

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

PRINTED: 12/13/2013
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 11/27/2013
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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 000	INITIAL COMMENTS A Recertification/Abbreviated Survey investigating KY #20948 was conducted on 11/19/13 through 11/27/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E". KY #20948 was substantiated with deficiencies cited.	F 000	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 Notification of Change The facility shall immediately inform the resident; consult with the resident's physician; and if known, notify the residents 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 interventions; 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. Criteria 1: Resident #1 is no longer a resident of this facility. Criteria 2: To determine if any other residents were potentially affected by this alleged deficient practice, the last 30 days of 24 hour reports have been reviewed by the Director of Nursing (DON) and Unit Managers on 12/24/13 and/or 12/27/13 to determine that physician notification has been completed and documented for all indicated changes in resident condition.	1/11/14
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Marc Chumbley Executive Director 1/31/14

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	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure it was determined the facility failed to ensure the physician was notified timely of a change in condition for one (1) of twenty-seven (27) sampled residents (Resident #1). Resident #1 was having difficulty eating and drinking because of nodules in his/her mouth causing increased pain, difficulty swallowing and coughing. Registered Nurse (RN) #1 failed to notify the physician by telephone related to a change in condition of Resident #1.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Management of Acute Change in Resident Status-Recommended Protocol", revised 01/15/11, revealed staff was to contact the physician to notify him/her of findings and to obtain orders when there was a change of condition in a resident.</p> <p>Record review revealed the facility admitted Resident #1 on 01/31/13 with diagnoses which included Acute Kidney Failure, Hypertension, Gastroesophageal Reflux, Anemia, Dehydration, Urinary Retention, Pressure Ulcers, Diabetes with Peripheral Circulatory Disorders, Hypothyroidism, and Renal Failure.</p>	F 157	<p>Continued from page 1</p> <p>Criteria 3: The INTERACT 3.0 Change in Condition and Care Path Tool shall be utilized by facility nurses as a reference for determining the need for physician notification, along with the facility's Physician Notification policy. A copy of the INTERACT 3.0 Change in Condition and Care Path Tool shall be kept at each nurses' station. Licensed nurses have received in-service education on use of the INTERACT 3.0 Change in Condition and Care Path Tool and the facility's Physician Notification Policy as provided by the DON and Staff Development Coordinator on 12/23/13, 12/24/13, 12/27/13, 12/28/13, 12/30/13, 12/31/13, 1/2/14, 1/3/14, 1/6/14 and 1/7/14.</p> <p>Criteria 4: The CQI indicator for the monitoring of physician notification 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: 1/11/14</p>	

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F 157	<p>Continued From page 2</p> <p>Review of Nursing Notes, dated 10/17/13 at 9:10 AM and 11:30 AM, on 10/18/13 at 8:30 AM and 9:30 AM, and on 10/19/13 at 11:AM and 4:30 PM, revealed Resident #1 had difficulty swallowing and was coughing with swallowing. In addition, the resident consumed less than fifty 50% of the meals provided. The resident's condition continued to decline to having to be spoon feed liquids and increased difficulty swallowing small bites of food. Review of a fax sent to the physician on 10/19/13 (no time) (a Sunday) to the primary care physician's office when the office was closed revealed a request to send the resident to the hospital. There was no call made to the on call physician resulting in a delay in the resident being sent to the emergency room for treatment. Further review of the Nursing Notes revealed the physician was contacted on 10/21/13 and sent to the hospital.</p> <p>An attempt to interview RN #1 was made with no success.</p> <p>Interview with the Director of Nursing (DON), on 11/27/13 at 11:40 AM, revealed RN #1 should have placed a phone call to the on call physician rather than faxing a request to send the resident to the hospital on a Sunday in an emergent situation.</p> <p>Interview with the facility's Medical Director and Resident #1's primary care physician, on 11/27/13 at 11:30 AM, revealed there was no one in the office on a Sunday to review fax messages and there was no question a fax on Sunday would not have been beneficial in notifying the Medical Director or the on call physician of a change in Resident #1's condition. He added he would have expected the facility staff to have acted</p>	F 157			

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F 157	Continued From page 3 differently and would have expected staff to call the on call physician if the situation was emergent.	F 157			
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy it was determined the facility failed to provide a safe, clean and comfortable environment related to resident shower rooms throughout the facility with broken and damaged tiles and corner guards in disrepair. The findings include: Review of an undated policy titled, "Maintenance Program", revealed the facility was to maintain the physical plant and equipment so that it is in proper repair and in good working condition at all times. The policy additionally revealed "The maintenance staff should keep all floors, ceilings, walls, tile, carpet and wallpaper in good repair. A tour of the facility premises, conducted 11/17/13 starting at 9:10 AM, revealed shower rooms throughout the facility had broken and damaged tiles in on the floor, edge of the walls and corners as follows:	F 252	F252 Safe, Clean, Comfortable, Homelike Environment The facility must provide a safe, clean, comfortable and homelike environment, allowing the residents to use his or her personal belongings to the extent possible. Criteria 1: The broken tiles and corner pieces in the resident shower rooms have been repaired or replaced by the maintenance department. Work was completed on 12/27/13 The toilet paper was immediately removed from the heater. Criteria 2: An audit of shower rooms was completed on 12/18/13 by the Restorative Coordinator to insure no paper products were stored on heaters. An audit was performed on 11/27/13 of resident rooms and care areas to identify areas requiring the attention of housekeeping or maintenance. Each item identified was prioritized and scheduled for completion by 12/27/13 under the supervision of the Administrator.	1/11/14	

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F 252	Continued From page 4 1. The South Unit shower room #1 was observed with a roll of toilet paper sitting directly on the wall heater which was on and blowing heat into the room. Interview with the Health Care Services Group Account Manager (HCSGAM) at the time revealed the toilet paper sitting on the functioning heater was a hazard and should never be placed on a heater. 2. The Central Unit shower room #2 was observed with broken and missing corner tile pieces. Interview with the HCSGAM at the time revealed the sharp edges left by missing tiles and the broken tiles could be hazardous to residents that utilized the shower rooms as contact with the sharp edges could cause injury. 3. The Pier Unit shower room #1 was observed with missing tile around an electrical outlet located just outside the open shower stall. The #2 shower room was also observed with a large gap of missing tile around an electrical outlet. The #3 shower room had corner trim that was loose and sticking out. 4. The Cove Unit shower room #1 was observed with missing and broken tile at the wall corner. 5. The shower room located on the Marina Unit (suite side) had the same open gap spaces around the electrical outlet by the shower and additionally had broken tiles at the edge of the floor and corner of the shower stall. Additionally, the shower room across from room #514 had tiles that were missing and broken tiles at the corners of the entrance door that residents pass through to enter the shower room. 6. The shower room located on the Harbor Unit	F 252	Criteria 3: The housekeeping and maintenance staff have received in service education by the Director of Environmental Services on routine inspection of the resident rooms and care areas to determine that issues are identified and addressed in a timely manner was provided on 12/11/13, 12/13/13, 12/16/13 and 12/19/13. The nursing staff have received in service education on Environmental Safety (including but not limited to no paper products place on heating units, reporting of broken or missing tile) by the Staff Development Coordinator and/or DON on 12/23/13, 12/24/13, 12/27/13, 12/28/13, 12/30/13, 12/31/13, 1/2/14, 1/3/14, 1/6/14 and 1/7/14. Criteria 4: The CQI indicator for the monitoring of the General Environment, including housekeeping and maintenance issues, will be utilized monthly x 2 months, then quarterly as per the CQI calendar under the supervision of the Housekeeping and Maintenance Supervisors. Criteria 5: 1/11/14		

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F 252	Continued From page 5 was observed to have broken tiles at the edge of the entrance door frame.	F 252			
F 279 SS=D	<p>Interview with the Environmental Services Director, on 11/27/13 at 10:00 AM, revealed staff should submit a work order to maintenance when they identify a need for any kind of repair to resident shower areas. She additionally stated maintenance staff should be doing a tour and informing her of any areas of disrepair.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of</p>	F 279	<p>F279 Resident Assessment The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>Criteria 1: Resident #1 is no longer a resident of the facility.</p> <p>Criteria 2: To determine if any other residents were potentially affected by this alleged deficient practice, an audit of the care plans for all residents with a diagnoses of diabetes was completed on 12/20/13 by the MDS nurses to determine that each had a plan of care for diabetes management.</p> <p>Criteria 3: The MDS nurses have received in-service education on development of a care plan to include all diagnoses that may impact resident care needs (using the TADD-X approach as per policy) as provided by the MDS Coordinator on 12/11/13</p>	12/31/13	

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F 279	<p>Continued From page 6</p> <p>the facility's policy and procedure it was determined the facility failed to develop a care plan with interventions related to the diagnoses of Diabetes Mellitus for one (1) of twenty-seven (27) sampled residents (Residents #1). Resident #1 was admitted with a diagnosis of Diabetes Mellitus and no care plan was developed to address the resident's care.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Development of a Care Plan", (no date), revealed "Care plans are to be created by the interdisciplinary care plan team." All pertinent diagnoses from the face sheet, Accumulative Diagnosis List, History and Physicals, Discharge Summaries, and Consults are to be care planned." "Don't forget the labs associated with these medications."</p> <p>Record review revealed the facility admitted Resident #1, on 01/31/13 with diagnoses which included Acute on Chronic Renal Failure, Hypertension, Gastroesophageal Reflux, Anemia, Urinary Retention, Pressure Ulcer, and Diabetes Mellitus.</p> <p>Review of the comprehensive care plan, dated 02/12/13, revealed no care plan for the management of Diabetes Mellitus and HGBA1C labs.</p> <p>Review of labs, dated 08/17/13, revealed an HBGA1C level of 8.1 with normal range being 4.5 to 6.2. The physician acknowledged the lab with no new orders to follow.</p> <p>Review of the Registered Dietician's progress</p>	F 279	<p>Continued from page 6</p> <p>Criteria 4: The CQI indicator for the monitoring of comprehensive care plan development shall be utilized monthly x 2 months and then every six months as per the established CQI calendar under the supervision of the DON.</p> <p>Criteria 5: 12/31/13</p>	

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F 279	<p>Continued From page 7</p> <p>note, dated 09/11/13 at 4:30 PM, revealed labs with an increased A1C level with no medications or other treatment for diabetes in place as well as Resident #1 receiving a regular diet.</p> <p>Further review of the care plan revealed there was no care plan developed to address the labs indicating increased A1C levels and no interventions for the monitoring of levels or of signs and symptoms of a low or high blood sugar.</p> <p>Resident #1 was admitted to the hospital on 10/21/13 with a diagnosis of Hyperosmolar Nonketotic Coma and a blood sugar level of 1,035. Review of the hospital history and physical, dated 10/21/13, revealed a diagnosis of Type II Diabetes.</p> <p>Interviews with Minimum Data Set (MDS) Nurse #1, on 11/22/13 at 8:40 AM and 11/26/13 at 2:12 PM, revealed she would not have implemented a care plan for a diagnosis if it was not signed by the physician and if the diagnoses were not signed the care plan would not have been updated until the diagnoses list was signed by the physician. However, further interview revealed she should have implemented a care plan for Resident #1 related to the diagnosis of Diabetes Mellitus due to the abnormal Hemoglobin (HGB) A1C labs (Test to measure hemoglobin in the red blood cells that have blood sugars attached to them) because the labs indicated the Diabetes Mellitus diagnosis active.</p> <p>Interviews with MDS Nurse #2, on 11/22/13 at 8:50 AM and on 11/26/13 at 2:17 PM, revealed she would have put a care plan in place if there had been an active diagnosis for Diabetes Mellitus. She stated she should have put a care</p>	F 279			

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F 279	Continued From page 8 plan in place related to the abnormal HGBA1C labs. Interview with the Director of Nursing, on 11/26/13 at 2:30 PM, revealed the MDS Nurse should have implemented a care plan related to Diabetes Mellitus.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to obtain an order for oxygen (O2) for one (1) of twenty-seven (27) sampled residents (Resident #8). The findings include: A review of facility policy titled, "Respiratory Care Services, Oxygen Therapy" undated, revealed all patients requiring oxygen will receive oxygen therapy in the prescribed manner, as dictated by the physician's order and the clinical needs of the patient. 1. Record review revealed the facility admitted Resident #8 on 11/10/12 with diagnoses which included Congested Heart Failure, Heart Disease and Hypertension. Observations of Resident #8 on 11/25/13 at 3:25 PM, on 11/26/13 at 2:00 PM and on 11/27/13 at	F 281	F 281 Professional Standards of Quality The services provided or arranged by the facility must meet professional standards of quality and be provided by qualified persons in accordance with each residents written plan of care. Criteria 1: Resident #8's chart was reviewed/revised on 11/26/13 by the Unit Manager to determine that a physician order for current oxygen use is present. Criteria 2: An audit of all medical records of residents utilizing oxygen was completed on 12/20/13 by the Unit Managers to determine that current physician orders addressed oxygen use. Criteria 3: Licensed nursing staff received in-service education on obtaining and documenting physician orders for all treatments (including but not limited to oxygen use) on 12/23/13, 12/24/13, 12/27/13, 12/28/13, 12/30/13, 12/31/13, 1/2/14, 1/3/14, 1/6/14 and 1/7/14 as provided by the DON/Staff Development Coordinator.	1/11/14

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F 281	Continued From page 9 9:15 AM revealed the resident was receiving O2 at three (3) liters/minute per nasal cannula. A review of the resident's November 2013 physician orders revealed there was no order for oxygen. However, review of the November 2013 Treatment Administration Record (TAR) revealed to administer O2 at 3 liters/min via nasal cannula. An interview with the DON on 11/27/13 at 9:50 AM, revealed the resident should have a current order for oxygen therapy. It is the responsibility of the charge nurses to review the new orders for accuracy.	F 281	Continued from page 9 Criteria 4: The CQI Indicator for monitoring the medical records (N-13) shall be utilized on a sample of current residents monthly x 2 months and then quarterly per established CQI calendar under the supervision of the DON. Criteria 5: 1/11/14		
F 323 SS=D	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 observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to provide an environment free of accident hazards related to the storage of oxygen (O2) cylinder tanks when not in use. Observations revealed two (2) O2 cylinder tanks were stored in room #508 unsecured by any device. The findings include:	F 323	F323 Free of Accident Hazards/Supervision/Devices The facility shall ensure that each resident receives adequate supervision and assistant devices to prevent accidents. Criteria 1: The oxygen tank in the therapy room is now properly secured, as completed by the maintenance department on 11/26/13. The oxygen tanks noted to be in an empty resident room and bathroom during the survey process was removed and placed in proper storage rack on 11/26/13 by the Unit Manager. Criteria 2: An audit of all resident care areas and resident rooms and restrooms was completed on 12/16/13 by the nursing department to determine that all oxygen tanks are properly stored/secured.	1/11/14	

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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 11/27/2013
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 10 Review of the facility's policy and procedure entitled, "Oxygen Tank Storage", no date, revealed the unused O2 cylinder tanks were to be secured by a chain or device to secure them in an upright position; the device could be a carrier, cart or sleeve designed to secure the tank to the back of a resident's wheelchair or geri-chair. Observation during the initial tour, on 11/25/13 at 11:15 AM, revealed two (2) portable O2 cylinder tanks in room #508. One (1) O2 cylinder tank was stored standing beside the toilet and one (1) was laying on it's side on the sofa. Both O2 cylinder tanks were unsecured by any device nor in a storage cart. Further observations, on 11/25/13 at 2:30 PM, on 11/26/13 at 9:30 AM and 4:00 PM and on 11/27/13 at 9:30 AM, revealed the two (2) O2 cylinder tanks remained unsecured in room #508 in the same positions as noted above. Interview, on 11/27/13 at 9:35 AM with Marina Unit Manager, revealed she was not aware the two (2) O2 cylinder-- tanks had been stored unsecured in room #508, after the resident who resided in that room had been transferred to the hospital, on 11/18/13. The Unit Manager stated the O2 cylinder tanks should have been taken to the medication room and secured in a carrier or cart when not in use. She had no explanation as to why the unsecured O2 cylinder tanks were left in room #508 for 7 days.	F 323	Continued from page 10 Criteria 3: Therapy, housekeeping, nursing and maintenance staff members received in-service education on proper storage of oxygen tanks on 12/23/13, 12/24/13, 12/27/13, 12/28/13, 12/30/13, 12/31/13, 1/2/14, 1/3/14, 1/6/14 and 1/7/14 as provided by DON and/or the Staff Development Coordinator. Criteria 4: The CQI indicator for Life Safety shall be utilized monthly x 2 months and then quarterly as per established CQI calendar under the supervision of the administrator. Criteria 5: 1/11/14		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364	Dietary Services: Each resident receives and the facility provides: food prepared by methods that conserve nutritive value, flavor, and appearance; food that is palatable, attractive and at the proper temperature.	1/8/14	

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F 364	<p>Continued From page 11</p> <p>value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to honor resident food likes/dislikes for one (1) of twenty-seven (27) sampled residents (Resident #13).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Food Preference Record", undated, revealed it was the policy of the facility to utilize a dietary cardex system to identify resident's individual diet orders and resident food preferences or special needs. The dietary cardex is designed to provide a ready source of relevant information about the resident, and provides the dietary manager and registered dietitian with a permanent and quick reference on individual information needed to provide nutritional care to each resident. Basic information may include food likes/dislikes. Preference cards should be used to make resident tray cards for meal service and should be updated as necessary.</p> <p>Record review revealed the facility admitted Resident #13 on 05/06/13 with diagnoses to include Down Syndrome, Vitamin B12 Deficiency and Diabetes.</p> <p>Observation of the breakfast meal for Resident #13, on 11/26/13 at 9:30 AM revealed the resident was served oatmeal. Review of the breakfast meal card revealed oatmeal was a</p>	F 364	<p>Continued from page 11</p> <p>Criteria 1: Resident #13 is receiving meals in accordance with his/her dietary likes/dislikes list.</p> <p>Criteria 2: All residents have the potential to be affected by this alleged deficient practice.</p> <p>Criteria 3: The dietary staff members received in-service education on following each residents likes/dislikes when preparing meals on 12/16/13, 12/19/13. The nursing staff members received in service training regarding following the tray card including but not limited to preference for likes and dislikes) on 12/23/13, 12/24/13, 12/27/13, 12/28/13, 12/30/13, 12/31/13, 1/2/14, 1/3/14, 1/6/14 and 1/7/14 as provided by the DON and/or Staff Development Coordinator.</p> <p>Criteria 4: The CQI indicator for monitoring tray accuracy shall be used 3 x per week for 4 weeks and then monthly as per established CQI calendar under the supervision of the Dietary Director and/or Registered Dietician.</p> <p>Criteria 5: 1/8/14</p>	

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F 364	Continued From page 12 resident dislike. An interview with the Unit Manager, on 11/26/13 at 10:21 AM, revealed meal tray items that are listed as a dislike should be removed from the tray and dietary should be notified to change the item. Staff should the trays match the meal cards when passing trays out. Interview with the Dietary Director, on 11/27/13 at 8:15 AM, revealed Resident #13's meal card for breakfast was not followed by the dietary staff and included oatmeal that was listed as a dislike. The Director stated the dietary department received an updated order form to take off the oatmeal as a dislike.	F 364			
F 371 SS=E	483.35(j) 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure food was prepared and served under sanitary conditions related to dishes with food debris observed sitting on the food preparation counter during resident food tray preparation as well as observation of a	F 371			

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F 371	Continued From page 13 food cart coming in contact with a housekeeping cart as it was being delivered for distribution. The findings include: 1. An observation, on 11/27/13 at 8:20 AM during the breakfast meal service, revealed a dirty dish sitting directly on the preparation counter as the food service staff prepared breakfast trays for residents. Interview with the Dietary Manager, on 11/27/13 at 8:30 AM, revealed the dirty bowl should not be in contact with the food preparation area and should have been removed. She stated the debris on the bowl appeared to be cheese from another meal and had not been adequately cleaned and sanitized by the dishwasher. Additional interview at 10:45 AM revealed there was no policy that addressed actual steps staff should take to ensure dishes were adequately cleaned and sanitized and were not used. Dishes that were not adequately cleaned and sanitized were to be recycled through the cleaning and sanitizing process to ensure adequate sanitation. 2. Observation, on 11/27/13 at 8:40 AM, revealed staff delivering the breakfast meal cart to the Harbor Unit. The meal cart was observed to pass a housekeeping cart just prior to passing through the double doors and the cart came in contact with a bag of trash hanging on the side of the housekeeping cart. The food cart came in contact with the bagged trash from the front right side of the cart across the entire cart to the left side which included the doors and handles of the doors. The staff delivering the cart continued on to the Harbor Unit and left the cart with the	F 371	F 371 Dietary Sanitation: The facility must store, prepare, distribute, and serve food under sanitary conditions. Criteria 1: The dirty dish was removed from the meal preparation area and taken to the area for dishwashing for re-cleaning and re-sanitizing. The meal cart was wiped down with cleansing wipes prior to distributing of the food trays. Criteria 2: All residents have the potential to be affected by this alleged deficient practice. Criteria 3: The dietary staff members received in-service education on dietary sanitation (including but not limited to ensuring dishes are adequately cleaned and sanitized, and food cart delivery) on 12/23/13, 12/24/13, and 12/26/13 by the Dietary Manager, Dietary Director and/or Registered Dietician. Criteria 4: The CQI indicator for Infection Control General shall be used monthly x 2 months and then quarterly per established CQI calendar under the supervision of the Infection Control monitor. The Dietary Department Audit will be utilized monthly per established CQI calendar under the supervision of the Dietary Manager and/or Registered Dietician. Criteria 5: 1/11/14	1/11/14	

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F 371	Continued From page 14 Harbor Unit staff without informing them the cart had been contaminated. Interview with kitchen staff #1, on 11/27/13 at 8:42 AM, who delivered the meal cart to the Harbor Unit, revealed she was unaware she had moved the meal cart into contact with the trash bag on the housekeeping cart just prior to delivering the cart and should have noticed. Interview with the Dietary Manager, on 11/27/13 at 8:45 AM, revealed she felt the food cart coming in contact with the housekeeping cart was an infection control problem.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	<p>Continued From page 15</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy and procedure it was determined the facility failed to ensure infection control practices related to handwashing and handling of a medication container were followed during a medication pass for one (1) unsampled resident (Resident A). Certified Medication Aide (CMA) #1 wasted a medication in a sharps container touching the lid of the container and then returned to the medication cart without washing her hands and proceeded to pass medications. During the medication pass she placed the lid to an eye drop container on the bed side table open side down.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "INFECTION CONTROL," (no date), revealed "It is the policy of the facility to provide a safe sanitary and comfortable environment. The facility will investigate, control, and attempt to</p>	F 441	<p>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.</p> <p>Criteria 1: Residents are receiving their medications under proper infection control practices.</p> <p>Criteria 2: All residents have the potential to be affected by this alleged deficient practice.</p> <p>Criteria 3: All licensed nurses and certified medication aides received in-service education on proper infection control practices during medication administration on 12/23/13, 12/24/13, 12/27/13, 12/28/13, 12/30/13, 12/31/13, 1/2/14, 1/3/14, 1/6/14 and 1/7/14 as provided by the Staff Development Coordinator and/or DON. All licensed nurses and certified medication aides will participate in a med pass skills review upon hire and annually thereafter.</p>	1/11/14

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F 441	<p>Continued From page 16</p> <p>prevent the development and transmission of infections.</p> <p>Observation of a medication pass, on 11/26/13 at 8:25 AM, revealed CMA #1 passing medications to Resident A. She pulled a narcotic that was not due to be passed and had to waste it. She crushed the pill and placed it in a medication cup, took the medication to a sharps container where she lifted the lid and proceeded to put the medication cup in the container causing her to have to lift the sharps container lid several times to get the cup to go down into the container. She then returned to the medication cart without washing her hands and began to pull other medications to be given. Additionally she was administering eye drops to Resident A and when she took the lid off of the eye drops container she placed in on the bed side table with the open end of the container on the table.</p> <p>Interview with CMA #1, on 11/26/13 at 9:00 AM, revealed she should have washed her hands after disposing of the medication in the sharps container and she should not have placed the lid to the eye drop container open side down on the bed side table because it was against infection control practices.</p> <p>Interview with the Director of Nursing (DON), on 11/26/13 at 2:30 PM, revealed CMA #1 should have washed her hands after handling the lid of the sharps container and she should not have placed the lid to the eye drop container open side down on the bed side table. Additionally she stated CMA #1 acted against policy and procedure for infection control practices.</p>	F 441	<p>Continued from page 16</p> <p>Criteria 4: The CQI indicator for monitoring infection control practice during medication pass shall be utilized weekly x 4 weeks, then monthly x 2 months and then quarterly as per established CQI calendar under the supervision of the DON.</p> <p>Criteria 5: 1/11/14</p>		

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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: 1975.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Seventeen (17) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967 and upgraded in 2013 with one hundred and forty-seven (147) smoke detectors and three (30) heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1975 and upgraded in 2013.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/26/13 and 11/27/2013. Redbanks was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Two-Hundred Twenty-Two (222) beds with a census of One-Hundred Seventy-Nine (179) on the day of the survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 12/27/13
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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 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "E" level.	K 000	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 state and federal law.	1/11/14	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards. The deficiency had the potential to affect eight (8) of seventeen (17) smoke compartments, staff, and one-hundred twenty (120) residents. The facility is certified for Two-Hundred Twenty-Two (222) beds with a census of One-Hundred Seventy-Nine (179) on the day of the survey. The facility failed to ensure four (4) doors closed	K 052	Life Safety Code Standard: The facility shall install, test and maintain a fire alarm system functioning as required by NFPA standards. Criteria 1: The Environmental Service Director contacted Vanguard to repair mag holders on 2 of 4 doors on 11/26/13. Repairs were completed and doors tested functioning correctly on 11/27/13. Two new mag holders were ordered for doors on 200 and 300 halls. They were installed on 12/10/13. Door stoppers were installed 12/23/13 behind doors on 600 hall to control distance between openings of doors close to rails in hallways. Criteria 2: All doors were inspected on 12/13/13 following first shift fire drill at 1pm by Environmental Service Director. All doors were found functioning properly. Criteria 3: The Maintenance Supervisor received in-service education regarding Fire Door Inspection procedure on 12/26/13 as provided by the Environmental Service Director.		

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K 052	<p>Continued From page 2 properly when electricity was cut to the door holders.</p> <p>The findings include:</p> <p>During the Life Safety Code tour, on 11/26/13 at 10:30 AM with the Director of Environmental Services, revealed a power failure revealed four (4) fire/smoke barrier doors would not close when the fire alarm was activated and cut the electricity to the mag locks for the doors.</p> <p>An interview, on 11/26/13 at 10:30 AM with the Director of Environmental Services, revealed she was not aware the fire/smoke barrier doors would not release when the electricity was terminated to the electronic mag locks.</p> <p>Reference: NFPA 72 (1999 Edition), 3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.</p>	K 052	<p>Continued from page 2</p> <p>Criteria 4: The Preventive Monthly Maintenance Checklist will be completed monthly and General Environment CQI Indicator will be completed monthly x 2 months and then every six months as per established CQI calendar under the supervision of the Administrator.</p> <p>Criteria 5: 1/11/14</p>	