Maintenance Director and/or designee will monitor the project through completion. The Maintenance Director will bring temperature logs to the Safety Meeting monthly to be reviewed by the Safety Committee to ensure ongoing compliance.</p> <p><b>Criteria 5</b> – Target Date:</p>	1/13/2014

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F 257	Continued From page 10	F 257	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>	
F 309 SS=D	<p>Interview, on 12/10/13 at 5:00 PM; and, on 12/11/13 at 7:50 AM respectively with the Administrator and Assistant Director of Nursing (ADON), revealed they expected the room temperature to be within regulatory guidelines and the residents should be kept safe.</p> <p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy/procedure review it was determined the facility failed to provide the necessary care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being for one (1) of ten (10) sampled residents (Resident #2). The facility failed to identify scabbed wounds on Resident #2's feet to ensure the wounds were monitored.</p> <p>The findings include:</p> <p>Review of the facility's policy for "Skin Care Management," (no date), revealed "an assessment is the basis for collecting data necessary to implement the plan of care" and the</p>	F 309	<p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b> F 309</p> <p><b>Criteria 1</b> – New orders were received for Resident #2 on 12/11/2013 for treatment to areas of concern from resident's physician.</p> <p><b>Criteria 2</b> – All skin assessments were reviewed by the acting DON and ADON on 12/11/2013 to ensure they were complete and in compliance. The facility acknowledges that all residents have the potential to be affected by this deficient practice.</p> <p><b>Criteria 3</b> – All nursing staff (certified and licensed) will be in-serviced by the DON and/or designee on January 15, 2014 relating to thoroughly reviewing a patient's body for changes while providing care and thoroughly completing skin assessments. ADON and/or designee will complete a skin assessment audit weekly and report the results to the Risk Manager and Quality Assurance Committee. The ADON and/or designee will review the skin assessment calendar 1x/week to ensure timely completion of skin assessments. ADON and/or designee will then randomly audit skin assessments to ensure accuracy x4 weeks and monthly thereafter.</p> <p><b>Criteria 4</b> – DON and/or designee will ensure that all staff is in-serviced and that the new systems are put in place to ensure ongoing compliance.</p> <p><b>Criteria 5</b> – Target Date:</p>	1/24/2014

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F 309	<p>Continued From page 11</p> <p>facility was to provide skin assessments, as indicated by the physician orders, for the residents. This was to be documented on the form, designated for that purpose".</p> <p>Record review revealed the facility admitted Resident #2 on 10/16/12, with diagnoses which included Insulin Dependent Diabetes, Peripheral Neuropathy, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 05/06/13, revealed the facility assessed Resident #2's cognition as moderately impaired, totally dependent on two (2) staff members' assistance for all aspects of his/her activities of daily living and he/she had acquired a Stage III pressure sore.</p> <p>Review of the Comprehensive Care Plan for skin breakdown and pressure ulcer development, dated 11/08/12, revealed Resident #2's skin assessments were to be performed, as per physician orders. Review of the physician orders, dated 11/27/13, revealed an order for weekly skin assessments and an order to apply skin prep to bilateral heels, until healed.</p> <p>Review of the Weekly Skin Assessments, revealed an assessment was completed on 11/28/13, that documented "no new areas and an open area to the coccyx, with a dressing in place." The next skin assessment was completed on 12/10/13, that documented dry skin to the bilateral auxiliary areas and a Stage IV to the coccyx area with a dressing.</p> <p>Observation of a skin assessment for Resident #2 performed by the Assistant Director of Nursing (ADON), on 12/11/13 at 10:50 AM, revealed one</p>	F 309		

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F 309	Continued From page 12 (1) open area on the lateral aspect of the left foot which measured 0.7 centimeters (cm) x 0.7 cm. and was scabbed in appearance, one (1) area to the left mid foot which measured 0.8 cm. x 0.8 cm. and was scabbed in appearance, and one (1) area to the right small toe which measured 0.4 cm x 0.5 cm. and was scabbed in appearance.  Interview with Resident #2, on 12/11/13 at 11:04 AM, revealed he/she had reported the areas to a staff member but was unsure of who. Resident #2 stated the areas "bother me when I try to sleep".  Interview with ADON, on 12/11/13 at 11:09 AM, revealed the areas appeared to be scabbed areas from possible blisters and stated she felt like they had been present for several days, although they had not been identified or received treatment.  Interview with the Director of Nursing (DON), on 12/11/13 at 11:15 AM, revealed she had completed the skin assessment on 12/10/13 and failed to identify the areas on the feet. She stated the areas appeared as blisters that had ruptured and appeared as though they had been there several days.	F 309			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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F 371	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen, revealed a large amount of ice on the walk-in freezer floor and dripping condensation from the freezer ceiling; some spices were noted to be out of date; eggs were observed stored over prepared food in the refrigerator and some eggs were broken, gloves, soiled briefs and debris, were observed lying on the ground, around the dumpsters.</p> <p>Review of the facility's census and condition, dated 12/10/13, revealed there were thirty-nine (39) residents in the facility and two (2) of those residents were tube feeders and did not eat food from the kitchen area.</p> <p>The findings include:</p> <p>Review of the facility's policy "Personal Appearance Policy", (no date), revealed "dining service employees must wear a hairnet or hats, per guidelines." An interview with the Dietary Manager, on 12/13/13 at 10:30 AM, there was no facility policy to address the dating of spices. All staff members were to monitor the cleanliness of the dumpster area and keep the area clean, as several disciplines utilized this area.</p> <p>1. Observation of the walk-in freezer, on 12/10/13 at 11:45 AM, revealed two (2) areas of</p>	F 371	<p><b>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY F 371</b></p> <p>1. <b>Criteria 1</b> – Dietary staff have increased scraping the floors and ceilings from 2x/week to 3x/week in an effort to eliminate the buildup of ice and condensation in the freezer. The Maintenance Director is consulting with refrigeration professionals on potential solutions to the problem. <b>Criteria 2</b> – The facility acknowledges that all residents have the potential to be affected by this deficient practice. <b>Criteria 3</b> – The Dietary Manager and/or designee will check the freezer and refrigerator at least 3x/week to ensure there is no ice buildup. <b>Criteria 4</b> – The Dietary Manager and/or designee will be responsible for ensuring the issue is resolved and no longer an ongoing concern. The Dietary Manager will present any issues at the safety meeting as well as any action taken to correct the issue. <b>Criteria 5</b> – Target Date:</p> <p>2. <b>Criteria 1</b> – The Dietary Manager immediately removed all expired spices from storage and disposed of them. <b>Criteria 2</b> – The facility acknowledges that all residents have the potential to be affected by this deficient practice. <b>Criteria 3</b> – The Dietary Manager and/or designee will check all inventory monthly to ensure it is not expired. Dietary staff is to complete dietary compliance rounds of dietary storage facilities 2x/week and submit copies of completed dietary compliance rounds to the Quality</p>	1/20/2014	

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F 371	Continued From page 14 ice, covering the floor from the back of the freezer to near the doorway. Observation of the same areas revealed condensation and dripping water from the ceiling.  Interview with the Dietary Manager, on 12/10/13 at 11:50 AM revealed she was aware of the freezing condensation and this had gone on "for years" and indicated the floor had to be scraped for ice, "at least twice a week."  2. Observation of the kitchen, on 12/13/13 at 9:45 AM, revealed spices: Chipole-Cinnamon Rub, dated 07/13/12; Lemon Pepper, dated 06/01/12; and Cream of Tarter, dated 04/24/09.  Interview with the Dietary Manager, on 12/13/13 at 10: 35 AM, revealed the spices were out of date if they were more than one year old.  3. Observation of the walk-in refrigerator, on 12/13/13 at 10:45 AM, revealed two (2) cartons of eggs, stored on the second of four shelves, above prepared individual salad plates. One of the egg cartons had a broken egg inside the carton.  Interview with the Dietary Manager, on 12/13/13 at 10:50 AM, revealed the eggs were from another department and the staff had stored the eggs in the refrigerator. The Dietary Manager stated the eggs should not have been stored above other foods.	F 371	Assurance Committee. All dietary staff will receive in-service training on January 15, 2014. <b>Criteria 4</b> – The Dietary Manager and/or designee will be responsible for ensuring the issue is resolved and no longer an ongoing concern. The Dietary Manager will present dietary compliance rounds to the Quality Assurance Committee. <b>Criteria 5</b> – Target Date:  3. <b>Criteria 1</b> – The Dietary Manager in-serviced the dietary staff on 12/18/2013 regarding safe food storage and administered a competency test. <b>Criteria 2</b> – The facility acknowledges that all residents have the potential to be affected by this deficient practice. <b>Criteria 3</b> – The Dietary Manager and/or designee will complete a safe food storage audit and will turn in the completed audit to the Quality Assurance Committee. The audit consists of checking appropriate storage temperatures, proper storage locations, stock rotation, labeling, etc. On a daily basis, the morning cook is assigned to check the storage to ensure everything is stored safely. <b>Criteria 4</b> – The Dietary Manager and/or designee will be responsible for ensuring the issue is resolved and no longer an ongoing concern. The Dietary Manager will present completed audits to the Quality Assurance Committee. <b>Criteria 5</b> – Target Date:	1/20/2014
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		1/20/2014

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F 431	<p>Continued From page 15</p> <p>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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to properly store controlled medications for two (2) unsampled deceased residents (Resident #11 and #12), who had</p>	F 431	<p><b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b> <b>F 431</b></p> <p><b>Criteria 1</b> – On December 13, 2013 the ADON removed the comfort packs and placed them in a double locking storage until contact could be made with Hospice organizations to determine responsibility of destroying the drugs. The comfort packs were destroyed on December 17, 2013 per facility policy and procedure.</p> <p><b>Criteria 2</b> – The facility acknowledges that all residents have the potential to be affected by this deficient practice. The ADON checked all medication storage facilities and carts for any concerns on 12/13/2013. No other concerns were identified.</p> <p><b>Criteria 3</b> – Upon a medication being discharged, it will be removed and destroyed per facility policy and procedure. The facility has revised the "Controlled Medication Disposal" policy to include destruction of medication from outside agencies like hospice, etc. Licensed staff will be in-serviced on January 15, 2014 regarding the updated policy by DON and/or designee. DON and/or designee will complete nursing department compliance rounds of the medication room monthly and report findings to the Safety Committee Meeting.</p> <p><b>Criteria 4</b> – DON and/or designee will be responsible for ensuring the issue is resolved and no longer an ongoing concern. Findings will be reported to the Safety Committee.</p> <p><b>Criteria 5</b> – Target Date:</p>	1/20/2014

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F 431	<p>Continued From page 16</p> <p>expired under Hospice Care. The residents' controlled medications were not stored under double lock and counted on the narcotic count sheets, in the Medication Room.</p> <p>The findings include:</p> <p>A interview with the Director of Nurses (DON,) on 12/13/13 at 4:20 PM revealed there was no policy on the storage or disposal of Hospice Medications.</p> <p>Observation of the Medication Room, on 12/13/13 at 2:35 PM, revealed three (3) unsealed boxes, labeled as "Comfort Packs," that were stacked near the medication refrigerator, on a counter.</p> <p>Interview with Registered Nurse (RN) #1, on 12/13/13 at 2:35 PM, revealed the Comfort Packs belonged to two (2) Hospice Residents. Resident #11 had expired three (3) weeks ago and Resident #12 expired approximately two (2) months ago. The RN stated the facility had called Hospice and had been waiting for them to come and dispose of the medications. The Comfort Packs contained Haldol (antipsychotic), Atropine, Morphine (pain narcotic), Ativan (anxiety narcotic) and other medications, some of which had been opened. However, there was no record of how much medication had been used and none of the medications were counted at shift change, with the other narcotics.</p> <p>Interview with Certified Medication Technician (CMT) #1, on 12/13/13 at 2:40 PM, revealed discharged residents' medications were usually sent back to the pharmacy, and the pharmacy technician usually visited the facility on a daily basis. The discharged residents' narcotics were</p>	F 431			

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F 431	Continued From page 17 placed in a slot into a large wooden locked box, until they were destroyed by the DON. However, the medications in question were the Hospice's property, but should have been under double lock.	F 431			
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.  (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	F 441			

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NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055		
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F 441	<p>Continued From page 18</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to properly clean the glucometer, used to take blood samples and determine the blood sugar level for eleven (11) Diabetic residents. In addition, the facility failed to ensure bedpans, bath basins and urinals were labeled and stored in a protective covering.</p> <p>The findings include:</p> <p>Review of the facility's policy for "Glucometer Decontamination," dated 2012, revealed the glucometer shall be decontaminated, with the facility approved wipes, following use on each resident. After performing the glucometer testing, the nurse shall perform hand hygiene, don gloves and use the disinfectant wipe to clean all external parts of the glucometer.</p> <p>The findings include:</p>	F 441	<p><b>483.65 INFECTION CONTROL, PREVENT, SPREAD, LINENS F 441</b></p> <p>1. <b>Criteria 1</b> – All glucometers in the facility were immediately cleaned by the ADON with disinfectant wipes on 12/13/2013. Registered Nurse #1 had previously been in-serviced by the facility to properly clean all resident care equipment in between uses. Registered Nurse #1 failed to follow facility protocol. Registered Nurse #1 received corrective action and in-service education on 12/13/2013. <b>Criteria 2</b> – The facility acknowledges that all residents have the potential to be affected by this deficient practice. All glucometers in the facility were immediately cleaned by the ADON with disinfectant wipes on 12/13/2013. <b>Criteria 3</b> – All licensed staff will be in-serviced on the facility policy titled "Glucometer Decontamination Policy" by the DON and/or designee on January 15, 2014. Compliance rounds will be completed monthly by the DON and/or designee to ensure ongoing compliance by the licensed staff. Results will be presented to the Quality Assurance Committee. <b>Criteria 4</b> – DON and/or designee will be responsible for ensuring the issue is resolved and no longer an ongoing concern. <b>Criteria 5</b> – Target Date:</p> <p>2. <b>Criteria 1</b> – Nursing staff (CNAs and nurses) removed all old bath basins, urinals, etc. from resident rooms on 12/13/2013. New items were issued and were marked with a permanent marker.</p>	1/20/2014	

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F 441	<p>Continued From page 19</p> <p>1. Interview with Registered Nurse (RN) #1, on 12/13/13 at 1:50 PM, revealed she did not clean the glucometer between finger sticks, as she "had never been told to do so."</p> <p>An interview with the Assistant Director of Nursing (ADON), on 12/13/13 at 3:05 PM, revealed the glucometer should be wiped down in between each finger stick with a bleach wipe and although she had not monitored "recently" to ensure this was being done, "the staff knew better."</p> <p>Interview with the Director of Nursing (DON,) on 12/13/13 at 2:55 PM, revealed the licensed staff members were to cleanse the glucometer, after each use, with a disinfecting bleach wipe and the staff had been trained to do this.</p> <p>Observation of the Medication Room, on 12/13/13 at 1:45 PM, revealed the disinfecting bleach wipes were available for use. Review of the inservice training, dated 03/07/13, revealed glucometer decontamination training had been taught, however, RN #1's name was not included in the training.</p> <p>2. Observations on 12/10/13 at 10:30 AM and 3:53 PM; and, on 12/13/13 at 5:00 PM revealed the following:</p> <p>Room (Rm) 115 bathroom - one bath basin under the sink with no label and no protective covering and a urinal hanging on the hand rail with no label.</p> <p>Rm 116 bathroom- one bed pan hanging on the rail above the toilet with no label or protective covering.</p> <p>Rm 204 bathroom- one bath basin on the floor</p>	F 441	<p>Bath basins will be stored in the resident's closet or drawers. Urinals, bed pans, etc. are placed in bags and labeled with the resident's name and date.</p> <p><b>Criteria 2</b> – The facility acknowledges that all residents have the potential to be affected by this deficient practice. All items were discarded on 12/13/2013 and new items were issued.</p> <p><b>Criteria 3</b> – The nursing staff (certified and licensed staff) will be in-serviced on January 15, 2014 by the DON and/or designee on a new cleaning schedule. This cleaning schedule will ensure that staff takes the time to change out old items; label new items and ensure proper storage of resident care items. Nursing department compliance rounds will be completed monthly by the DON and/or designee to ensure ongoing compliance by the licensed staff. Results will be presented to the Quality Assurance Committee.</p> <p><b>Criteria 4</b> – DON and/or designee will be responsible for ensuring the issue is resolved and no longer an ongoing concern.</p> <p><b>Criteria 5</b> – Target Date:</p>	1/20/2014

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F 441	Continued From page 20 underneath the sink with no label or protective covering.  Rm 205 bathroom- two (2) urinals sitting on the back of the toilet with no label and no protective covering, one bed pan hanging on the hand rail with no label, and a bath basin on the floor underneath the sink with no label or protective covering.  Rm 206 bathroom- one bed pan hanging from the hand rail with no label and a urinal on the back of a commode with no label or protective covering.  Rm 207 bathroom- one bed pan with a brown substance noted on the wall next to where the bed pan was hanging on the hand rail, the bed pan was not in a protective covering.  Rm 208 bathroom- one bath basin on the floor with a bed pan sitting in the bath basin, neither was labeled or in a protective covering.  Rm 209 bathroom- one bath basin sitting on a clear plastic stacking drawer with no label or protective covering.  Rm 210 bathroom- one bath basin on the floor underneath the sink, with no label or protective covering noted.  Rm 211 bathroom- one bed pan hanging on the hand rail with no label or protective covering.  Rm 212 bathroom- one bath basin on the floor underneath the sink with no label and no protective covering and one urinal with no label or protective covering.	F 441			

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F 441	Continued From page 21 Rm 213 bathroom- one bath basin underneath the sink with no protective covering and no label.  Rm 214 bathroom- one bed pan hanging from the hand rail, with no label and one bath basin sitting on the sink with no label or protective covering.  Interview with the Director of Nursing (DON) and Assistant DON, on 12/13/13 at 5:10 PM, revealed it was the facility's policy to label all bath basins, urinals and bedpans and to store them in a protective covering.	F 441			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1994.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1995, with 114 smoke detectors and 07 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1994.</p> <p>GENERATOR: Type II generator installed in 1995. Fuel source is Diesel.</p> <p>A Standard Life Safety Code survey was conducted on 12/10/13. River's Bend Retirement Community was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for forty (40) beds with a census of thirty-nine (39) 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</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 2/6/2014
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Fire).	K 000	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.  NFPA 101 Life Safety Code Standard K 011  Criteria 1 – The facility contacted an architect to review the current design of the facility and the architect has deemed that the walls are to code specifications. The facility has contracted with GBS Enterprises, Inc. to install 90-minute fire resistant doors for all three passage ways dividing the skilled area, the assisted living area and the daycare area in the building. GBS Enterprises agreed to handle the project on January 14, 2014 and responded on January 24, 2014 that the time frame for delivery will be approximately six (6) weeks from January 24, 2014. Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 – New doors will be installed at the passage ways to meet the code specifications by a licensed contractor. The facility has contracted with GBS Enterprises, Inc. to install 90-minute fire resistant doors for all three passage ways dividing the skilled area, the assisted living area and the daycare area in the building. GBS Enterprises agreed to handle the project on January 14, 2014		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire walls were in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for forty (40) beds with a census of thirty-nine (39) on the day of the survey. The facility failed to ensure the fire walls were properly fire rated to protect the skilled wings from the assisted living facility and the daycare.  The findings include:  Observation, on 12/10/13 at 2:14 PM with the Maintenance Supervisor, revealed the facility did not have two (2)-hour fire rated walls dividing the	K 011			

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K 011	<p>Continued From page 2</p> <p>skilled area, the assisted living, and the daycare in the building. Further observation revealed the facility had installed doors in the smoke barriers that were rated for forty-five (45) minutes.</p> <p>Interview, on 12/10/13 at 2:14 PM with the Maintenance Supervisor, revealed he was unaware the doors were not rated properly for separation and the walls were not rated properly for occupancy separation.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations. 19.1.1.4.1 Additions. Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. (See 4.6.11 and 4.6.6.) 19.1.1.4.2 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire doors. (See also Section 8.2.) 19.1.1.4.3 Doors in barriers required by 19.1.1.4.1 shall normally be kept closed. Exception: Doors shall be permitted to be held open if they meet the requirements of 19.2.2.2.6.</p> <p>8.2.3.2 Fire Protection-Rated Opening Protectives. 8.2.3.2.1 Door assemblies in fire barriers shall be of an</p>	K 011	<p>and responded on January 24, 2014 that the time frame for delivery will be approximately six (6) weeks from January 24, 2014. Criteria 4 – The Maintenance Director and/or designee will monitor the project through completion. Criteria 5 – Target Date:</p>	01/24/2014	

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K 011	Continued From page 3 approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1.	K 011	NFPA 101 Life Safety Code Standard K 025  Criteria 1 – The Maintenance Director and/or designee will correct the penetrations to the smoke partition above room #225 by January 10, 2014 by patching the holes and placing fire resistant caulk in all open areas. The facility is also going to install access areas to the smoke barriers located at room numbers 227, 236 and next to the human resources office by the target date. Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 – As part of the preventative maintenance plan, the Maintenance Director and/or designee will check all smoke barriers monthly to ensure that all smoke barriers are intact and there are no penetrations. Criteria 4 – The Maintenance Director and/or designee will monitor the project through completion. The Maintenance Director will present a report of monthly findings to the Quality Assurance Committee. Criteria 5 – Target Date:	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance	K 025		01/24/2014

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K 025	<p>Continued From page 4</p> <p>with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for forty (40) beds with a census of thirty-nine (39) on the day of the survey. The facility failed to ensure one (1) smoke barrier was sealed around pipes and wires to resist the passage of smoke and there was access for staff to check three (3) smoke barriers.</p> <p>The findings include:</p> <p>Observations, on 12/10/13 between 12:00 PM and 3:00 PM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at room #225, was penetrated by pipes and wires. Further observation revealed the smoke barriers located at rooms #227, 236, and next to the Human Resources office had no access to check the integrity of the smoke barriers.</p> <p>Interview, on 12/10/13 between 12:00 PM and 3:00 PM with the Maintenance Supervisor, revealed they were aware of the penetrations at room #225 because a contractor had done some work that was not resealed. Further interview revealed there was no good way to get to the noted smoke barriers to check for penetrations.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p>	K 025		

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K 025	Continued From page 5 (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.  8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  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	K 050		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  12/10/2013
NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055	
(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 050	<p>Continued From page 6</p> <p>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 record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for forty (40) beds with a census of thirty-nine (39) on the day of the survey. The facility failed to ensure that fire drills were conducted quarterly on the 2nd and 3rd shifts.</p> <p>The findings include:</p> <p>Fire Drill review, on 12/10/13 at 10:40 AM with the Maintenance Supervisor, revealed the fire drills were not conducted during the 3rd quarter of 2013 on 2nd shift; and, the 2nd quarter of 2013 on 3rd shift.</p> <p>Interview, on 12/10/13 at 10:40 AM with the Maintenance Supervisor, revealed he was unaware the fire drills were not conducted quarterly on each shift. Further interview revealed he had them marked out on his personal calendar and had written the different shifts wrong on the calendar.</p>	K 050	<p>NFPA 101 Life Safety Code Standard K 050</p> <p>Criteria 1 – The facility has developed a rotating twelve month calendar for fire drills. Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 – As part of the monthly safety meeting, the Maintenance Director and/or designee will present the fire drill report to the Safety Committee. On a quarterly basis, the Quality Assurance Committee will review all fire drills to ensure compliance. Criteria 4 – The Risk Manager and/or designee will ensure that fire drills are completed to code and are reviewed by the Safety Committee and Quality Assurance Committee. Criteria 5 – Target Date:</p>	1/2/2014

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K 050	Continued From page 7	K 050	NFPA 101 Life Safety Code Standard K 062	
K 062 SS=F	<p>Reference: NFPA 101 (2000 edition)</p> <p>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>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</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have quarterly inspections performed of the fire sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for forty (40) beds with a census of thirty-nine (39) on the day of the survey. The facility failed to ensure a second quarter sprinkler inspection was conducted during 2013.</p> <p>The findings include:</p> <p>Sprinkler report review, on 12/10/13 at 10:55 AM with the Maintenance Supervisor, revealed the facility did not have documentation for a second quarter inspection of the fire sprinkler system. Components located in the fire sprinkler system</p>	K 062	<p>Criteria 1 – The facility has ended agreements with the previous fire protection and services agency on December 16, 2013. The facility will now use Premier Fire Protection, Inc. to oversee required quarterly automatic sprinkler system inspections.</p> <p>Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice.</p> <p>Criteria 3 – As part of an ongoing effort to correct this concern, the Maintenance Director and/or designee will present all monthly and quarterly inspections to the Safety Committee. On a quarterly basis, the Quality Assurance Committee will review all monthly and quarterly inspections to ensure ongoing compliance.</p> <p>Criteria 4 – The Risk Manager and/or designee will ensure that fire drills are completed to code and are reviewed by the Safety Committee and Quality Assurance Committee.</p> <p>Criteria 5 – Target Date:</p>	12/16/2013

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K 062	<p>Continued From page 8</p> <p>must be inspected monthly and quarterly accordingly to NFPA requirements and the records for the inspection made available for the authority having jurisdiction.</p> <p>Interview, on 12/10/13 at 10:55 AM with the Maintenance Supervisor, revealed he was unaware the sprinkler system had not been inspected in the second quarter of 2013. Further interview revealed the sprinkler company had an employee that was telling them he was completing the inspections but not actually doing the inspections. He revealed he never checked behind the sprinkler company because there had never been a problem with them before.</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1</p>	K 062		

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K 062	Continued From page 9 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10  Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1	K 062		

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K 062	Continued From page 10 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection	K 062		

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K 062	Continued From page 11 Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 12  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the emergency generator according to NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for forty (40) beds with a census of thirty-nine (39) on the day of the survey. The facility failed to ensure there was battery backup lighting at the generator transfer switch.  The findings include:  Observation, on 12/10/13 at 2:50 PM with the Maintenance Supervisor, revealed the facility did not have any battery-powered lighting installed in the area where the transfer switch for the emergency generator was located.  Interview, on 12/10/13 at 2:50 PM with the Maintenance Supervisor, revealed he was not aware of the requirement for the battery backup lighting.  Reference: NFPA 110 (1999 Edition).  5-3.1 The Level 1 or Level 2 EPS equipment location shall be	K 144	NFPA 101 Life Safety Code Standard K 144  Criteria 1 – The Maintenance Director installed a battery-powered lighting unit on December 18, 2013. Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 – The facility ensured that a battery-powered lighting unit was installed on December 18, 2013. Criteria 4 – As part of the preventative maintenance plan, the Maintenance Director and/or designee will test the battery-powered lighting unit monthly. Criteria 5 – Target Date:	12/18/2013
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K 144	Continued From page 13 provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.	K 144			