

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

PRINTED: 02/09/2012
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 01/26/2012
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 000	INITIAL COMMENTS An abbreviated survey (KY #17716) was conducted on 01/25/12 through 01/26/12 to determine the facility's compliance with Federal requirements. KY #17716 was substantiated with deficiencies cited at the highest scope and severity of "D."	F 000	Redbanks Plan of Correction Abbreviated Survey 1/26/2012 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. The facility must record and periodically update	F 157	F 157 Notification of Changes 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 a need to alter treatment significantly. Criteria 1: Resident #1 is no longer a resident of the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Page TITLE: Administrator (X6) DATE: 3/9/12

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 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/procedure, it was determined the facility failed to immediately inform the physician of a significant change in the resident's physical status for one resident (#1), in the selected sample of three residents. Resident #1 exhibited signs and symptoms of a possible fracture; however, Licensed Practical Nurse (LPN) #4 did not notify the resident's physician immediately. The resident was transported to a scheduled physician's appointment, and was a direct admit to the hospital with a fractured femur.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Physician/Legal Representative Notification," revised 08/06, revealed the facility "would immediately consult with the resident's physician when there was a significant change in the resident's physical status. The charge nurse would make two attempts to notify the attending physician in a ten minute time period. If unsuccessful, the physician on call or the Medical Director would be notified."</p> <p>A record review revealed Resident #1 was admitted to the facility on 05/11/07 with diagnoses to include Osteoporosis and Dementia. A review of the quarterly Minimum Data Set (MDS), dated 12/18/11, revealed the facility identified the resident to be moderately cognitively impaired</p>	F 157	<p>Criteria 2: The last 30 days of events have been reviewed by the DON, QA Coordinator and Staff Development Coordinator to determine that MD notification has been completed, and that injuries of unknown origin have been thoroughly investigated and reported. There were no unreported injuries of unknown origin identified in the review.</p> <p>Criteria 3: Licensed nursing staff have received inservice education on resident events, including but not limited to: reporting of events to the MD/RP, and thorough investigation of events as provided by the DON and/or Staff Development Coordinator on 2/7,2/9, 2/11, 2/14, 2/15, 2/16, and 2/18.</p> <p>Criteria 4: The CQI indicator for the monitoring of MD 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:</p>	2/19/12	

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F 157	<p>Continued From page 2</p> <p>and required total assistance with bed mobility and bathing, extensive assistance for transfers, eating, dressing, and hygiene. The resident did not ambulate (walk).</p> <p>An interview with LPN #4, on 01/26/12 at 2:00 PM, revealed she was the nurse taking care of Resident #1, on 11/14/11. The resident had a scheduled appointment to see the Orthopedic physician, related to the resident's left hand fracture. She assessed the resident before the appointment, and revealed the resident's leg looked "different." She revealed the resident was lying in bed, and it appeared her leg was "turned in" at the knee (more so than usual). The resident had pain upon movement. She revealed the resident was confused and not as alert as usual. She revealed the resident's son was going to accompany the resident to the appointment. The son was informed of the resident's pain, and she revealed the son was going to inform the physician, at the appointment. LPN #1 revealed she should have notified the resident's physician before sending him/her to the scheduled appointment.</p> <p>An interview with the Orthopedic physician, on 01/26/12 at 8:10 AM, revealed when Resident #1 arrived at his office, he/she was in moderate pain with movement. He revealed the resident should have been sent to the emergency room instead of a scheduled appointment, as he/she presented with an acute fracture of the femur.</p> <p>An interview with the Director of Nursing (DON), on 01/26/12 at 4:15 PM, revealed the nurse should have notified the resident's physician immediately, instead of waiting for a scheduled</p>	F 157			

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F 157	Continued From page 3 appointment.	F 157		
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 appropriate corrective action must be taken.	F 225	F 225 Investigate/Report Allegations The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. The facility must have evidence that all alleged violations are thoroughly investigated. Criteria 1: Resident #1 is no longer a resident of the facility. Criteria 2: The last 30 days of events have been reviewed by the DON, QA Coordinator and Staff Development Coordinator to determine that MD notification has been completed and that injuries of unknown origin have been thoroughly investigated and reported. There were no unreported injuries of unknown origin identified in the review.	

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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure that all alleged violations including injuries of unknown source were reported in accordance with State law through established procedures. The facility failed to provide evidence that an alleged violation was thoroughly investigated to prevent further potential abuse for one resident (#1), in the selected sample of three residents. Resident #1 sustained a fracture on 11/09/11 and on 11/14/11; however, the investigations did not provide consistent evidence of the cause of the fractures; and the fractures were not reported as injuries of unknown source. The findings include: A review of the facility's policy/procedure, "Adult Abuse, Corporal Punishment, Neglect, Involuntary Seclusion, Exploitation and Injuries of Unknown Origin," undated, revealed "events such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse were identified and monitored by adherence to the incident documentation policy and to the protocol for investigation of incidents of unknown origin." A review of the facility's policy/procedure, "Event Report," undated, revealed "an event report is to be completed for any occurrence which is not considered a normal occurrence in a facility, or	F 225	Criteria 3: -Licensed nursing staff have received inservice education on resident events, including but not limited to reporting of events to the MD/RP, and thorough investigation of events as provided by the DON and/or Staff Development Coordinator on 2/7,2/9, 2/11, 2/14, 2/15, 2/16, and 2/18. -The Administrator, DON, and Staff Development Coordinator were provided inservice education on the Abuse Policy and Procedure, and the need to report injuries of unknown source, as provided by the Nurse Consultant on 2/13/2012. Criteria 4: -The CQI indicator for the monitoring of event investigations will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON. Criteria 5:	2/19/12	

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F 225	<p>Continued From page 5</p> <p>has an undesirable outcome, or results in, or may result in, more serious consequences. These events may include but are not limited to skin tears, lacerations, falls or suspected falls, injuries of unknown origin," etc. Further review revealed that Section I was to be completed by the Charge Nurse on duty and Section II was a final disposition (24 hour follow-up).</p> <p>A record review revealed Resident #1 was admitted to the facility on 05/11/07 with diagnoses to include Osteoporosis and Dementia. A review of the quarterly Minimum Data Set (MDS), dated 12/18/11, revealed the facility identified the resident to be moderately cognitively impaired and required total assistance for bed mobility and bathing, extensive assistance for transfers, eating, dressing, and hygiene. The resident did not ambulate (walk).</p> <p>A review of the facility's investigation, undated, revealed Resident #1 sustained a fracture to the left hand and had bruising to the left orbital (eye) area, on 11/09/11. The investigation revealed Certified Nurse Aide (CNA) #1 gave the resident a bath before breakfast, on 11/09/11. Swelling was noted to the resident's left hand, but it was not reported at that time. According to the investigation, breakfast trays arrived on the floor between 7:45 AM and 8:15 AM. CNA #1 prepared the resident for breakfast in the bed, but did not feed the resident. After breakfast, around 10:30 AM, CNA #1 reported bruising to the resident's eye and hand. The investigation revealed Resident #1 was questioned by staff and stated "I fell and leaned forward." It was assumed the resident nodded off to sleep in the recliner after eating breakfast, leaned forward, and raised</p>	F 225			

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F 225	<p>Continued From page 6</p> <p>his/her hands forcefully, catching the bedside table as the resident fell forward. The investigation revealed inconsistent statements as to whether the resident was in bed, or in the recliner for breakfast. Additionally, staff that were working the prior shift were questioned about the resident's injuries, and it was determined the resident also told CNA #2 about a fall.</p> <p>An interview with CNA #2, on 01/25/12 at 4:35 PM, revealed, on 11/09/11 at approximately 6:00 AM, the resident was lying on his/her left hand and it was "turned funny" and was swollen. She revealed the resident made a statement about a fall the night before; however, it was not witnessed. The CNA reported the swelling to Licensed Practical Nurse (LPN) #2.</p> <p>An interview with LPN #2, on 01/26/12 at 9:10 AM, revealed she was in the resident's room on the morning of 11/09/11, and noticed the resident's hand was red, "like he/she had been laying on it." She revealed she did not report it at that time.</p> <p>An interview with the Program Manager, on 01/26/12 at 2:55 PM, revealed she conducted an investigation related to Resident #1's injuries discovered on 11/09/11. She revealed the resident was questioned, and stated "I went forward." When asked about the resident's cognition, she revealed it changes from day to day. She revealed most of the time, the resident was cognitively impaired; however, she revealed she took his/her word for what happened. She further revealed she was aware the resident's left hand was swollen during the prior shift. She revealed a thorough investigation was conducted,</p>	F 225		

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F 225	<p>Continued From page 7</p> <p>even though she was not able to determine when the injuries occurred.</p> <p>An interview with the Team Development Registered Nurse (RN), on 01/26/12 at 3:30 PM, revealed she conducted an investigation of the resident's injuries and provided the written summary to the surveyor. She revealed the resident stated that he/she fell, and was able to repeat it to other staff members. She further revealed the resident was not reliable all the time, as the resident had Dementia; however, she felt confident in the facility's determination.</p> <p>A record review revealed the resident was admitted to the hospital on 11/14/11 with a fractured femur, and returned to the facility on 11/16/11.</p> <p>A review of a fall investigation, dated 11/14/11, revealed Resident #1 sustained a fracture of the femur. The fracture was discovered, on 11/14/11, during an appointment with the orthopedic physician. The resident exhibited signs/symptoms of pain, just prior to the appointment. The investigation revealed CNA #5 observed the resident on the edge of the bed on 11/11/11. CNA #5 had to reposition the resident from the edge of the bed, to avoid a fall. The resident's recliner was near the bed at the time. Further review of the investigation revealed when CNA #5 positioned the resident from the edge of the bed, the resident stated "ouch." CNA #5 was not sure if the resident's feet were under the recliner prior to the transfer. It was determined by the facility, that the resident's toes were under the recliner, and when the resident was assisted further into the bed, it caused the femur fracture; however,</p>	F 225		

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F 225	<p>Continued From page 8</p> <p>the incident on 11/11/11 was not reported at that time.</p> <p>An interview with CNA #5, on 01/26/12 at 10:55 AM, revealed she heard Resident #1 yelling for help, on 11/11/11, and observed the resident sitting on the edge of the bed. She revealed the resident's feet were on the floor, and his/her legs were leaned against the recliner. She put her arms under the resident's arms and "wiggled" the resident back further on the bed, but she revealed the resident did not complain of pain at that time. She revealed the resident did not complain of specific pain to the leg, until after the resident returned from the hospital, on 11/16/11, with the fractured femur.</p> <p>An interview with RN #3, on 01/26/12 at 2:30 PM, revealed he worked the morning of 11/11/11. He revealed he was not made aware of any incident during his shift. He stated that CNA #5 asked him for assistance to reposition the resident in bed. He revealed the resident was sitting all the way back in the bed with his/her feet close to the floor at the time he entered the room. He revealed the resident appeared to be in no pain, and there was no reason for him to think the resident was injured. He further revealed that he also worked on 11/13/11, and the resident did not complain of any pain to his/her leg at that time.</p> <p>A review of the "Pain Management Flow Sheet," dated November 2011, revealed the resident did not receive pain medication specifically for right leg pain until 11/16/11.</p> <p>An interview with LPN #4, on 01/26/12 at 2:00 PM, revealed the resident had an appointment to</p>	F 225			

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F 225	<p>Continued From page 9</p> <p>see the Orthopedic physician on 11/14/11, as a follow-up to the left hand fracture. She revealed the resident was lying in bed that day, and his/her leg looked "different." She revealed it was "turned in" at the knee (more so than usual), and there was pain with movement. She revealed the resident was confused, and not as alert as usual. She stated that the son was informed of the pain, and she asked the son to inform the Orthopedic physician at the scheduled appointment.</p> <p>An interview with the Team Development RN, on 01/26/12 at 3:30 PM, revealed she conducted the investigation of the femur fracture and provided the summary to the surveyor. She revealed after the investigation, it could not be determined "for sure" when the resident's fracture occurred.</p> <p>An interview with the Director of Nursing (DON), on 01/26/12 at 4:15 PM, revealed she was responsible for reporting injuries of unknown origin; however, negligence was not suspected.</p>	F 225			