

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

PRINTED: 08/12/2011
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 C 07/30/2011
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 881 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 000	INITIAL COMMENTS	F 000	Redbanks Plan of Correction Abbreviated Survey 7/30/11	
F 333 SS=D	<p>An Abbreviated Survey investigating complaint #KY00016803 was initiated on 07/28/11 and concluded on 07/30/11. KY00016803 was substantiated with deficiencies cited at 483.25 Quality of care and 483.75 Administration with the highest scope/severity of a "D".</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure residents were free of any significant medication errors for one (1) of three (3) sampled residents (Resident #1). Resident #1 received fifteen thousand (15,000) units of heparin (blood-thinning medication) instead of three hundred (300) units of heparin as ordered as a heparin flush for a PICC (peripheral inserted central catheter used as form of intravenous access) line.</p> <p>The findings include: Review of the medical record revealed the facility readmitted Resident #1 on 06/12/11, upon discharge from a hospital re-admission on 05/31/11. Review of the medical record for Resident #1 revealed diagnoses which included Failure to Thrive, Urinary Tract Infection, History of Pneumonia, Chronic Kidney Disease, Cirrhosis of Liver, Diabetes and Cardiac Dysrhythmias.</p>	F 333	<p>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.</p> <p>F 333 Free of Significant Medication</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Criteria 1: Resident #1 was discharged from the facility on 6/24/11.</p> <p>Criteria 2: There are currently 12 residents receiving port and/or IV therapy/flushes at the facility. The IV med, fluid, flush and site documentation has been reviewed on or by 8/17/11 by the DON or Designee which includes MDS Coordinator, Program Manager, Quality Assurance Nurse or Team Development Nurse to determine that it is complete and accurate.</p>	

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AUG 20 2011
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Page TITLE: Administrator (X6) DATE: 8/18/11

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

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F 333	Continued From page 2 07/29/11 at 9:00 AM revealed once the error was discovered all licensed staff were required to complete inservice regarding heparin dosing prior to conducting medication pass. Interview with Resident #4's physician, on 07/29/11 at 11:30 AM, revealed shortly after the medication error was discovered orders were implemented immediately which included monitoring the patient for signs and symptoms of bleeding related to the heparin overdose. The resident's physician further stated he ordered diagnostic blood work and monitored the results for anticipated abnormal values related to the overdose of heparin.	F 333		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain clinical records which were complete and accurate for	F 514	F 514 Resident Records – Complete/Accurate/Accessible. The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Criteria 1: Resident #1 was discharged from the facility on 6/24/11. Criteria 2: There are currently 12 residents receiving port and/or IV therapy/flushes at the facility. The IV med, fluid, flush and site documentation has been reviewed on or by 8/17/11 by the DON or Designee which includes MDS Coordinator, Program Manager, Quality Assurance Nurse or Team Development Nurse to determine that it is complete and accurate.	

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F 514	<p>Continued From page 3</p> <p>one (1) of three (3) sampled residents (Resident #1) in accordance with accepted professional standards and practice.</p> <p>Resident #1 had an IV (intravenous) PICC (peripheal inserted central catheter used as form of intravenous access) line with orders for a PICC line flush. However, documentation was not accurate or complete on Resident #1's Routine Injection Flow Sheet or IV Site Inspection Flow Sheet.</p> <p>The findings include:</p> <p>Review of the medical record revealed the facility readmitted Resident #1, upon discharge from the hospital on 06/12/11. Review of the medical record revealed Resident #1's diagnoses included Failure to Thrive, Urinary Tract Infection, History of Pneumonia, Chronic Kidney Disease, Cirrhosis of Liver, Diabetes and Cardiac Dysrhythmias.</p> <p>Review of the Physical's Orders revealed an order, dated 06/12/11, for a PICC line flush every eight (8) hours with three hundred (300) units of heparin. The time of administration of the first dose was noted to be "2400" (12 midnight). However, the actual time of administration per interview of the facility staff, including the Director of Nursing, Unit Charge Nurse and Licensed Practical Nurse (LPN) #4, who administered the medication was noted to be "0200" (2:00 AM).</p> <p>Interview on 07/28/11 at 6:35 PM with LPN #4 revealed she did not give the medication at "2400" (midnight) as documented but had administered the medication close to 2:00 AM on</p>	F 514	<p>Criteria 3: -Licensed nursing staff have received inservice education on the use of the new IV infusion flow sheet, and the instructions for filling this out accurately for residents receiving IV therapy as provided by Team Development, Coordinator, on, 8/4/11, 8/5/11, 8/6/11, 8/7/11, 8/10/11, 8/11/11, 8/12/11, 8/16/11, 8/17/11.</p> <p>-Licensed nursing staff have received inservice education on IV therapy, including but not limited to: administration of IV medications, which includes IV flush medications, IV site assessment, and documentation of IV therapy, as provided by the DON/Staff Educator/Pharmacy IV Consultant on 8/4/11, 8/5/11, 8/6/11, 8/7/11, 8/10/11, 8/11/11, 8/12/11, 8/16/11, and 8/17/11.</p> <p>Criteria 4: -The CQI indicator for the monitoring of IV therapy documentation will be utilized monthly X 2 months and then annually as per the established CQI calendar, under the supervision of the DON. -IV documentation will be reviewed by Program Managers in the facility morning meeting daily during the week, and on Monday for the weekend, for 4 weeks, and then monthly thereafter.</p> <p>Criteria 5: August 18, 2011</p> <p style="text-align: right;">8/19/11</p>

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F 514	<p>Continued From page 4 06/13/11.</p> <p>Review of the IV Injection Flow Sheet revealed no documentation of the flush being given as ordered on 06/14/11 at 10:00 AM; 06/16/11 at 12:00 AM; 06/17/11 at 4:00 PM and 06/18/11 through 06/22/11 at 8:00 AM or 4:00 PM.</p> <p>Review of the IV Site Inspection Flow Sheet revealed no documentation on any of the three shifts for June 13th through June 17th. Review of the Nurses Notes and Weekly Skin Assessment, dated 06/21/11 revealed the IV site was "infiltrated". However, further record review revealed that the site was not infiltrated and the line remained patent.</p> <p>Interview with the Quality Review nurse on 07/29/11 revealed the IV Site Inspection Flow Sheet should have been utilized for all shifts to document the IV site condition. She also stated the IV Injection Flow Sheet should have been utilized to document the IV flushes that were administered. Further interview revealed the nurse had charted using the word "infiltration" in error. During the interview, the Quality Review Nurse also acknowledged she had been unaware of the overall breakdown in the facility's process for documentation of residents with IV's.</p>	F 514			