

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

acceptable

PRINTED: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185225	(x2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(x3) DATE SURVEY COMPLETED 07/16/2014
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NAME OF PROVIDER OR SUPPLIER ROSEDALE GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 07/08/14 and concluded on 07/16/14, with deficiencies cited at the highest Scope and Severity of an "F". 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 000	PLAN OF CORRECTION: The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care.	
F 241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to promote dignity and respect while feeding one (1) of thirty (30) sampled, and five (5) unsampled residents (Unsampled Resident C). Observation during the meal service revealed staff stood over the resident while feeding, and failed to provide any social interaction with the resident during the meal. The findings include: Review of the facility's policy titled "Residents' Rights for Residents in Kentucky Long-Term Care Facilities", undated, revealed each resident was to be treated with consideration, respect and full recognition of his dignity and individuality. Continued review revealed the policy did not state a specific protocol related to feeding residents. Interview with Clinical Coordinator #1. on	F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY – Rosedale Green is committed to promoting care for residents in a manner and in an environment that enhances each resident's dignity and respect in full recognition of his or her individuality. Rosedale Green has a policy and procedure that addresses staff expectations during meal service titled "Serving Meals". This policy and procedure was not requested during the survey, but does indicate "staff should be seated when assisting residents with meals. Attention should be provided directly to the resident to enhance the dining experience and to promote socialization". The policy and procedure on "Serving Meals" was reviewed by the Director of Nursing on 7/18/14 and was determined to be appropriate. Per regulatory requirements all Certified Nursing Assistants receive specific training related to assisting residents with meals, and must pass a standardized state test to become Certified.	8/22/14

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Executive Director (X6) DATE: 8/19/14

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 patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable after 90 days following the date of the 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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F241	<p>Continued From page 1</p> <p>07/10/14 at 9:10 AM, revealed it was facility practice for staff to sit and maintain eye contact while feeding residents.</p> <p>Medical record review revealed Unsampled Resident C was admitted by the facility on 04/24/12 with diagnoses which included Hypertension, Anxiety, Depression and Dysphagia (difficulty swallowing). Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/21/14, revealed a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident was moderately cognitively impaired.</p> <p>Review of the Comprehensive Care Plan, dated 06/09/14, revealed Resident C was care planned for Communication, with an intervention to face the resident when speaking and to maintain eye contact. Continued review revealed Resident C was also care planned to require assistance and supervision with eating, related to the resident's inability to perform the Activities of Daily Living (ADLs) independently.</p> <p>Observation during the breakfast meal service, on 07/10/14 at 8:57 AM, revealed Certified Nurse Aide (CNA) #6 stood while feeding Unsampled Resident C. Continued observation revealed CNA #6 was faced away from the resident, and only turned in order to place a spoonful of food in the resident's mouth before turning away again. CNA #6 did not maintain eye contact or attempt to engage Resident C in conversation, or provide any social interaction with the resident.</p> <p>Interview with CNA #6, on 07/10/14 at 8:57 AM, revealed she should have been seated and making eye contact when she fed Resident C.</p>	F241	<p>The staff member assisting Resident C at the breakfast meal on 7/10/14 at 8:57 was educated on the same day (7/10/14) by the Neighborhood Nurse Manager. This education included the expectation that staff sit and converse with the resident during meal assistance. The employee indicated that she understood and was aware of this policy.</p> <p>Any resident requiring assistance with meals has the potential to be affected if this policy is not followed. Therefore, all staff who assist residents with meals will be re-inserviced by 8/22/14. These inservices will be given by the Neighborhood Nurse Managers, ADON, and Nursing Supervisors and include the expectation that staff sit and converse with the resident when assisting them during meals.</p> <p>Monitoring of meal service to ensure staff are sitting and conversing with residents will be completed each day by the neighborhood nurse manager, a charge nurse, the unit coordinator or a dietary supervisor. These audits will be given to the ADON/QA Nurse so that a weekly audit can be completed and, if any, trends identified.</p> <p>The ADON/QA Nurse will compile these audits on a weekly basis beginning 8/11/2014 and will continue weekly until no concerns are identified, or at least 4 weeks. If concerns are not identified after 4 weeks, these audits will change to monthly and will continue for the next year.</p> <p>The ADON/QA Nurse will provide the DON a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p>	

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F241	Continued From page 2 She stated she had not been specifically trained on the practice, she just knew this was the correct feeding position. Interview with CNA #16, on 07/11/14 at 11:01 AM, revealed staff were to sit down and maintain eye contact when feeding any resident. Continued interview with Clinical Coordinator #1, on 07/10/14 at 9:10 AM, revealed staff were not to hover over the resident when feeding, and were to make the dining experience personable. She stated sitting while feeding was a way to preserve dignity for the resident. Interview with the Director of Nursing, on 07/11/14 at 6:00 PM, revealed her expectation for maintaining resident dignity was for staff to sit down and promote conversation when feeding a resident. She stated staff were to keep the residents clean of food, and maintain eye contact. She further stated it was a dignity issue if staff stood over the residents while feeding them.	F241	This facility has QA/PI meetings monthly. Audits concerning dignity during meal service will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance. The Administrator is responsible to ensure compliance with meal service will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.	
F280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE –REVISE CP - Rosedale Green is committed to honoring the right of each capable resident to participate in planning care and treatment or changes in care and treatment. Rosedale Green is also committed to developing a comprehensive care plan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	8/22/14

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F280	<p>) Continued From page 3</p> <p>disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was reviewed and revised after falls for two (2) of thirty (30) sampled residents (Residents #1 and #7). Resident #1 sustained falls on 02/02/14, 03/01/14, 06/19/14, 06/29/14, and 07/06/14, and Resident #7 sustained falls on 10/13/13, 12/08/13, 12/30/13, 01/01/14, 01/27/14, and 01/30/14; however, the residents' care plans were not reviewed and/or revised related to the multiple falls.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Planning/Care Conferences", effective 06/01/08 and revised 04/01/12, revealed revisions to the plan of care were to be made, at a minimum, according to the Minimum Data Set (MDS) Assessment completion criteria, or sooner if indicated.</p> <p>Review of the facility's policy titled "Fall Management", effective 06/01/08 and revised 01/16/12, revealed the plan of care was to be</p>	F280	<p>The policy and procedures titled "Fall Management" and "Care Planning / Care Conferences" were reviewed by the Director of Nursing on 7/18/14 and were determined to be appropriate.</p> <p>All licensed/registered nurses will be inserviced on or before 8/22/14 by the Neighborhood Nurse Manager, MDS/RAI Nurse, the ADON, or nursing supervisor on the expectation that a new intervention be noted on each fall event completed.</p> <p>Each MDS/RAI nurse and Nurse Manager will be inserviced on or before 8/22/14 by the ADON or Director of Nursing on the expectation that the plan of care be reviewed after each fall and a new intervention must be noted on the care plan, as appropriate, with each fall that occurs.</p> <p>Review of Resident #1 with the interdisciplinary team, indicated, interventions were in fact implemented after each fall to assist in minimizing the risk for further falls; however, the plan of care was not updated to include the new/updated interventions.</p>		

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F280	<p>Continued From page 4</p> <p>reviewed and revised after each fall, to include new interventions as appropriate, in order to minimize the risk of further falls.</p> <p>1. Record review revealed the facility admitted Resident #1 on 08/19/13, and readmitted him/her on 05/13/14, with diagnoses which included Hemiplegia (paralysis affecting one side of the body), Hypertension, Diabetes, Depression, and Paralysis Agitans (muscle tremors and rigidity). Continued review revealed the resident fell five (5) times in the previous six (6) months as follows: on 02/02/14, the resident was self-transferring to a recliner chair in the common area; on 03/01/14, the resident was lowered to the floor by staff; on 06/19/14, the resident was found on the floor next to the head of his/her bed; on 06/29/14, the resident was found on his/her knees on the floor mat at his/her bedside; and on 07/06/14, the resident was found on the floor in the common area.</p> <p>Review of Resident #1 Comprehensive Care Plan for the period including 02/02/14 through 07/06/14, revealed it was not revised to include additional interventions after these five (5) falls, in order to help prevent further falls.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 07/11/14 at 6:06 PM, revealed she was the MDS nurse for Resident #1's unit and was responsible to review and revise the resident's care plan. She stated staff nurses did not have access to update the Plan of Care (POC), but they were to complete the Accident/Incident (A/I) form after any fall, and should document any interventions in the progress note. She acknowledged there were no new interventions on Resident #1's care plan after the falls and</p>	F280	<p>The MDS Nurse responsible for Resident #1's Plan of Care, was educated by the Director of Nursing on 7/10/14 regarding the expectation that a new or updated intervention be documented following each fall, to assist in minimizing the risk for further falls.</p> <p>The plan of care for Resident #1 was reviewed on 7/10/14 by the MDS/RAI Nurse and was updated to reflect the interventions that were implemented after each fall.</p> <p>With regards to resident #7, the resident's falls during the last 10 months were reviewed on 7/11/14 by the Neighborhood Nurse Manager and the interdisciplinary team, to determine additional interventions that may be appropriate to minimize the risk of further falls. The plan of care for Resident #7 was reviewed on 7/11/14 by the MDS/RAI Nurse and was updated to reflect the interventions identified.</p> <p>Any resident that experiences a fall has the potential to be affected if their plan of care is not reviewed for new/updated interventions and documented in their care plan. Therefore, all residents who have experienced a fall within the last 90 days, will be reviewed by the MDS nurse or Nurse Manager to insure that a new intervention was implemented and the care plan was updated appropriately. This review will be completed by 8/22/14.</p>	

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F280	<p>Continued From page 5</p> <p>stated she did not know why the care plan was not revised after each fall.</p> <p>Interview with the Director of Nursing (DON), on 07/11/14 at 5:10 PM, revealed the staff nurse was responsible for completing the A/I form, including any new interventions in the POC section of the form. She stated the Unit Manager or the MDS Nurse updated the care plan with the new interventions after each fall. After review of Resident #1's POC with the DON, she stated she did not see that the POC was revised with any interventions after the falls. She further stated the MDS nurse was responsible to ensure the care plan was updated as indicated.</p> <p>2. Medical record review revealed the facility admitted Resident #7 on 03/24/09 with diagnoses which included Alzheimer's Disease, Paralysis Agitans, Depression, Anxiety, Macular Degeneration and Insomnia.</p> <p>Review of the facility's fall investigations revealed Resident #7 fell nine (9) times in the previous ten (10) months, with no revisions to the care plan for six (6) of the nine (9) falls. Continued review of the fall investigations revealed the six (6) falls were identified as follows: on 10/13/13 at 4:48 AM, the resident was found sitting on the floor; on 12/08/13 at 12:32 AM, the resident was found coming out of the bed onto his/her knees before landing in a sitting position on a floor mat bedside the bed; on 12/30/13 at 3:44 AM, the resident was noted to have fallen, with no details documented; on 01/01/14 at 12:05 AM, the resident was found sitting on the floor mat, with his/her back to the bed and legs outstretched; on 01/27/14 at 4:47 AM, the resident slid out of bed into an upright sitting position on the floor mat; and on 01/31/14</p>	F280	<p>The ADON/QA Nurse will audit the care plan for all residents that experience a fall each week to ensure that the care plan was revised as appropriate. Weekly monitoring will begin the week of 8/11/14 and will continue for 4 weeks. Monthly monitoring of at least 10 falls per month will then continue for each month for the next year.</p> <p>The ADON/QA Nurse will provide the DON a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning care plan interventions related to falls will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p> <p>The Administrator is responsible to ensure compliance with care planning related to falls will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.</p>	

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F280	<p>Continued From page 6</p> <p>at 12:15 AM, the resident was noted to have fallen with no details included.</p> <p>Review of Resident #7's Comprehensive Care Plan revealed it was not revised to include additional interventions to prevent further falls after these six (6) falls.</p> <p>Interviews with Licensed Practical Nurse (LPN) #8, on 07/11/14 at 2:00 PM and at 2:05 PM, revealed she was a staff nurse on the unit where Resident #7 resided. She stated if a resident had a fall, the licensed nurse was to assess the resident, attempt to find out what happened, notify the family and the Physician, initiate any new orders and arrange a transfer for further evaluation if indicated. Continued interview revealed the nurse was also responsible for completing a falls report, and initiating a new intervention. She further stated the falls report was forwarded to the Unit Manager, who updated the Care Plan.</p> <p>Interview with the Unit Manager, on 07/11/14 at 3:00 PM, revealed she had only been in her present position since March of 2014. She stated she reviewed all fall reports for discussion at the daily (Monday through Friday) Quality Assurance (QA) meetings. Continued interview revealed following the collaborative discussion during the QA meeting, the Unit Manager was responsible for updating and revising the resident's Care Plan. She stated Resident #7's falls occurred prior to her assuming the position as Unit Manager, and she could not say why the previous Unit Manager did not update the resident's Care Plan after the six (6) falls documented from October 2013 through January 2014. She further stated the previous Unit Manager was no longer</p>	F280		

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F280 F371 SS=F	<p>) Continued From page 7 employed by the facility. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to distribute and serve food under sanitary conditions, as evidenced by cold food temperatures were not obtained during tray line service. In addition, dietary staff failed to check food temperatures at the point of service, and failed to perform hand sanitization consistently during the handling of food on the tray line.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled "Food Cooking and Holding Temperatures", not dated, revealed cold food could not be placed on the serving line if the temperature was greater than thirty-eight (38) degrees Fahrenheit. Continued review revealed when the temperature of cold food on the serving line reached forty-one (41) degrees Fahrenheit, it was to be pulled from the</p>	F371	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY- Rosedale Green is committed to procuring food from sources approved or considered satisfactory by Federal, State, or local authorities; and to store, prepare, distribute, and serve food under sanitary conditions.</p> <p>The "Food Cooking and Holding Temperatures" policy was reviewed by the Dietary Director on 7/10/14 and was determined to be appropriate.</p> <p>The Dietary Director reviewed and revised the current temperature logs on 7/31/14 to identify all foods that require temperature monitoring, including cold foods.</p> <p>All dining staff will be inserviced by 8/22/14 by the Dietary Director and/or Dietary Supervisors on the temperature policy and the new temperature log forms.</p>	8/22/14

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F371	<p>Continued From page 8</p> <p>line and replaced with items of the correct temperature.</p> <p>Review of the instructions printed on the "Daily Menu Temperature Log" revealed food temperatures were to be taken at least every forty-five (45) minutes during meal service. Continued review revealed cold foods must register at forty (40) degrees Fahrenheit or below. Specific foods, including milk, pudding, cottage cheese and dietary supplements were required to be at thirty-five (35) degrees Fahrenheit or lower. Further review revealed if food temperatures did not meet these standards, each affected item was to be pulled from the line. Furthermore, every food item was required to be checked for the proper temperature.</p> <p>Review of the Daily Menu Temperature Log dated 07/08/14, for the tray line on four (4) units, revealed milk temperatures were recorded for all three meals, and a pie temperature was documented as "other" at lunch. Further review of the temperature logs revealed no other cold food temperatures were recorded, contrary to the printed instructions.</p> <p>Observation during the second kitchen tour, on 07/09/14 at 11:20 AM, revealed hot food temperatures were checked prior to distribution to the tray line; however, continued observation revealed the cold food temperatures, with the exception of the milk, were not checked.</p> <p>Interview with Front Line/Cafeteria worker #1, on 07/11/14 at 11:05 AM, revealed cold foods should be forty (40) degrees Fahrenheit or lower, and milk was to be kept at or below thirty-five (35) degrees Fahrenheit. Continued interview</p>	F371	<p>The Dietary Director reviewed the "General Food Handling and Preparation" policy on 7/11/14 and determined the policy to be appropriate.</p> <p>Dietary server #8 was re-educated on hand washing and glove use by the Dietary Director on 7/9/14.</p> <p>All dining staff will be inserviced by 8/22/14 by the Dietary Director and/or Dietary Supervisors on hand washing and glove use.</p> <p>Dietary Supervisors will complete a daily audit for 4 weeks to ensure proper hand washing & glove changing, and that food temperatures are being taken and recorded appropriately. These audits will be given to the Dietary Director who will review and complete a weekly audit, identifying trends if appropriate.</p> <p>The Dietary Director will compile these audits on a weekly basis beginning 8/11/2014 and will continue until no concern are identified, or at least 4 weeks. If concerns are not identified after 4 weeks, these audits will change to monthly and will continue for the next year.</p> <p>The Dietary Director will provide the Assistant Administrator with a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p>	

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NAME OF PROVIDER OR SUPPLIER ROSEDALE GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015
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F371	<p>Continued From page 9</p> <p>revealed cold food temperatures should be checked according to policy; if cold foods were not at the proper temperature, they were to be discarded and replaced.</p> <p>Interview with the Dietary Supervisor, on 07/11/14 at 11:10 AM, revealed food temperatures were always taken for hot foods and cold foods when they were listed on the menu. He stated the food temperatures were to be checked regularly as they were considered hazardous if the temperature was greater than thirty-eight (38) degrees Fahrenheit.</p> <p>Interview with the Dietary Manager, on 07/11/14 at 11:15 AM, revealed if food was held in the refrigerator, temperatures were not checked. If cold folds were distributed to the tray line, temperatures should be checked regularly. Continued interview revealed cold food temperatures were checked in the kitchen prior to distribution to the individual unit tray lines, but were not checked after they left the kitchen.</p> <p>2. Review of the facility's policy titled "General Food Handling and Preparation", revised 05/10/12, revealed staff were to wash their hands with warm, soapy water after touching themselves, residents, or objects such as door handles, wheel chairs, condiment bottles, and ice scoops. Continued review revealed gloves were to be worn while working in the kitchen, and hands were to be washed with glove changes.</p> <p>Observation, on 07/09/14 at 12:40 PM, revealed Dietary Server #8 served food from the tray line while wearing gloves. The Dietary Server left the serving line to place a phone call, returned to the trav line and continued serving food. without</p>	F371	<p>This facility has QA/PI meetings monthly. Audits concerning food temperature monitoring, hand washing, and glove use will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p> <p>The Administrator will ensure compliance with hand washing, glove use, and food temperatures will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.</p>	

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F371	<p>Continued From page 10</p> <p>removing and replacing the contaminated gloves and performing handwashing. Further observation revealed the server left the tray line to place another phone call, and returned to the food service line, again without handwashing or a glove change.</p> <p>Interview with Dietary Server #8, on 07/09/14 at 1:10 PM, revealed he/she should of changed gloves and washed hands between tasks. Further interview revealed it was an infection control problem and the server did not realize he/she had left tray line and returned to serve food on multiple occasions without performing handwashing and a change of gloves.</p> <p>Interview with the Assistant Dietary Manager, on 07/09/14 at 5:35 PM, revealed employees were to remove their gloves and wash their hands prior to applying new gloves. Continued interview revealed these steps should be performed between all tasks. The Assistant Dietary Manager acknowledged Dietary Server #8 did not follow the correct procedure during the food service on 07/09/14.</p>			
F431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be</p>	F431	<p>483.60(b),(e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS – Rosedale Green is committed to employing or obtaining the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>	8/22/14

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F431	<p>1 Continued From page 11</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide secure storage of medications for one (1) of thirty (30) sampled residents (Resident #14), and two (2) of five (5) unsampled residents (Residents A and B). Observations revealed the residents' prescription medications were stored in their rooms in an unsecured manner and accessible to other residents.</p> <p>The findings include:</p>	F431	<p>Rosedale Green is also committed to ensuring that drugs and biologicals used in the facility be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>Rosedale Green is committed to ensuring that, in accordance with State and Federal laws, the facility is storing all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>Rosedale Green is further committed to providing separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>		

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F431	<p>Continued From page 12</p> <p>Review of the facility's policy titled "Medication Storage in the Facility-Bedside Medication Storage," undated, revealed bedside medication storage was permitted for residents who were able to self-administer medications, upon the written order of the prescriber and when it was deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. Continued policy review revealed procedures for storage included: a written order for the bedside storage of medication must be present in the resident's medical record; the medications should be stored in a manner that prevents access by other patients; residents must be instructed on the proper use of bedside medications; any medications found at bedside, unauthorized for bedside storage were to be given to the charge nurse; and bedside medication storage was to be monitored by the Director of Nursing (DON) or her designee.</p> <p>Interview with the Director of Nursing (DON) on 07/11/14 at 5:16 PM revealed her expectations for bedside medications was for the medication to be stored at the bedside, in a drawer, for resident safety. She further stated it was her expectation that discontinued medications be discarded or returned to the pharmacy.</p> <p>Review of the facility's list of wandering residents, provided on 07/11/14, revealed nine(9) wandering residents resided on the units where Residents #14, A and B resided.</p> <p>1. Medical record review revealed Resident #14 was admitted by the facility on 12/12/13 with diagnoses which included Hypertension, Personality Disorder, Irritable Bowel Syndrome and Chronic Pain.</p>	F431	<p>The Director of Nursing reviewed the facility policy "Medication Storage in the Facility-Bedside Medication Storage" on 7/18/14 and determine the policy to be appropriate.</p> <p>Regarding Resident #14, the medication found in her bathroom, was discontinued by the physician, therefore it was immediately discarded on 7/11/14 by the Neighborhood Nurse Manager.</p> <p>The medication noted for Resident #14 was not administered by the resident, but rather was applied by nursing staff. Since this medication was discontinued, the medication was removed from the resident's room and no changes were made to the order.</p> <p>The Neighborhood Nurse Manager inserviced Resident #14's care givers on 7/11/14 regarding appropriate medication storage and immediately removing discontinued medication.</p> <p>All nursing staff will be inserviced by 8/22/14 by the Neighborhood Nurse Managers, Nursing Supervisors, MDS/RAI Nurse, and ADON regarding medications ordered to be kept at bedside and has been discontinued should be immediately removed from the residents room and given to the Charge Nurse.</p>	

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F431	<p>Continued From page 13</p> <p>Observation of Resident #14's room, on 07/09/14 at 5:30 PM, revealed a container of prescribed Antifungal Micro-Guard Miconazole Nitrate Powder 2% was stored on a shelf in the shared bathroom.</p> <p>Record review revealed there was no documented evidence of a nursing assessment for Resident #14 to keep the medication at the bedside or within his/her room, and no documented evidence of a Physician's Order for the medication to be kept at the bedside. Review of the Physician's Order, dated 05/10/14, revealed the prescription medication found in the bathroom was to have been discontinued.</p> <p>Interview with Certified Nurse Aide (CNA) #7, on 07/10/14 at 9:01 AM, revealed Resident #14's antifungal medication had always been stored in the bathroom. She stated it would be an issue for residents who could wander into the wrong room and use the medication for reasons other than for what it was intended. She further stated if the medication was authorized to be kept at the bedside, it should be there and not in the bathroom. Continued interview revealed if the medication label did not indicate "store at bedside", then it was to be stored in a locked box on the medication cart. CNA #7 acknowledged the medication for Resident #14 was not stored properly.</p> <p>Interview with Clinical Coordinator #1, on 07/10/14 at 9:20 AM, revealed the medication found in Resident #14's bathroom should have been stored in a locked box on the medication cart.</p>	F431	<p>With regards to Resident A, the medication in the bathroom was not applied by the resident, but rather was applied by staff. The order was updated on 7/11/14 by the Charge Nurse to indicate 'may keep at bedside for staff application'.</p> <p>Upon becoming aware of the medication location for Resident A, it was moved to an appropriate storage location on 7/10/14 by the Neighborhood Nurse Manager.</p> <p>In regards to Resident B, the medication in the bathroom was not applied by the resident, but rather was applied by staff. The order was updated on 7/11/14 by the Charge Nurse to indicate 'may keep at bedside for staff application'.</p> <p>With regards to Resident B, upon becoming aware of the medication location, it was moved to an appropriate storage location on 7/8/14 by the Neighborhood Nurse Manager.</p> <p>The caregivers for Resident A & Resident B were inserviced on 7/11/14 by the Neighborhood Nurse Managers regarding appropriate medication storage when a physician's order indicated that the item could be stored at bedside.</p>	

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F431	<p>Continued From page 14</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 07/11/14 at 10:12 AM, revealed he passed medications for the Autumn Woods unit. He acknowledged Resident #14's medication, which was found stored in the shared bathroom, had been discontinued in May 2014. Continued interview revealed he did not know how the medication came to be stored in the bathroom. He stated the medication should have been stored on the cart until it was discontinued by the Physician, at which time it should have been discarded.</p> <p>Subsequent interview with Clinical Coordinator #1, on 07/11/14 at 2:50 PM, revealed the residents' rooms were to be checked every shift for safety hazards. She stated because the improperly stored medication posed a safety concern, it should have been removed from the bathroom.</p> <p>2. Record review revealed Unsampled Resident A was admitted by the facility on 04/05/14 with diagnoses which included Hypertension, Spinal Stenosis, Diabetes, Bipolar Disorder, Anxiety, and Depression.</p> <p>Observation of Resident A's room, on 07/08/14 at 2:50 PM, and on 07/10/14 at 8:47 AM, revealed a tube of Antifungal Miconazole Nitrate Cream 2% was located on the back of the sink in a shared bathroom. The medication was labeled with the Physician's instruction to keep the medication at the bedside.</p> <p>Review of Resident A's Physician Order, dated 06/26/14, revealed special instructions to keep the medication at bedside.</p>	F431	<p>Any resident with medications that are kept at the bedside have the potential to be affected. An audit will be completed by 8/22/14 by the Neighborhood Nurse Manager to determine which residents have a physician's order for medications to be kept at bedside. Any medication kept at bedside to be applied by staff will have the order updated as of 8/22/14 by the charge nurse to state 'may be kept at bedside for staff application'. If the resident is going to apply the medication themselves, the order will reflect "may keep at bedside for application by the resident" and a self administration of medication assessment will be completed by 8/22/14 by the MDS/RAI Nurse to determine appropriateness. The residents will also receive appropriate education on medication storage by 8/22/14 by the Charge Nurse, Nurse Manager, or MDS/RAI Nurse if the medication is being stored at bedside for their use.</p> <p>The interview between the DON and the surveyor on 7/11/14 did indicate that the facility does have and completes, when appropriate, a self administration of medication assessment. However, this assessment was not completed in these circumstances because the residents were not applying the medication, the medication was the responsibility of the nursing staff to apply. The DON stated that if the resident were to be the one to apply the medication, a self administration of medication assessment should be completed.</p>	
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F431	<p>1. Continued From page 15</p> <p>Continued medical record review revealed no documented evidence Resident A had been educated on the medication, and no completed nursing assessment to determine self administration safety for Resident A was present.</p> <p>Interview with CNA #5, on 07/10/14 at 8:52 AM, revealed the medication should be stored at the bedside, not in the bathroom. She stated the medication should not be where it was accessible for other residents to use.</p> <p>Further interview with Clinical Coordinator #1, on 07/10/14 at 9:10 AM, revealed the medication for Resident A should have been stored at the bedside and not in the bathroom on the sink. She acknowledged a potential for harm to other residents related to infection control and improper ingestion.</p> <p>Interview with MDS Nurse #1, on 07/10/14 at 9:15 AM, revealed the resident and the staff should have been educated on the proper storage of bedside medication.</p> <p>3. Record review revealed Resident B was admitted by the facility on 06/29/12 with diagnosis which included Depression, Acute Kidney Failure, and Insomnia.</p> <p>Review of Resident B's Medication and Administration Record, dated 07/01/14 through 07/10/14, revealed the resident was prescribed Remedy Calazime Protect Paste (menthol-zinc oxide) 2-20%. Continued review revealed it was to be applied to the coccyx and perineal area after incontinent episodes, every shift and as needed. Further review revealed the medication could be left at the bedside.</p>	F431	<p>All nursing staff will be inserviced by 8/22/14 by the Nurse Manager, MDS/RAI Nurse, Nursing Supervisor, or ADON regarding the following :</p> <p>1) any medication noted to be in a resident room/bathroom must have a physicians order to keep at bedside, 2). The medication must have a label that indicates 'may be kept at bedside', and who is administering it –per staff or resident. 3). If the resident is administering the medication, a self administration assessment must be completed first to determine appropriateness, 4) must also be kept in a drawer or locked box, and 5) must be given to the nurse if discontinued or not properly labeled.</p> <p>A weekly audit of at least 10 resident rooms per neighborhood (40 rooms total) will be completed by the Nurse Manager, STNA, Charge Nurse, or Unit Coordinator beginning the week of 8/4/14. The audit will include: appropriate storage of medication at bedside, appropriate medication labeling (at bedside for resident/staff application), appropriate physician order, self medication assessment if necessary, and no discontinued medication in the resident room. Weekly monitoring will occur for 6 weeks. Monthly monitoring will then continue for the next year. These audits will be given to the ADON/QA Nurse so that a weekly audit can be completed and, if any, trends identified.</p>	

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F431	Continued From page 16 Observation with the Clinical Coordinator, on 07/08/14 at approximately 2:40 PM, revealed Resident B's prescribed medication was stored on top of the resident's storage drawers in the shared bathroom, and was accessible to any resident who entered the room. Interview with the Clinical Coordinator, on 07/08/14 at 2:42 PM, revealed the medication stored in the shared bathroom belonged to Resident B and should not have been left out, and she removed the medication out of resident's bathroom. Continued interview with the Clinical Coordinator revealed other residents could wander into the bathroom and misuse the medication. Interview with the Director of Nursing (DON), on 07/11/14 at 5:15 PM, revealed prescribed medications should be secured, and should not be left out for other residents to see. She stated residents' medications should be left in a bedside drawer or stored within a treatment cart. The DON reported it was important to prevent other residents from wandering into the wrong room and using medications inappropriately. Continued interview with the DON revealed the facility does not assess residents to see if they can safely administer their own medications, but should. Continued interview revealed a tube of antifungal cream stored in a bathroom could be mistaken by another resident as toothpaste, and if used as such could be harmful.	F431	The ADON/QA Nurse will compile these audits on a weekly basis beginning 8/11/2014 and will continue weekly until no concerns are identified, or at least 6 weeks. If concerns are not identified after 6weeks, these audits will change to monthly and will continue for the next year. The ADON/QA Nurse will provide the DON a summary of the audit information on a monthly basis, in conjunction with the QA/PI process. This facility has QA/PI meetings monthly. Audits concerning resident medication stored at bedside will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance. The Administrator is responsible to ensure compliance with resident medications stored at bedside will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.	
F441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS -	8/22/14

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F441	<p>Continued From page 17</p> <p>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>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record</p>	F441	<p>Rosedale Green is committed to establishing and maintaining 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>The policy and procedures on "Use of Oxygen" and "Cleaning, Disinfection and Sterilization", were reviewed by the DON on 7/18/14 and were determined to be appropriate.</p> <p>Review of facility practice for changing out oxygen tubing each week, revealed that the staff would remove the new tubing from the sealed bag to place the current date on the tube itself. The tubing was then placed back in the storage bag.</p> <p>In regards to Resident E, while the tubing was dated 09/08/13, review of the resident's order history indicated that the residents order for the nebulizer was discontinued 10/5/13. This information was shared with the surveyor during the survey.</p> <p>The MDS/RAI nurse removed nebulizer tubing out of resident E's room on 7/8/14. Due to the facility's practice of removing new tubing from the sealed bag to place a weekly change date on the tube, it appeared as if there was used tubing in the resident's room from 9/8/13. Again, the resident's physician had discontinued the nebulizer use 10/5/13 due to the resident no longer using it.</p>	

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NAME OF PROVIDER OR SUPPLIER ROSEDALE GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015
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F441	<p>1. Continued From page 18</p> <p>review, it was determined the facility failed to ensure infection control was maintained, as evidenced by nebulizer tubing dated 09/03/13 remained in use, for one (1) of five (5) unsampled residents (Resident E). In addition, a community shower room floor was soiled with a brown substance.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled "Use of Oxygen", undated, revealed it did not address nebulizer tubing changes; however, interview with the Director of Nurses (DON), on 07/09/14 at 6:25 PM, revealed it was her expectation the tubing be changed once a week.</p> <p>Review of the medical record revealed Resident E was admitted by the facility on 12/07/10 with diagnoses which included Pulmonary Congestion, Depression, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/07/14, revealed the facility assessed Resident E to have a Brief Interview for Mental Status (BIMS) score of twelve, which indicated the resident was moderately cognitively impaired, but interviewable.</p> <p>Observation during the initial facility tour, on 07/08/14 at 2:40 PM, revealed Resident E's nebulizer tubing was dated 09/08/13. The tubing was lying on the bedside table uncovered. Interview with Resident E at the time of the observation revealed he/she used the nebulizer machine and tubing once or twice a month.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/08/14 at 5:55 PM, revealed the nebulizer tubing should have been changed weekly, and</p>	F441	<p>Any resident with oxygen tubing or HHN tubing has the potential to be affected; therefore, all residents who have oxygen and HHN's were audited on 7/8/14 by the Nurse Manager to ensure that their tubing had been changed appropriately.</p> <p>All licensed/registered nurses will be inserviced by 8/22/14 by the Neighborhood Nurse Managers, MDS/RAI Nurse, Nursing Supervisor, or ADON regarding the protocol of changing out tubing, including dating, labeling, and storage.</p> <p>With regards to the 'soft brown substance' noted on the floor in the shower area, this was cleaned up on 7/8/14 by the STNA.</p> <p>All nursing staff will be educated by 8/22/14 by the Nurse Manager and MDS/RAI Nurse regarding infection control, specifically that the shower room should be cleaned after each use and no soiled materials should be left.</p> <p>Weekly monitoring of five (5) residents per neighborhood (20 total) oxygen tubing will be completed by the Nurse Manager or Nursing Supervisor beginning the week of 8/4/14 and will continue for 4 weeks. Monthly monitoring will then continue for the next year.</p> <p>Daily monitoring of the shower rooms will be completed by the Nurse Manager, STNA, Charge Nurse or Unit Coordinator beginning the week of 8/11/14 and will continue for 4 weeks. These audits will be given to the ADON/QA Nurse so that a weekly audit can be completed and, if any, trends identified.</p>	
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NAME OF PROVIDER OR SUPPLIER ROSEDALE GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015	
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F441	<p>I. Continued From page 19</p> <p>stored in a bag when not in use. He stated he should have caught it on rounds. LPN #1 further stated it was an infection control concern with the potential to further compromise the resident's lung disease.</p> <p>Interview with the MDS Unit Supervisor, on 07/08/14 at 6:00 PM, revealed the tubing changes were to occur every week on night shift. She stated since the tubing was marked 09/08/13, it did not appear staff had simply written the wrong date. The MDS Unit Supervisor further stated failure to change the tubing regularly could cause an infection in the resident's lungs.</p> <p>Telephone interview with LPN #3, on 07/09/14 at 6:15 PM, revealed she worked on the night shift, and tubing change due dates were computer-generated to alert staff. She stated she did not know how Resident E's changes were missed. Continued interview revealed it was all of the nurses' responsibility to make observations during rounds, as well as watch for computer generated tubing change due dates. She stated failure to change the tubing was an infection control concern.</p> <p>Continued interview with the DON, on 07/09/14 at 6:25 PM, revealed if nebulizer tubing were expired, she would expect all nurses to take responsibility for changing the expired tubing. She further stated all nurses were to follow facility protocol regardless of what shift was customarily responsible for changing and dating the tubing. The DON indicated failure to follow the protocol was a concern related to a potential for infection.</p>	F441	<p>The ADON/QA Nurse will compile these audits on a weekly basis beginning 8/11/2014 and will continue weekly until no concerns are identified, or at least 4 weeks. If concerns are not identified after 4 weeks, these audits will change to monthly and will continue for the next year.</p> <p>The ADON/QA Nurse will provide the DON a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning infection control will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p> <p>The Administrator is responsible to ensure compliance with infection control will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.</p>	

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	<p>Continued From page 20</p> <p>2. Review of the facility's policy titled "Cleaning, Disinfection and Sterilization" (undated), revealed gross blood, secretions and debris was to be removed as soon as possible.</p> <p>Review of the inservice "Teachable Moments" related to Nursing Infection Control Measures, dated 01/27/14, revealed proper infection control procedures must be maintained at all times to ensure the well-being and safety of the residents, especially for residents with weakened immune systems, and poor nutritional and fluid intake. Further review revealed most infections and illnesses were spread through the transference of blood, body fluids and excrement, via contact with mucous membranes and broken skin.</p> <p>Observation during the initial tour, on 07/08/14 at 2:30 PM, revealed a soft brown substance was on the floor of the community shower room on the Willow Glenn unit.</p> <p>Interview with CNA #10, on 07/08/14 at 3:00 PM, revealed the shower area should have been cleaned up after the shower was given. Further interview revealed it was an infection control concern if the showers were not properly cleaned.</p> <p>Interview with LPN #7, on 07/08/14 at 3:10 PM, revealed it appeared the substance on the floor in the shower room was bowel movement, and it should not have been left. She stated she would not want to take a shower in there. Further interview revealed this was an infection control concern.</p> <p>Interview with CNA #16, on 07/11/14 at 11:20 AM, revealed each aide was responsible to clean up bowel movement from the floor for each resident.</p>			

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F441	<p>Continued From page 21</p> <p>and notify housekeeping to disinfect the floor area. Further interview revealed the floor should not have been left soiled and stated staff had been inserviced on the issue recently.</p> <p>Interview with CNA #19, on 07/11/14 at 11:35 AM, revealed the aides were responsible for cleaning up bowel movement as it occurred. She stated housekeeping staff then came to sanitize the floor. Continued interview revealed it was an infection control issue if bowel movement were left on the floor where other residents could be exposed to it.</p> <p>Interview with LPN #6, on 07/11/14 at 11:40 AM, revealed every aide was responsible for cleaning up after each resident, and the soiled shower room floor should have been cleaned with sani-wipes or a bleach solution to disinfect it. Further interview revealed bowel movement should be cleaned up immediately related to infection control issues and foul odors.</p> <p>Interview with CNA #20, on 07/11/14 at 12:15 PM, revealed shower areas were to be cleaned with bleach, and bowel movement should never be left on the floor as it was unsanitary. Continued interview revealed staff had just received training on the issue, and were to always clean up contaminated substances.</p> <p>Interview with CNA #4, on 07/11/14 at 2:25 PM, revealed any bowel movement was to be cleaned up before leaving the shower room. She stated it was an infection control issue and it should not have occurred.</p> <p>Interview with the Assistant Director of Nursing, on 07/11/14 at 4:50 PM, revealed if there was</p>	F441		

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F441	Continued From page 22 bowel movement on the floor, whoever saw it should immediately call housekeeping to clean and sanitize. She stated someone must have just missed it.	F441		

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K000	<p>0 INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II (222)</p> <p>SMOKE COMPARTMENTS: Seventeen (17) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 07/09/14 and concluded on 07/11/14. Rosedale Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for two hundred ten (210) beds with a census of one hundred ninety-eight (198) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>PLAN OF CORRECTION:</p> <p>The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care.</p>	
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RECEIVED
AUG 10 2014
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Linda Goodman* TITLE: Executive Director (X6) DATE: 8/10/14

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 patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable after 90 days following the date of the 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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K056 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete automatic sprinkler coverage was provided. The deficiency had the potential to affect six (6) of seventeen (17) smoke compartments, seventy-seven (77) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 07/09/14 at 11:29 AM, revealed the cleaning supply closet for the women's shower room on the second floor near room 209 was not protected by automatic sprinkler coverage. The same was found for all</p>	K056	<p>NFPA 101 LIFE SAFETY CODE STANDARD- Rosedale Green is committed to comply with NFPA 13, Stand for the Installation of Sprinkler System to provide complete coverage for all portions of the building; NFPA 25, Standard of Inspection, Testing, and Maintenance of Water-Based Fire Protection System.</p> <p>Upon identifying the small closets in each shower room, the facility's Sprinkler Vendor was contacted on 7/9/14 to install sprinklers in each of these closets.</p> <p>An audit was conducted on 7/10/14 by the Environmental Services Department of the entire facility to ensure all other areas, including closets had necessary sprinklers.</p> <p>An audit will also be completed by the Sprinkler Vendor prior to 8/11/14 to ensure all areas of the facility meet the requirements of NFPA 13. If any additional areas are identified, the vendor will install sprinklers as necessary prior to 8/22/14.</p> <p>The audits will be communicated with the Administrator by 8/11/14, as well as the QA/PI committee at the August monthly meeting.</p> <p>On-going compliance with sprinkler installation is the responsibility of the Environmental Services Director and Administrator.</p>	8/22/14

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K056	<p>Continued From page 2</p> <p>male/female shower rooms on floors 1 and 2. There were a total of eight (8) shower rooms with the deficiency. The findings were acknowledged by the Maintenance Director and the Assistant Administrator. Interview with the Maintenance Director and the Assistant Administrator revealed the facility had failed to identify these areas during a recent project that included adding automatic sprinkler coverage for all resident room closets.</p> <p>The findings and census were confirmed with the Administrator during exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met:</p> <p>(a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.</p> <p>(b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill.</p> <p>(c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</p> <p>Table 19.1.6.2 Construction Type Limitations</p>	K056		

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K056	<p>Continued From page 3</p> <table border="1"> <thead> <tr> <th>Construction Type</th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> </tr> </thead> <tbody> <tr> <td>I(443)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>I(332)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>II(222)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>II(111)</td> <td>X</td> <td>X*</td> <td>X*</td> <td>NP</td> </tr> <tr> <td>II(000)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>III(211)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>III(200)</td> <td>X*</td> <td>NP</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>IV(2HH)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>V(111)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>V(000)</td> <td>X*</td> <td>NP</td> <td>NP</td> <td>NP</td> </tr> </tbody> </table> <p>X: Permitted type of construction. NP: Not permitted. *Building requires automatic sprinkler protection. (See 19.3.5.1.) 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5.</p> <p>Reference: Centers For Medicare and Medicaid Services Survey and Certification Letter 13-55-LSC NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1</p>	Construction Type	1	2	3	4	I(443)	X	X	X	X	I(332)	X	X	X	X	II(222)	X	X	X	X	II(111)	X	X*	X*	NP	II(000)	X*	X*	NP	NP	III(211)	X*	X*	NP	NP	III(200)	X*	NP	NP	NP	IV(2HH)	X*	X*	NP	NP	V(111)	X*	X*	NP	NP	V(000)	X*	NP	NP	NP	K056		
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IV(2HH)	X*	X*	NP	NP																																																							
V(111)	X*	X*	NP	NP																																																							
V(000)	X*	NP	NP	NP																																																							
K144 SS=F		K144	NFPA 101 LIFE SAFETY CODE STANDARD- Rosedale Green is committed to comply with NFPA 99, Generators inspected weekly and exercised under load for 30 minutes per month.	8/22/14																																																							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEDALE GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015
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(X4) ID PREFIX TAG	SUMMARY OF 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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K144	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to inspect the emergency generator, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect seventeen (17) of seventeen (17) smoke compartments, two hundred twenty (220) residents, staff and visitors.</p> <p>The findings included:</p> <p>Record review of the facility generator inspection logs for the last twelve (12) months, on 07/09/2014 at 3:36 PM, revealed the facility had failed to inspect the emergency generator from 01/30/14 until 02/10/14, 02/15/14 until 02/24/14, and 02/24/14 until 03/10/14. The findings were acknowledged by the Maintenance Director and The Assistant Administrator. Interview with the Maintenance Director and the Assistant Administrator revealed the facility was not aware the weekly emergency generator inspections were missed for those dates. Further interview revealed the facility had no Quality Assurance in place to ensure weekly emergency generator inspection were completed as required.</p> <p>Reference: NFPA 110 (1999 edition)</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all</p>	K144	<p>The Generator Inspection Logs were updated by the Director of Environmental Services on 7/28/14. The Environmental Services team will be inserviced by the Environmental Services Director by 8/11/14 regarding the expectations of completing the log weekly, as well as testing the generator under the full load – once per month.</p> <p>The Environmental Services Director will review the logs on a weekly basis beginning 8/11/14, and complete a monthly audit for the next year which will identify compliance with inspections and testing.</p> <p>The Environmental Services Director will provide the Assistant Administrator a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning generator testing and inspection will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p> <p>The Administrator is responsible to ensure the QA audits will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185225	(x2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER ROSEDALE GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015	
(X4) ID PREFIX TAG	SUMMARY OF 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
K144	Continued From page 5 appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded	K144		