

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

PRINTED: 10/07/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2010
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NAME OF PROVIDER OR SUPPLIER REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An annual survey was conducted on 09/21-23/10 to determine the facility's compliance with Federal requirements for recertification. It was determined the facility did not meet the minimum Federal requirements for recertification, with the highest scope and severity at a "G". Additionally, an abbreviated survey (KY #15112) was conducted 09/21-23/10 and was unsubstantiated with no deficiencies cited.	F 000	Plan of Action Redbanks Standard Survey 9/21 – 9/23/10 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.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F 157 Physician Notification A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a).	

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

TITLE

(X6) DATE

Chris Page

Administrator

10/15/10

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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to notify the physician regarding the failure to obtain a urinalysis (UA) as ordered, for one resident (#2), in the selected sample of 28. The physician ordered the UA to be collected on 06/15/10, however, the UA was not collected until 07/06/10. Findings include: A record review revealed Resident #2 was admitted to the facility on 05/13/10, with diagnoses to include Dementia, Diabetes Mellitus Type 2, Hypertension, and Hypothyroidism. A review of the quarterly Minimum Data Set (MDS), dated 08/10/10, revealed the facility identified Resident #2 as moderately cognitively impaired and frequently incontinent of bladder. A review of the Physician's Orders, dated 06/15/10, revealed the UA was ordered due to a noted change in the resident's voiding pattern and behaviors of voiding in a trash can. However, a review of the clinical record revealed no evidence the UA was collected as ordered. A review of the "Lab Tracking Record", dated June 2010, revealed the UA was scheduled to be collected, on 06/16/10, however, there were no initials (per a nurse), indicating the collection of the UA. The "Lab Tracking Record", dated July	F 157	<p>Criteria 1: The physician and family/responsible party have been updated on the current lab results for resident #2.</p> <p>Criteria 2: The lab orders for all current residents have been reviewed by the DON and Administrative nurses to determine that labs have been obtained and the physicians notified of the results.</p> <p>Criteria 3: Facility licensed nurses have received inservice education on the need to obtain labs and notify the physicians of the results timely, and to document this notification, as provided by the Staff Development Coordinator and/or designee on 10/7-27/2010</p> <p>Criteria 4: The CQI indicator for the monitoring of physician lab notification will be utilized monthly X 2 months and then every six months as per the established CQI calendar.</p> <p>Criteria 5: October 28, 2010</p>	10/28/10	

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F 157	<p>Continued From page 2</p> <p>2010, revealed an entry reflecting the collection of a UA, on 07/06/10. A review of Physician's Orders, dated 07/09/10, revealed an order was received for Bactrim DS (antibiotic), one by mouth twice daily, for seven days for the diagnosis of Urinary Tract Infection (UTI). However, there was no documentation in the clinical record indicating the physician was made aware the UA was not obtained, on 06/15/10, as ordered.</p> <p>An interview with Registered Nurse (RN) #2, on 09/23/10 at 3:05 PM, revealed she noticed the UA had not been obtained in June, and collected the specimen, on 07/06/10. She stated she felt it was a "nursing judgement", whether to notify the physician or not regarding lab work omitted. She stated "If a regular lab is missed, I wouldn't call the physician." However, she stated the physician should have been notified, regarding the UA omitted for Resident #2.</p> <p>An interview with the Director of Nursing, on 09/22/10 at 4:10 PM, revealed she expected the nursing staff to notify the resident's physician and family, if a lab test was missed.</p> <p>An interview with the Program Manager (#2), on 09/23/10 at 1:00 PM, revealed nursing staff were expected to notify the physician in the event a lab test was not obtained, as ordered.</p> <p>An interview with the resident's primary physician, on 09/23/10 at 2:40 PM, revealed he could not recall being notified that the UA had not been obtained, as ordered. He stated he expected the nursing staff to notify him in the event orders were not followed.</p> <p>A review of the policy/procedure, "Physician/Legal</p>	F 157		

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F 157	Continued From page 3 Representative Notification", (undated), revealed it was the policy of the facility to inform the resident's physician and legal representative when there was a need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment). The policy revealed if the situation was not critical, the attending physician would be notified during regular business hours and may be done by fax. The attending physician must be notified by phone or fax within 24 hours.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 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. 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. 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. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when	F 164	F 164 Privacy and Confidentiality The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Criteria 1: Administrative nursing observations have determined that Residents #2 and 16 are provided privacy by pulling the privacy curtains completely during care. Criteria 2: Administrative nursing observations have determined that residents are provided privacy by pulling the privacy curtains completely during care.	

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F 164	<p>Continued From page 4</p> <p>release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure the provision of personal privacy during care for two residents (#2, #16), in the selected sample of 28. Observations revealed privacy curtains were not completely closed during care. Findings include:</p> <p>1. A record review revealed Resident #2 was admitted to the facility on 05/13/10, with diagnoses to include Dementia, Diabetes Mellitus Type 2, Hypertension, and Hypothyroidism.</p> <p>A review of a quarterly Minimum Data Set (MDS), dated 08/10/10, revealed the facility identified Resident #2 as moderately cognitively impaired and required physical help with bathing. The MDS revealed Resident #2 was usually continent of bowel and frequently incontinent of bladder.</p> <p>An observation, on 09/22/10 at 8:45 AM, revealed privacy was not provided for Resident #2 during provision of bathing/incontinent care. The Nurse Aide (NA) did not pull the privacy curtain while bathing the resident. The resident's roommate was in bed and could visualize Resident #2 during the provision of the bath.</p> <p>An interview with the NA, on 09/22/10 at 2:47 PM, revealed she was aware of the importance of providing privacy during care and she did not ensure the privacy for Resident #2.</p>	F 164	<p>Criteria 3: Nursing staff have received in-service education provided by the Staff Development Coordinator and/or designee on the provision of privacy during care including but not limited to pulling the privacy curtains completely. 10/7-27/2010</p> <p>Criteria 4: The CQI indicator for the monitoring of resident privacy will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Social Service and/or designee.</p> <p>Criteria 5: October 28, 2010</p>	10/28/10

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F 164	<p>Continued From page 5</p> <p>2. A record review revealed Resident #16 was admitted to the facility on 02/14/06 with diagnoses to include Transient Ischemic Attack (TIA), Hypertension, Alzheimer's Dementia, Fractured Hip, Osteoarthritis, Chronic Obstructive Pulmonary Disease, and Gastroesophageal Reflux Disease.</p> <p>A review of the quarterly MDS, dated 07/02/10, revealed the facility identified Resident #16 as severely cognitively impaired and required physical help with bathing. The MDS revealed Resident #16 was incontinent of bowel and frequently incontinent of bladder.</p> <p>An observation, on 09/22/10 at 1:15 PM, revealed Certified Nurse Aide (CNA) #5 did not ensure privacy during incontinent care for Resident #16, by pulling the privacy curtain completely. The curtain was observed partially open and the resident was visible to anyone entering the resident's room, during the care.</p> <p>An interview with CNA #5, on 09/22/10 at 2:45 PM, revealed the statement, "I forgot to pull the privacy curtain all the way around."</p> <p>An interview with the Director of Nursing, on 09/22/10 at 4:10 PM, revealed she expected staff to close the door and pull the privacy curtain all the way around the resident's bed. She stated that the CNAs are instructed to provide privacy, during CNA training.</p> <p>A review of the Mosby's Textbook for Long Term Care Nursing Assistants, 5th Edition, revealed each person had the right to full visual privacy. The textbook revealed full visual privacy was</p>	F 164		

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F 164	Continued From page 6 described as complete freedom from public view, while in bed. Always pull the curtain completely around the bed before giving care.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225	F 225 Abuse The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Criteria 1 & 2: -Employee files have been audited by the Business Office Manager and Director of Human Resources to determine that abuse registry and criminal record checks have been obtained. 10/4-27/2010 -Abuse registry and criminal record checks will be requested/obtained prior to hire of new employees by 10/28/10. Criteria 3: The Staff Development Coordinator will provide the Director of Human Resources with proof of abuse registry and criminal record check information prior to hire for verification, and prior to the scheduling of employee orientation training.	

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F 225	Continued From page 7 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to conduct a Nurse Aide Abuse Registry check for one employee (#1), in a sample of 10 personnel files reviewed, prior to employment. Findings include: A review of the personnel record for Employee #1, a Certified Nursing Assistant (CNA), revealed a hire date of 06/02/10; however, the Nurse Aide Abuse Registry check was not completed, until 06/06/10. An interview with the Staff Development Coordinator, on 09/22/10 at 10:15 AM, revealed she was responsible for conducting the Abuse Registry checks. The facility policy required the nurse aide abuse registry check be completed before a prospective employee was hired. She stated, prior to hire, the nurse aide abuse check, sexual offender check, criminal records check and everything in the classroom was completed before the employee could "touch a resident on the floor". She stated Employee #1 was hired, on 06/02/10, and she thought the nurse aide abuse check was completed that day, but stated, "I don't know how the abuse registry check was missed". A review of the facility policy entitled, "Nurse Aide Abuse Registry" (undated), revealed before employment began, the Nurse Aide Abuse Registry would be checked to assure the potential employee was not listed on the registry.	F 225	Criteria 4: The CQI indicator for the monitoring of timeliness of abuse registry and criminal record checks will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator. Criteria 5: October 28, 2010	10/28/10	

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F 282 SS=G	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure care was provided in accordance with care plan interventions for one resident (#17), in the selected sample of 28. The facility assessed and care planned Resident #17 as requiring assistance of two staff members for transfer to and from the toilet. On 09/05/10, the facility left Resident #17 unsupervised and unassisted on the toilet, the resident fell and sustained a fracture to the right radius and ulnar (forearm bones). Additionally, the facility failed to ensure a sensor pad alarm was functional as directed by Resident #17's plan of care. Findings include:</p> <p>1. A record review revealed Resident #17 was admitted to the facility on 04/05/10 with diagnoses to include Hepatic Coma, End Stage Renal Disease and Cirrhosis of the Liver. A review of Resident #17's Fall Assessment Screening Tool (FAST), dated 07/19/10, revealed the resident had scored 80 on the assessment tool, with a score of 65 or greater indicating a high risk for falls. A review of the significant change Minimum Data Set (MDS) assessment information, dated 07/27/10, revealed the facility identified Resident #17 as moderately cognitively impaired, at risk for falls and requiring extensive</p>	F 282	<p>F282 Comprehensive Care Plans The services provided or arranged by the facility shall be provided by qualified staff in accordance with each resident's plan of care.</p> <p>Criteria 1: Resident #17 receives toileting assistance and fall prevention interventions as indicated on the care plan.</p> <p>Criteria 2: An audit was completed by the program managers to determine that residents on their units are receiving toileting assistance and fall prevention interventions in accordance with their care plans.</p> <p>Criteria 3: The non-licensed nursing staff have received inservice education as provided by the DON/Staff Development Coordinator on the provision of toileting assistance and fall prevention interventions in accordance with each resident's care plan, conducted on 10/7-27/2010.</p>		

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F 282	<p>Continued From page 9</p> <p>assistance of two staff members for transfer and toileting.</p> <p>A review of Resident #17's care plan, dated last reviewed on 07/30/10, for the "Inability to perform activities of daily living (ADL) of bathing, dressing, grooming, bed mobility, toileting, transferring, ambulating, locomotion, and eating", related to decreased strength and endurance, physical weakness, Diabetes Mellitus, Dementia, and Diabetic Peripheral Neuropathy included interventions to set up the meal tray for the resident for independent dining every meal and provide extensive assistance of two staff for all toileting needs every two hours and as needed. Resident #17's care plan revealed the problem, at risk for falls/injury related to Dementia, Diabetes, Chronic Renal Disease, impaired safety awareness, decreased strength and endurance with physical weakness, dated 04/15/10 with a review date of 07/30/10. Interventions for the fall care plan included, alarming floor mat at all times. The CNA care plan, dated September 2010, noted two person assist with toileting in the bathroom was required for Resident #17 and an alarm mat was to be by the bed at all times.</p> <p>A review of the nurse's notes, dated 09/05/10 at 3:00 PM, revealed the resident had been assisted to the bathroom and had sustained an "un-witnessed" fall. The resident complained of pain to the right eye, right cheek, right wrist, right hip, and right knee. The facility notified Resident #17's family and physician regarding the fall. The facility transferred the resident to the emergency room of the local hospital, at 4:03 PM.</p> <p>A review of an x-ray report for Resident #17, dated 09/05/10, revealed a nondisplaced distal</p>	F 282	<p>Criteria 4: The CQI indicator for the monitoring of toileting assistance and fall prevention interventions in accordance with the care plan will be utilized monthly X 2 months and then quarterly as per the established CQI calendar, under the supervision of the DON.</p> <p>Criteria 5: October 28, 2010</p>	10/28/10

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F 282	<p>Continued From page 10</p> <p>radial fracture as well as a fracture through the distal ulna including the ulnar styloid.</p> <p>An interview with CNA #1, on 09/23/10 at 9:40 AM, revealed she assisted Resident #17 to the bathroom on 09/05/10 at approximately 3:00 PM. CNA #1 stated she had remained with the resident for approximately five minutes when another call light sounded. She asked the resident to pull the emergency light when the resident had finished using the bathroom. CNA #1 revealed she left Resident #17 alone in the bathroom to answer the other call light. Shortly afterward, another CNA came and informed her Resident #17 had sustained a fall in the bathroom. CNA #1 revealed she was aware Resident #17 was a two person assist for transfers and toileting but had been unable to find another CNA when the resident needed to use the bathroom.</p> <p>An interview with the Certified Medication Aide (CMA) #1, on 09/23/10 at 10:00 AM, revealed she had been working the back hall on 09/05/10 when she heard a noise and then the family of Resident #17's roommate began yelling for help. CMA #1 then entered the bathroom to find Resident #17 lying in the floor on his/her right side. She stated she notified the licensed staff on duty.</p> <p>An interview with LPN #1, on 09/23/10 at 10:15 AM, revealed she had responded when CMA #1 needed assistance after Resident #17 had sustained the fall. LPN #1 stated the fall was unwitnessed as CNA #1 had left the resident in the bathroom alone.</p> <p>An observation of Resident #17, on 09/21/10 at 4:00 PM, revealed the resident was asleep in a</p>	F 282		

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F 282	<p>Continued From page 11</p> <p>reclining chair by the bed with a cast present to the resident's right wrist. A padded mat was beside the bed and under the footrest of the recliner. Under the padded mat was a sensor alarm mat that did not alarm when pressure was applied and released. An observation of Resident #17, on 09/21/10 at 5:10 PM, revealed the alarm mat was still not functioning. An interview with the Licensed Practical Nurse (LPN) #2, on 09/21/10 at 5:10 PM, revealed LPN #2 stepped on the sensor mat to determine if the mat was functioning and mat did not alarm. LPN #2 then checked the alarm and noted the alarm was turned off. She stated it was the CNAs responsibility to ensure all alarms were functioning properly every shift.</p> <p>An interview with the Unit Program Manager, on 09/23/10 at 1:30 PM, revealed she expected the staff to follow the resident's plan of care to determine how to safely transfer the resident. She stated the CNA should also always explain the procedure being completed. The Unit Program Manager revealed Resident #17 was a high fall risk and should have never been left alone in the bathroom. She stated all high fall risk residents should never be left alone in the bathroom especially a resident who was also cognitively impaired. Furthermore she stated that she expected all sensor alarms to be on and functional as directed by the plan of care.</p> <p>An interview with the Director of Nursing (DON), on 09/23/10 at 2:10 PM, revealed she would expect staff to remain in the bathroom with Resident #17 at all times due to the resident being high risk for falls and being cognitively impaired. The DON stated she expected all residents care to be provided as directed by the</p>	F 282			

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F 282	Continued From page 12 plan of care and for all alarms to be in place and functional if staff was not present with the resident.	F 282			
F 315 SS=E	Interviews with the Unit Program Manager, on 09/23/10 at 1:30 PM, and Resident #17's private sitter, on 09/23/10 at 8:30 AM, revealed Resident #17 could no longer feed him/herself independently since sustaining the fractures. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure appropriate care and services to prevent infections related to incontinent care and/or catheter care was provided for four residents (#2, #7, #13 and #16), in the selected sample of 28. Findings include: A review of the policy, "Care of Indwelling Catheter" (no date), revealed the caregiver should wash their hands and don gloves, prior to provision of catheter care.	F 315	F 315 Urinary Incontinence Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Criteria 1: Administrative nursing observations indicate that residents #2, 7, 13, and 16 are provided peri-care and catheter care in accordance with infection control standards of practice.		

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F 315	<p>Continued From page 13</p> <p>1. A record review revealed Resident #7 was admitted to the facility with diagnoses to include a History of Urinary Tract Infections (UTI), Fractured Hip, Diabetes Mellitus, Dementia, Congestive Heart Failure (CHF) and Pressure Ulcers.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 07/14/10, revealed the facility identified Resident #7 as incontinent of bowel, had an indwelling catheter and required total assistance for personal hygiene.</p> <p>A review of the physician's orders, dated 09/2010, revealed an order for indwelling catheter care every shift. A review of the care plan, dated 08/13/10, for "Risk for Urinary Tract Infection, related to an Indwelling Catheter, revealed an intervention to provide catheter care every shift and as needed.</p> <p>An observation, on 09/22/10 at 10:35 AM, revealed Certified Nurse Aide/Certified Medication Aide (CNA/CMA) #1 provided catheter care for Resident #7. During the observation, it was noted that Resident #7 had an incontinent (bowel) episode, which required incontinent care, prior to catheter care. Observation revealed CNA/CMA #1 did not wash her hands and change her gloves after provision of incontinent care and prior to the catheter care. Additionally, CNA/CMA #1 applied a barrier cream to the resident's buttocks, following the catheter care, without washing her hands and changing gloves.</p> <p>An interview with CNA/CMA #1, on 09/22/10 at 10:58 AM, revealed she was aware she should have washed her hands and donned new gloves, following incontinent care and should have used</p>	F 315	<p>Criteria 2: Administrative nursing observations indicate that residents are provided peri-care and catheter care in accordance with infection control standards of practice.</p> <p>Criteria 3: Nursing assistants have received inservice education on the provision of peri-care and catheter care, and handwashing/changing of gloves in accordance with infection control standards of practice as provided by the Staff Development Coordinator/designee on 10/8-27/2010.</p> <p>Criteria 4: The CQI indicator for the monitoring of peri-care/catheter care and handwashing will be utilized monthly X 2 months and then quarterly in accordance with the established CQI calendar under the supervision of the DON.</p> <p>Criteria 5: October 28, 2010</p>	10/28/10

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F 315	<p>Continued From page 14</p> <p>new gloves to apply the barrier cream. An interview, on 09/23/10 at 1:35 PM, revealed she had been inserviced regarding handwashing and donning gloves; however, she did not follow the procedure.</p> <p>An interview with Registered Nurse (RN) #1, on 09/22/10 at 10:58 AM, revealed CNA/CMA #1 should have washed her hands and changed gloves following the incontinent care, catheter care and prior to applying the barrier cream.</p> <p>An interview with Licensed Practical Nurse (LPN) and Program Manager #1, on 09/23/10 at 1:50 PM, revealed she expected CNA/CMA #1 to follow the policy regarding handwashing and donning of gloves, after completing each task.</p> <p>An interview with the Director of Nursing (DON), on 09/23/10 at 3:05 PM, revealed she expected staff to follow policy and procedures for incontinent care, catheter care and to follow guidelines for handwashing.</p> <p>A review of the inservices provided related to Infection Control, Peri-Care and Handwashing revealed the staff observed were inserviced on 04/20/10 and again for Handwashing, on 06/29/10.</p> <p>2. A record review revealed Resident # 13 was admitted with a diagnosis of Cerebrovascular Accident.</p> <p>A review of the quarterly MDS assessment, dated 08/06/10, revealed the facility identified Resident #13 as moderately cognitively impaired, incontinent of bowel and bladder and required total assistance of staff for care needs.</p>	F 315			

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F 315	<p>Continued From page 15</p> <p>A review of the care plan, dated 05/21/10, for "Inability to Perform ADL's", revealed an intervention for staff to provide incontinent care every two hours and as needed.</p> <p>An observation, on 09/23/10 at 10:45 AM, revealed CNA #3 provided incontinent care for Resident #13. CNA #3 used a wet wash cloth and made one downward stroke from front of the resident's perineum towards the rectal area, and then used the same surface area of the same wash cloth for three addition stokes from right to left of the perineal area. Afterwards, CNA #3 placed the contaminated wash cloth in a basin of water, which contained clean wash cloths. She retrieved another wash cloth from the contaminated water to continue the incontinent care process.</p> <p>An interview with CNA #3, on 09/23/10 at 10:00 AM, revealed she received training related to provision of incontinent care at the facility, prior to assignment of direct resident care.</p> <p>An interview, on 09/23/10 at 12:45 PM, with RN #5 revealed she expected a CNA to perform incontinent care bathing the perineal area of the resident's body, front to back and expected the CNA to use a different surface of the wash cloth with each stroke.</p> <p>An interview, on 09/23/10 at 3:15 PM, with the Director of Nurses revealed she expected CNAs to perform perineal/incontinent care as instructed and in accordance with facility policy and procedures to include handwashing and glove changes.</p>	F 315		

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F 315	<p>Continued From page 16</p> <p>3. A record review revealed Resident #2 was admitted to the facility on 05/13/10, with diagnoses to include Dementia, Diabetes Mellitus Type 2, Hypertension and Hypothyroidism.</p> <p>A review of the quarterly MDS, dated 08/10/10, revealed the facility identified Resident #2 as moderately cognitively impaired, required physical help with bathing, usually continent of bowel and frequently incontinent of bladder.</p> <p>An observation of provision of incontinent care, on 09/22/10 at 8:45 AM, revealed the Nurse Aide (NA) filled a bath basin with water, applied a no-rinse foam cleanser to a washcloth and cleansed the perineal area of the resident from front to back. The NA rinsed the contaminated washcloth in the bath basin and cleansed between the resident's labia. The NA placed the contaminated washcloth into the bath basin and obtained another washcloth with no-rinse foam cleanser, cleansed between the resident's buttocks. The washcloth had been rinsed in the wash basin, containing contaminated water. The washcloth was then placed back in the wash basin. Another washcloth was obtained and used to cleanse the buttocks after rinsing the cloth in the contaminated bath water/basin. Afterwards the NA dried the perineal area and buttocks with a clean towel.</p> <p>An interview with the NA, on 09/22/10 at 2:47 PM, revealed she had been employed since 08/16/10 and was currently taking the CNA classes. She revealed she was aware she should not reuse a washcloth while providing incontinent care and should not rinse new washcloths in the contaminated water. She stated, "I should have put the used washcloths in a blue bag instead of</p>	F 315		

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F 315	<p>Continued From page 17 leaving them in the bath basin."</p> <p>4. A record review revealed Resident #16 was admitted to the facility on 02/14/06, with diagnoses to include Transient Ischemic Attack (TIA), Hypertension, Alzheimer's Dementia, Fractured Hip, Osteoarthritis, Chronic Obstructive Pulmonary Disease, and Gastroesophageal Reflux Disease.</p> <p>A review of the quarterly MDS, dated 07/02/10, revealed the facility identified Resident #16 as severely cognitively impaired, required physical help with bathing, was incontinent of bowel and frequently incontinent of bladder.</p> <p>An observation during the provision of incontinent care, on 09/22/10 at 1:15 PM, revealed CNA #5 filled a bath basin with water. She used a washcloth with no-rinse foam cleanser to cleanse the perineal area. The washcloth was rinsed in the bath basin and the area was cleansed again with the same washcloth. CNA #5 was observed to rinse the washcloth in the bath basin and cleanse the resident's buttocks with the same washcloth. The resident's perineal area and buttocks were dried with a clean towel.</p> <p>An interview with CNA #5, on 09/22/10 at 2:45 PM, revealed she realized she did not use appropriate hygiene technique during incontinent care. She stated "we never reuse washcloths while providing care."</p> <p>An interview with the DON, on 09/22/10 at 4:10 PM, revealed she expected the nursing staff to follow the facility's policy for provision of incontinent care.</p>	F 315		

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F 315	Continued From page 18 A review of Mosby's Textbook for Long Term Care Nursing Assistants, 5th Edition, revealed the procedure for giving female perineal care included rinsing the perineum with a clean washcloth. Then, separate the labia and stroke downward from front to back. Use a clean part of the washcloth for each stroke or use more than one washcloth if necessary.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure adequate supervision to prevent accidents for one resident (#17) in the selected sample of 28. The facility failed to follow the "Resident's Safe Environment" policy and procedure and failed to follow care plan interventions to prevent falls for Resident #17. The facility assessed and care planned Resident #17 as being high risk for falls and requiring two staff to assist with all toileting needs. On 09/05/10, facility staff left Resident #17 unassisted and unsupervised while toileting. The resident fell and sustained nondisplaced distal radial fracture and a fracture through the distal ulna including the ulnar styloid (forearm bones).	F 323	F 323 Accidents The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Criteria 1: Resident #17 receives toileting assistance and fall prevention interventions as indicated on the care plan. Criteria 2: An audit was completed by the program managers to determine that residents on their units are receiving toileting assistance and fall prevention interventions in accordance with their care plans.	

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F 323	Continued From page 19 Findings include: A review of the facility's policy entitled "Resident's Safe Environment" revealed it was the policy of the facility to evaluate all residents for fall risks. The policy further stated that each resident would be evaluated for fall risks by using the FAST evaluation form. The policy directed to follow interventions outlined in the recommendations for each level of risk identified by the FAST evaluation. Interventions outlined for a high level of risk included continuous supervision and attendance in the shower or bathroom. 1. A record review revealed Resident #17 was admitted to the facility, on 04/05/10, with diagnoses to include End Stage Renal Disease and Cirrhosis of the Liver. A review of Resident #17's Fall Assessment Screening Tool (FAST), dated 07/19/10, revealed the resident had scored 80 on the assessment tool, with a score of 65 or greater indicating a high risk for falls. A review of the significant change Minimum Data Set (MDS) assessment information, dated 07/27/10, revealed the facility identified Resident #17 as moderately cognitively impaired, at risk for falls and requiring extensive assistance of two staff members for transfer and toileting. A review of Resident #17's care plan, dated last reviewed 07/30/10, revealed the facility staff was to provide Resident #17 with extensive assistance of two staff for transfer onto and off the toilet. Review of the at risk for falls/injury care plan detailed Resident #17 was at risk for falls due to Dementia, impaired safety awareness, decreased strength and endurance with physical weakness. A review of Resident #17's Certified Nursing Assistant (CNA) care plan, dated September of	F 323	Criteria 3: The non-licensed nursing staff have received inservice education as provided by the DON/Staff Development Coordinator on the provision of toileting assistance and fall prevention interventions in accordance with each resident's care plan, including but not limited to resident supervision and monitoring of alarm function, conducted on 10/7-27/2010. Criteria 4: The CQI indicator for the monitoring of toileting assistance and fall prevention interventions in accordance with the care plan will be utilized monthly X 2 months, and then quarterly as per the established CQI calendar, under the supervision of the DON. Criteria 5: October 28, 2010	10/28/10

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F 323	<p>Continued From page 20</p> <p>2010, revealed the staff was to provide resident #17 with "two person assist" for toileting in the bathroom.</p> <p>A review of nurse's notes, dated 09/05/10 at 3:00 PM, revealed the resident had been assisted to the bathroom and had sustained an "un-witnessed" fall. The facility notified Resident #17's family and physician regarding the fall. The facility transferred resident #17 to the emergency room of the local hospital, at 4:03 PM.</p> <p>A review of an x-ray report for Resident #17, dated 09/05/10, revealed a nondisplaced distal radial fracture as well as a fracture through the distal ulna including the ulnar styloid. (forearm) .</p> <p>An interview with CNA #1, on 09/23/10 at 9:40 AM, revealed she assisted Resident #17 to the bathroom, on 09/05/10 at approximately 3:00 PM. CNA #1 stated she remained with the resident for a short period of time, when another resident's call light sounded. She asked Resident #17 to pull the emergency light when finished using the bathroom and left Resident #17 alone in the bathroom to answer the call light. Shortly afterward, another CNA came and informed the CNA that Resident #17 had sustained a fall. CNA #1 stated she was aware Resident #17 was a two person assist for transfers and toileting.</p> <p>An interview with the Certified Medication Aide (CMA) #1, on 09/23/10 at 10:00 AM, revealed the family of Resident #17's roommate yelled out for help when Resident #17 fell. CMA #1 entered the bathroom to find Resident #17 lying on the floor on his/her right side. She informed the licensed staff on duty.</p>	F 323		

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F 323	<p>Continued From page 21</p> <p>An interview with LPN #1, on 09/23/10 at 10:15 AM, revealed she responded to CMA #1's request for assistance after Resident #17 sustained the fall. LPN #1 stated the fall was unwitnessed, as CNA #1 left the resident in the bathroom alone. She assessed the resident prior to moving him/her and noted a scrape on the resident's right knee and a reddened area to the right cheek. After assisting the resident to the chair, LPN #1 also noted a hematoma was developing to the resident's right eye and wrist. She then notified the physician and family and had Resident #17 transferred to the local emergency room at 4:03 PM.</p> <p>An interview with the Unit Program Manager, on 09/23/10 at 1:30 PM, revealed she expected the staff to remain with Resident #17 at all times when toileting, due to the resident's high risk for falls and cognitive impairment.</p> <p>An interview with the Director of Nursing (DON), on 09/23/10 at 2:10 PM, revealed she would expect staff to remain in the bathroom with Resident #17 at all times, due to the resident being high risk for falls and being cognitively impaired.</p> <p>Interviews with the Unit Program Manager, on 09/23/10 at 1:30 PM, and with Resident #17's private sitter, on 09/23/10 at 8:30 AM, revealed Resident #17 could no longer feed himself/herself independently since the resident sustained the fractures.</p> <p>The facility could provide no evidence that continuous supervision was provided for Resident #17 on 09/05/10 while toileting. Therefore, the facility did not ensure care plan interventions were</p>	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2010
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(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 323	Continued From page 22 being followed by staff to ensure the safety of resident's at risk for falls.	F 323		
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 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.	F 441	F 441 Infection Control 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. Criteria 1: Administrative nursing observations indicate nursing assistants perform handwashing and changing of gloves in accordance with infection control standards of practice when	

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NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(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 23 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to follow their established infection control program, requiring staff to wash their hands after each direct resident contact for which hand washing was indicated by accepted professional practice. The staff failed to change gloves while providing care to three residents (#2, #7 and #16), in the selected sample of 28. Findings include: 1. A record review revealed Resident #7 was admitted to the facility with diagnoses to include a History of Urinary Tract Infections (UTI), Fractured Hip, Diabetes Mellitus, Dementia, Congestive Heart Failure (CHF) and Pressure Ulcers. A review of the quarterly Minimum Data Set (MDS) assessment, dated 07/14/10, revealed the facility identified Resident #7 as incontinent of bowel and had an indwelling catheter. The resident required total assistance for incontinent care. A review of the current care plan for incontinence, dated 11/30/10, revealed interventions included incontinent care every two hours and PRN (as needed). The care plan for an indwelling catheter included interventions for catheter care every shift. An observation on 09/21/10 at 3:50 PM and 09/22/10 at 9:00 AM, revealed Resident #7 was alert and verbal with an indwelling catheter to bed	F 441	providing care for residents #2, 7, and 16. Criteria 2: Administrative nursing observations indicate that nursing assistants perform handwashing and changing of gloves in accordance with infection control standards of practice Criteria 3: Nursing assistants have received inservice education on the provision of peri-care and catheter care, and handwashing/changing of gloves in accordance with infection control standards of practice as provided by the Staff Development Coordinator/designee on 10/8-27/2010. Criteria 4: The CQI indicator for the monitoring of peri-care/catheter care and handwashing will be utilized monthly X 2 months and then quarterly in accordance with the established CQI calendar under the supervision of the DON. Criteria 5: October 28, 2010	10/28/10

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NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 24 side drainage.</p> <p>An observation, on 09/22/10 at 10:35 AM, revealed Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) #1 provided catheter care for Resident #7. Resident #7 had an incontinent episode of the bowels, which required incontinent care be provided prior to performing the catheter care. CNA/CMA #1 did not to wash her hands and don new gloves following provision of the incontinent care and prior to the provision of catheter care. CNA/CMA #1 was also observed applying a barrier cream to the buttocks following the catheter care, without washing her hands and changing gloves.</p> <p>An interview with CNA/CMA #1, on 09/22/10 at 10:58 AM, revealed she should have washed her hands and changed her gloves following the incontinent care and she should have used new gloves to apply the barrier cream. An interview, on 09/23/10 at 1:35 PM, revealed she had been inserviced regarding proper hand washing; however, she did not follow that procedure.</p> <p>An interview with Registered Nurse (RN) #1, on 09/22/10 at 10:58 AM, revealed CNA/CMA #1 should have washed her hands and changed gloves following the incontinent care, catheter care and prior to applying the barrier cream.</p> <p>An interview with Licensed Practical Nurse (LPN) and Program Manager #1, on 09/23/10 at 1:50 PM, revealed she expected CNA/CMA #1 to follow the policy and wash her hands after completion of each task.</p> <p>An interview with the Director of Nursing (DON), on 09/23/10 at 3:05 PM, revealed she would</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 25</p> <p>expected staff to follow the policy and procedures for incontinent care, catheter care and to follow the guidelines for handwashing. All staff had been inserviced on proper care techniques.</p> <p>A review of the inservices for Infection Control, Peri-Care and Handwashing revealed the facility inserviced staff, on 04/20/10 and again for Handwashing, on 06/29/10. The inservice included the washing of hands and donning new gloves prior to direct care of a resident and when moving from a contaminated-body site during resident care.</p> <p>2. A record review revealed Resident #2 was admitted to the facility on 05/13/10 with diagnoses to include Dementia, Diabetes Mellitus Type 2, Hypertension, and Hypothyroidism.</p> <p>A review of the quarterly MDS, dated 08/10/10, revealed Resident #2 was identified by the facility as moderately cognitively impaired and required physical help with bathing. The MDS revealed Resident #2 was usually continent of bowel and frequently incontinent of bladder.</p> <p>An observation of incontinent care, provided on 09/22/10 at 8:45 AM, revealed the NA and CNA #2 did not wash their hands prior to donning gloves. After incontinent care was provided, the NA opened the resident's closet to get a pull-up before taking off her contaminated gloves and washing her hands.</p> <p>An interview with the NA, on 09/22/10 at 2:45 PM, revealed she should wash her hands before and after providing care for a resident. She stated "I</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 26</p> <p>realize I didn't wash my hands like I should, but I haven't been checked off in class for handwashing yet."</p> <p>An interview with CNA #2, on 09/22/10 at 3:45 PM, revealed she should wash her hands before entering and leaving a resident's room. She did not wash her hands before providing care to Resident #2. She stated, "I forgot."</p> <p>3. A record review revealed Resident #16 was admitted to the facility on 02/14/06 with diagnoses to include Transient Ischemic Attack (TIA), Hypertension, Alzheimer's Dementia, Fractured Hip, Osteoarthritis, Chronic Obstructive Pulmonary Disease, and Gastroesophageal Reflux Disease.</p> <p>A review of a quarterly MDS, dated 07/02/10, revealed the facility identified Resident #16 as severely cognitively impaired and required physical help with bathing. The MDS revealed Resident #16 was incontinent of bowel and frequently incontinent of bladder.</p> <p>An observation of the provision of incontinent care, on 09/22/10 at 1:15 PM, revealed CNA #6 did not wash her hands before donning gloves, prior to providing care for Resident #16.</p> <p>An interview with CNA #6, on 09/22/10 at 3:00 PM, revealed hands should be washed before and after providing resident care. She realized she did not wash her hands before providing care to Resident #16.</p> <p>An interview with the Director of Nursing (DON), on 09/22/10 at 4:10 PM, revealed she expected staff to wash their hands before and after</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
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F 441	Continued From page 27 providing care. Hands should be washed before donning gloves and between glove changes. A review of the policy/procedure, "Handwashing", (undated), revealed handwashing and hand antisepsis shall be regarded by the facility as the single most important means of preventing the spread of infections. The policy revealed the use of gloves did not replace handwashing/hand antisepsis.	F 441		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to provide timely laboratory services for one resident (#2), in the selected sample of 28. Findings include: A record review revealed Resident #2 was admitted to the facility on 05/13/10 with diagnoses to include Dementia, Diabetes Mellitus Type 2, Hypertension, and Hypothyroidism. A review of the quarterly Minimum Data Set (MDS), dated 08/10/10, revealed the facility identified Resident #2 as moderately cognitively impaired, frequently incontinent of bladder and usually continent of bowel. A review of the Physician's Orders, dated 06/15/10, revealed a urinalysis (UA) was ordered	F 502	F 502 Laboratory Services The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Criteria 1: The physician and family/responsible party have been updated on the current lab results for resident #2. Criteria 2: The lab orders for all current residents have been reviewed by the DON and Administrative nursing to determine that labs have been obtained and the physicians notified of the results.	

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NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 861 KIMSEY LANE HENDERSON, KY 42420	
(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 502	<p>Continued From page 28</p> <p>due to a change in the resident's voiding pattern and the behavior of toileting in trash cans. There was no evidence provided which revealed UA was obtained on 06/15/10, as ordered.</p> <p>A review of the, "Lab Tracking Record", dated June 2010, revealed it specified a UA was to be collected, on 06/16/10. However, there were no initials made by the nurse indicating the UA had been collected on that day. The "Lab Tracking Record," for July 2010 indicated a UA was collected, on 07/06/10.</p> <p>A review of the Physician's Orders, dated 07/09/10, revealed Bactrim DS (antibiotic) one by mouth twice daily for seven days was ordered for a diagnosis of Urinary Tract Infection (UTI).</p> <p>An interview with Licensed Practical Nurse (LPN) #3, on 09/23/10 at 9:50 AM, revealed she worked the night of 06/15/10. She stated the UA should have been on the calendar for 06/16/10. She would have tried to obtain a voided specimen from Resident #2, and the specimen would have been sent with laboratory services provided the morning of 06/16/10. If unable to obtain the specimen, it would have been passed on to the day shift staff for follow-up. She would have charted in the resident's record a reason for not obtaining the specimen.</p> <p>An interview with Registered Nurse (RN) #2, on 09/22/10 at 11:40 AM, and 09/23/10 at 3:05 PM, revealed all lab orders were placed on the "Lab Tracking Record". The book was initialed by the nurse after the lab was collected by laboratory services. She noticed the UA was not obtained in June as ordered and the specimen was collected on 07/06/10.</p>	F 502	<p>Criteria 3: Facility licensed nurses have received inservice education on the need to obtain labs and notify the physicians of the results timely, and to document this notification, as provided by the Staff Development Coordinator and/or designee on 10/8-27/2010</p> <p>Criteria 4: The CQI indicator for the monitoring of physician lab notification will be utilized monthly X 2 months and then every six months as per the established CQI calendar.</p> <p>Criteria 5: October 28, 2010</p>	10/28/10

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NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
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F 502	Continued From page 29 An interview with RN #3, on 09/23/10 at 10:40 AM, revealed a call was placed to the facility's lab services and no UA results were found dated in June 2010. She stated there was no evidence the UA was obtained, as ordered. An interview with RN #4, on 09/23/10 at 2:45 PM, revealed after a review of the lab record, it was discovered the UA had been missed. She faxed the 07/06/10 UA results to the physician as soon as possible, because the lab had been ordered in June. A review of the policy/procedure, "Laboratory Protocol", (undated), revealed the night shift nurse would collect all urine specimens on the shift prior to the morning lab pick up. The policy revealed the night shift charge nurse was supposed to check the lab tracking sheet every night to determine which labs would be drawn the next morning, and a lab requisition would be completed.	F 502			

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NAME OF PROVIDER OR SUPPLIER REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 09/21/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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