

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

PRINTED: 07/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
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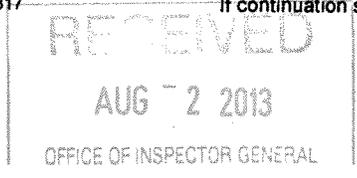
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-RIVERSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327
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F 000	INITIAL COMMENTS A standard recertification survey was initiated on 06/25/13 and concluded on 06/27/13 and the Life Safety Code survey was conducted on 06/25/13 with deficiencies cited at the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	<p>This Plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverside Manor Health Care Center does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F221</p> <p>1. The facility obtained a medical diagnosis for the use of a restraint for resident #8 on 6/27/2013. The facility obtained a physician order for the restraint for resident #8 on 6/27/2013. The facility did get the consent from the responsible party for use of a restraint on resident #8 on 6/27/2013. A least restrictive restraint assessment was done on resident #8 on 6/27/2013.</p> <p>2. The facility interdisciplinary team (consisting of licensed nurses, therapy, activities, and social services) will review all residents with positioning devices and ensure the restraint assessment is completed, consent is obtained by resident/responsible party and a proper medical diagnosis is on a physician order. This was done on 7/18/13.</p>	8/9/13
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy, it was determined the facility failed to ensure a medical diagnosis for the use of a restraint was on the Physician's Order, failed to obtain the resident/responsible party's consent prior to the use of the restraint, and failed to complete a least restrictive Restraint Assessment prior to the use of a lap buddy for one (1) of sixteen (16) sampled residents and three (3) unsampled residents, (Resident #8). The facility failed to obtain a medical diagnosis for the use of a Lap Buddy by Resident #8 and failed to obtain written consent for the use of the Lap Buddy. The findings include: Review of the facility's policy titled Restraints,	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* 7/18/2013 TITLE: *Executive Director* (X6) DATE: *7/31/13*

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 221 Continued From page 1
dated 04/28/09, revealed the facility's definition of physical restraints was any manual method or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual could not remove easily which restricts freedom of movement or normal access to one's body. Further review of the facility's policy revealed the physician should write an order for the use of the restraint that stated the type of device to be used, medical symptom(s) device was to be used for, and when the device was to be used. Additional review revealed initial evaluation and at least quarterly reviews should be done to include restraint reduction, less restrictive restraining measures, restraint elimination and entrapment risks.

Review of the clinical record for Resident #8 revealed the facility admitted the resident on 03/29/13, with diagnoses of Cerebrovascular Disease, Atherosclerosis and Atrial Fibrillation. Review of the Quarterly Minimum Data Set (MDS), dated 04/26/13, revealed the facility assessed Resident #8 to have a Brief Interview Mental Status score of three (3), indicating the resident was cognitively impaired. Further review of the MDS revealed Resident #8 required extensive assistance of two (2) staff for transfers and toilet use and extensive assistance of one (1) staff for dressing and personal hygiene. Additional review of the MDS revealed Resident #8 utilized a wheelchair as a mobile device and utilized a chair that prevented rising daily.

Observations, on 06/25/13 at 10:35 AM, 11:42 AM, 12:14 PM, 3:59 PM, and on 06/26/13 at 7:34 AM and 9:30 AM, revealed Resident #8 was sitting in a wheel chair in a common area of the

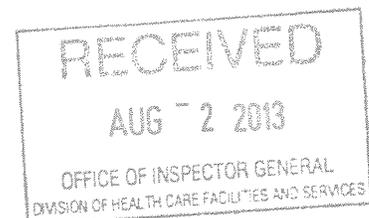
F 221

3. The unit manager will review all new orders regarding positioning devices/restraints and give to interdisciplinary team to review for appropriate assessments, consents, and medical diagnosis's for the resident. The nursing and rehab staff will be educated on the use of assistive devices by the District Director of Clinical Operations/Staff Development Coordinator on 7/31/2013 thru 8/6/2013.

4. Monthly, the interdisciplinary team will review all restraints/positioning devices for appropriate medical diagnosis, physician orders, consents, and assessments and improper findings will be reported monthly for 3 months or until compliance is sustained, to the Performance Improvement Committee for tracking and trending purposes with follow up action taken as needed.

5. Completion Date: 8/9/2013

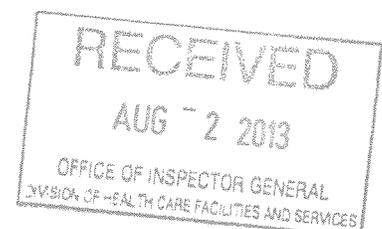
8/9/13



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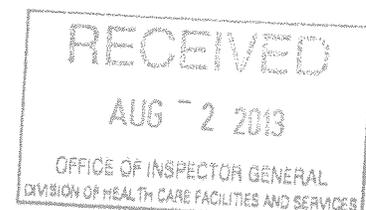
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F 221	<p>Continued From page 2</p> <p>facility with a lap buddy across the resident's lap. Resident #8 was unable to normally access his/her lower body due to the placement of the lap buddy.</p> <p>Record review of Resident #8's Comprehensive Plan of Care at risk for falls related to weakness and decreased mobility, initiated 05/06/13, revealed Resident #8 was to have a standard wheelchair with a lap buddy. Review of Occupational Therapy notes, dated 05/23/13, under section identified as Restraints, revealed the use of a lap tray on a Broda chair. Further record review revealed a physician's order for a reclining Broda Chair while out of bed, dated 05/06/13, and an Occupational Therapy order that was co-signed by the physician on 06/20/13, to discontinue the Broda chair and tray, and to add a standard chair with a lap buddy. Further review revealed an order, dated 06/26/13, to clarify the use of a wheel chair with a lap buddy for positioning secondary to leaning forward. Review of the Acknowledgement of Physical Restraint Use form, dated 06/13/13, thirty-eight (38) days after the Physician's order, revealed the responsible party's consent for a Broda Chair with tray. There was no evidence found of the Responsible Party's consent for the use of a lap buddy nor evidence of a pre-restraint evaluation.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 06/27/13 at 10:14 AM, revealed the facility's process was that Occupational Therapy puts the device on a trial use and then the Interdisciplinary Team decides if it was a restraint. The MDS Coordinator stated the criteria used to determine if a device was a restraint was: (1) could the resident transfer independently; and</p>	F 221		8/9/13



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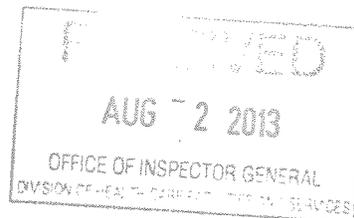
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F 221	Continued From page 3 (2) did the resident attempt to get up. Further interview revealed, the device was restrictive to the resident due to the fact the resident was unable to remove the device or normally access their lower body and lower extremities. Interview with the Director of Nursing (DON), on 06/27/13 at 9:30 AM, revealed the facility did not view the lap buddy as a restrictive device due to the fact that Resident #8 could not rise from the chair. Further interview revealed she did not think restricting movement or access to the body was restraining the resident. The DON further stated she had not known Resident #8 to want to place her hands in her lap, scratch her knee or access her lower body or lower extremities.	F 221		8/9/13
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who	F 278		



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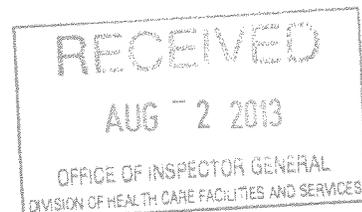
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F 278	<p>Continued From page 4</p> <p>willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to accurately code the Minimum Data Set (MDS) for the use of a restraint for one (1) of sixteen (16) sampled residents and three (3) unsampled residents (Resident #11).</p> <p>Findings include: The facility did not provide a policy regarding the accuracy of coding an MDS assessment.</p> <p>Observations, on 06/26/13 at 2:45 PM, revealed Resident #11 was sleeping in bed, the bed was in a low position, and a fall mat was at the bedside. Next to the bed was a Broda chair and a Lap Buddy. On 06/27/13 at 7:45 AM, Resident # 11 was observed eating breakfast in the dining room, sitting at a table, with the Lap Buddy attached to the Broda chair. Resident #11's food and drink were placed on the Lap Buddy and the resident was eating from the lap buddy.</p> <p>Review of the clinical record for Resident #11</p>	F 278	<p><u>F278</u></p> <ol style="list-style-type: none"> 1. The Minimum Data Set (MDS) has been corrected for resident #11 on 7/18/2013. A corrected MDS has been transmitted on 7/23/2013. 2. The Interdisciplinary team will review the most current MDS for each resident to assess for accuracy and correct any information determined to be inaccurate. This was done on 7/18/2013 3. The District Director of Case Management will in-service the Interdisciplinary Team on the accuracy of the information coded on Section "P" on each MDS prior to affixing their signatures on 7/31/2013. 4. The Case Manager or MDS Coordinator will monitor through observation and record review, at least monthly for 3 months, then quarterly, to assure accurate assessment and coding of the MDS. Any coding errors will be reported to the monthly Performance Improvement Committee for tracking and trending purposes with follow up action taken as needed. 5. Completion Date: 8/9/2013 	8/9/13



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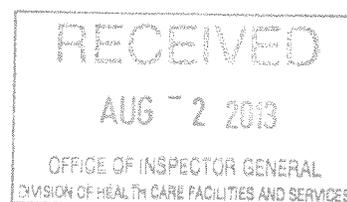
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F 278	<p>Continued From page 5</p> <p>revealed the facility admitted the resident on 08/08/11, with diagnoses of Senile Dementia with Delusional Features, Hemiplegia due to Cerebrovascular Disease, Osteoarthritis, Generalized Muscular Weakness, and Lack of Coordination. Review of the Physician's order revealed a Broda chair and enough time allowed for Resident #11 to eat from the Broda Tray at meals as desired. The facility completed the most recent MDS on 06/13/13 and did not code the resident's use of a restraint. Review of the care plan revealed the staff was to check the resident every thirty minutes, release the tray the from Broda chair every two hours for 15 minutes during toileting or activities, and the resident was to be up daily in the Broda chair for mobility with tray for positioning activities and meal times due to her being at a risk for falls, Dementia and poor safety awareness.</p> <p>Interview, on 06/27/13 at 9:30 AM, with the Director of Nursing revealed the care plan team had discussed Resident #11's care and had determined the lap buddy was a positioning device and not a restraint.</p> <p>Interview, on 06/27/13 at 10:00 AM, with the MDS Coordinator revealed the care plan team felt the lap buddy was a positioning device and not a restraint. The MDS Coordinator stated the resident could not reach the lower extremities nor place their hands in their lap. In addition, the resident could not remove the Lap Buddy when he/she wanted to.</p>	F 278	8/9/13
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility</p>	F 282	



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F 282	<p>Continued From page 6</p> <p>must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to follow the written care plan for one (1) of sixteen sampled residents and three (3) unsampled residents (Unsampled Resident C) regarding the use of an assistive device. The facility staff did not provide Unsampled Resident C with a Kennedy cup during two meals.</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding the provision of assistive devices.</p> <p>Observations, on 06/25/13 during the 12:00 PM meal service, revealed Unsampled Resident C did not have a Kennedy cup for his/her beverage of ice tea and was observed to not drink the beverage. On 06/26/13 at 7:40 AM during the breakfast meal, revealed Unsampled Resident C did not have a Kennedy cup for his/her cool beverages, and was observed to not drink his/her cool beverages. At 10:00 AM, of the same morning, Unsampled Resident C was observed in his/her room with a Kennedy cup on his/her bedside table containing ice water, the resident was observed to independently use the Kennedy cup and drink a cool beverage.</p>	F 282	<p><u>F282</u></p> <p>1. The resident (un-sampled C) will receive her cool beverages in a Kennedy cup for all meals starting 6/27/2013.</p> <p>2. The Interdisciplinary Team will review the assistive device list and compare it with the physician orders to ensure accuracy for all residents with assistive devices. This was done on 7/23/2013.</p> <p>3. The accurate assistive devices will be noted on the resident tray tickets and in the kitchen area. The nutrition services manager will be responsible for keeping these updated with any new physician orders. All dietary staff will be in-serviced by the staff development coordinator on 6/27/2013 in regards to following the physician orders as noted on the tray tickets.</p>	8/9/13



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F 282 Continued From page 7
Review of the clinical record for Unsampled Resident C revealed the facility admitted the resident on 05/02/12, with diagnoses of Amyotrophic Lateral Sclerosis, Depressive Disorder, Basal Cell Carcinoma of skin, and Neoplasm of unspecified nature of the brain. Review of the Physician's order written, dated 06/10/13 revealed the resident was to receive a coffee cup with lids for hot liquids and a Kennedy cup for all cold liquids. Review of the nursing care plan revealed an intervention had been initiated on 05/08/13 that stated the resident needed a 2 handled cup for liquids. Another intervention had been initiated on 06/11/13 that indicated the resident was to have a lid on the coffee cup. It noted the resident attempts at times to take the lid off and after staff put it on. The resident had a Kennedy cup at bedside to aide in drinking related to contractures and muscle weakness.

Interview with the Dietary Manager, on 06/2/13 at 9:50 AM, revealed not providing the Kennedy cup was a mistake and the resident should have had a Kennedy cup for liquids.

Interview with the Director of Nursing, on 06/27/13 at 9:30 AM, revealed it was her expectation that Unsampled Resident C was provided a Kennedy cup at all meals for the cool beverages, just as the resident received one at the bedside.

F 431 483.60(b), (d), (e) DRUG RECORDS, SS=E LABEL/STORE DRUGS & BIOLOGICALS

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

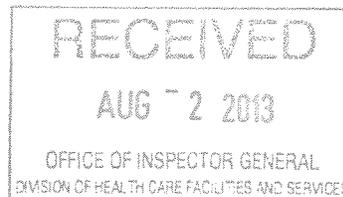
F 282

4. The DNS or SDC will make twice weekly reviews of dining service to ensure assistive devices are correctly being used for a period of 3 month or until compliance is sustained, and errors will be taken to Performance Improvement Committee for tracking and trending purposes with follow up action taken as needed.

5. Completion date 8/9/2013.

8/9/13

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F 431 Continued From page 8

accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

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.

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.

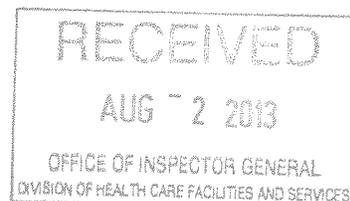
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, record review, and review of the facility's policy, it was determined the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls. The facility failed to ensure formal mechanisms were in place to assure the

F 431

F431

- The facility has purchased new thermometers and new refrigerators for the storage of medications. The refrigerators were ordered on 7/11/13 with delivery by 8/9/2013. The facility put in place new thermometers on 6/28/2013.
- The facility ordered new medication for each resident that had medications stored in the refrigerators on 6/25/2013.
- Licensed nurses will document temperatures on the refrigerator logs daily, any variations outside the excepted parameters will be addressed immediately. The Staff Development Coordinator educated all Licensed nurses on proper storage of refrigerated medications and acceptable temperatures on 6/25/2013 and 6/26/2013.
- The Staff Development Coordinator will monitor temperature logs weekly for 3 months and report the findings to the Performance Improvement Committee for tracking and trending purposes with follow up action taken as needed.
- Date completed 8/9/2013

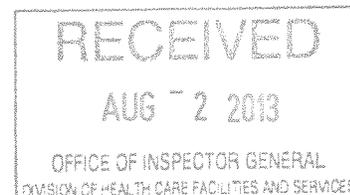
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-RIVERSIDE		STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327		
(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 431	<p>Continued From page 9</p> <p>medications were stored safely in appropriate environmental controls and to maintain accurate and timely medication records for two (2) of two (2) medication refrigerators.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Storage of Medications, dated 12/11/04, revealed medications requiring storage in a cool place should be refrigerated. Further review revealed, refrigeration temperatures should be between thirty-six (36) degrees Fahrenheit (F) and forty-six (46) degrees (F). Further review revealed the refrigerators should have a thermometer and be monitored routinely with corrective action taken if any problems were identified.</p> <p>Review of the facility's Medication Refrigerator Log, dated 05/28/08, revealed a designated area for each day of the month to record the temperature, staff initials, and comments. Additional review revealed, staff should document the action to be taken in the "Comment" section of the form, should the temperature exceed the normal range of thirty-six (36) degrees (F) to forty-six (46) degrees (F).</p> <p>Observation of Hall Three's (3) medication refrigerator, on 06/25/13 at 2:00 PM, revealed the temperature of the refrigerator to be twenty-three (23) degrees (F).</p> <p>Review of Hall Three (3)'s Medication Refrigerator Log revealed of the last one hundred seventy-six (176) days, one hundred thirty-one (131) days exceeded the normal range and thirteen (13) days with no documented</p>	F 431		8/9/13



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F 431 Continued From page 10
temperatures. There was no evidence found that actions were taken to adjust or correct the temperatures.

Review of Hall One and Two (1 & 2)'s Medication Refrigerator Log revealed of the last one hundred seventy-six (176) days, one hundred eight (108) days exceeded the normal range and sixteen (16) days with no documented temperatures. Adjustments were made the three (3) days the temperatures exceeded normal; however, there was no evidence of any follow up temperatures.

Interview with Licensed Practical Nurse (LPN) #1, on 06/25/13 at 2:25 PM, revealed the temperature controls should be adjusted if out of range and documented on the Medication Refrigerator Log.

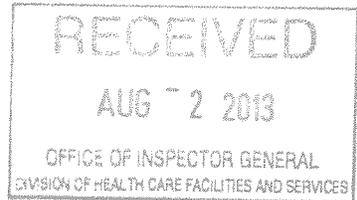
Interview with Hall One (1) Unit Manager (UM), on 06/25/13 at 2:25 PM, revealed the temperatures should be adjusted if out of range or reported to maintenance and documented on the Medication Refrigerator Log.

Interview with the Director of Nursing (DON), on 06/25/13 at 3:12 PM, revealed her expectation was the staff were to follow the facility's policy to record the temperature daily. Further interview revealed, for out of range temperatures, her expectation would be for the staff to adjust the temperature control, document the adjustment and follow up to confirm the correct temperatures were obtained.

Interview with the Pharmacist Director, on 06/26/13 at 8:58 PM, revealed the products contained in the refrigerators had manufacturer

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F 431 Continued From page 11
recommendations of storage temperatures between thirty-six (36) degrees (F) and forty-six (46) degrees (F). Further interview revealed for diversions outside the normal ranges, the medications needed to be inspected for normal color, consistency and any shards of ice prior to administration.

F 431

8/9/13

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

F 441

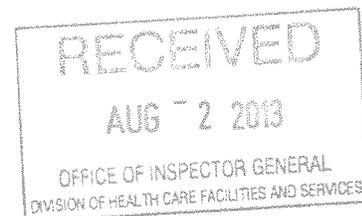
The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

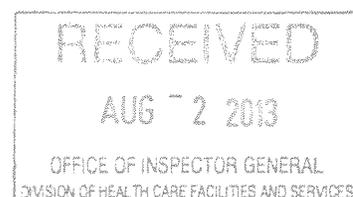
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted



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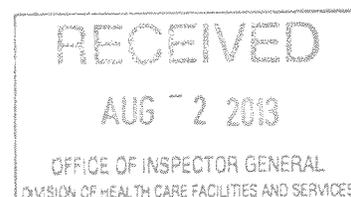
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F 441	<p>Continued From page 12 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews and review of the facility's policy, it was determined the facility staff failed to perform proper hand washing and gloving technique during the packing of sterile gauze during a dressing change for one (1) of sixteen (16) residents and three (3) unsampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Clean Dressing Change Policy- PRO 66103, dated 04/28/10, and the Infection Control Program-POL: 628, dated 08/31/12 revealed the importance of the staff to utilize the proper hand washing and gloving techniques during dressing changes.</p> <p>Observations, on 06/26/13 at 9:00 AM, during a skin assessment and wound dressing change for Resident #1's Stage IV sacral decubitus ulcer, revealed LPN #2 and RN #1 were observed packing a contaminated piece of sterile gauze into Resident #1's wound. During the dressing procedure, LPN #2 contaminated the glove on her right hand when she received a set of keys. She placed the keys in her pocket, without</p>	F 441	<p>F441</p> <p>1. Resident #1 had a new dressing change done on 6/26/2013 with RN following policy 66103 on clean dressing changes.</p> <p>2. On 6/30/2013 the certified wound nurse and DNS reviewed the week of 6/23/2013 and 6/30/2013 pressure and non-pressure skin logs for tracking and trending of wound degeneration related to possible inappropriate aseptic technique with the dressing changes. No concerns were identified. The staff development coordinator will educate licensed nurses using skills competencies testing for correct infection control procedures, according to policy 66103, during wound care to include dressing changes on 6/28/2013 thru 7/9/2013.</p> <p style="text-align: right;">8/9/13</p>



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F 441	<p>Continued From page 13</p> <p>washing her hands or changing her gloves. Both LPN #2 and RN #1 proceeded with the dressing change, and LPN #2 touched the sterile gauze with the contaminated glove and RN #1 packed the gauze into Resident #1's Stage IV decubitus ulcer.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 02/24/12, with diagnoses of Pneumonia, Cellulitis, Urinary Tract Infection, Dementia without Behavioral Disturbances, Dysphagia, Pressure Ulcer Stage II - III, and Osteoporosis. Review of Physician orders revealed the resident was to receive a dressing change every three days. The physician's order stated to apply Gentamycin packing with Mesalt and cover with Enoxtra. Apply foam and then apply adhesive foam. Change every three days and as needed (PRN) to the pressure ulcer on the coccyx.</p> <p>Interview, on 06/26/13 at 3: 20 PM, with LPN #2 regarding Resident #1's dressing change revealed she did not know why she did that and just was not thinking. The LPN stated she knew the proper procedure for hand washing and gloving during a dressing change and just forgot.</p> <p>Interview, on 06/26/13 at 3:30 PM, with RN #2 regarding Resident #1's dressing change revealed she really did not remember, because she was nervous during the dressing change, but should not have packed the contaminated gauze into the resident's wound. The RN also stated she knew to wash her hands and change gloves whenever gloves are contaminated; however, she stated she failed to do this.</p>	F 441	<p>3. The District Director of Clinical operations/ Staff Development Coordinator will do random monitoring of at least 2 Licensed Nurses completing dressing changes monthly for 3 months with the dressing change audit tool given to Director of Nursing. Any identified issues will be corrected at that time. The staff development coordinator will conduct weekly surveillance monitoring using an infection control audit tool on all units for any infection control issues with any identified concerns addressed at that time.</p> <p>4. The Director of Nursing will report the results of the monthly dressing change audits and the weekly infection control surveillance monitoring to the Performance Improvement Committee monthly for three months, or until compliance is sustained, for tracking and trending purposes with follow up action taken as needed.</p> <p>5. Date Completed 8/9/2013.</p>	8/9/13



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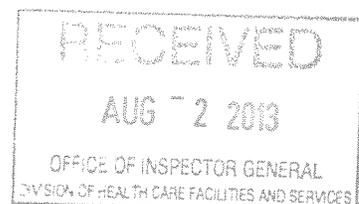
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F 441	Continued From page 14 Interview with the Director of Nursing, on 06/27/13 at 9:30 AM, revealed it was her expectation that all nursing staff follow the proper hand washing and gloving technique during all dressing changes. All of the nursing staff are trained during orientation and updated throughout the year regarding policies and procedures.	F 441		8/9/13
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1962 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Type V (111) SMOKE COMPARTMENTS: Five (5) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is diesel. A standard Life Safety Code survey was conducted on 06/25/13. Kindred Nursing and Rehabilitation Riverside was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy nine (79) beds with a census of seventy nine (79) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	This Plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverside Manor Health Care Center does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	8/9/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>x Jeffrey Bayley</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>7/31/13</i>
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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
Deficiencies were cited with the highest deficiency identified at "F" level.

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, patients, staff and visitors. The facility is certified for seventy nine (79) beds with a census of seventy nine (79) on the day of the survey. The facility failed to maintain self-closing doors protecting hazardous areas.

The findings include:

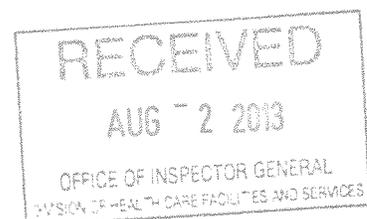
1. Observation, on 06/25/13 at 2:11 PM, with the Maintenance Supervisor revealed a bungee cord

K 029

1. The bungee cord holding the door to the dry storage unit open has been removed by the maintenance director on 6/26/2013. The maintenance director has installed self-closing devices to keep the doors closed to the receptionist office, copy room, and staff development office on 7/8/2013

2. The Maintenance Director will inspect all doors during monthly routine Preventive Maintenance Room checks beginning on 7/8/2013. The room checks will be documented in the center's Preventive Maintenance log.

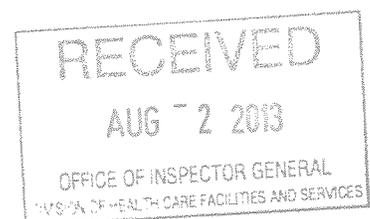
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K 029	<p>Continued From page 2</p> <p>holding the door to the dry storage room open. The door is required to be self-closing and was equipped with a self-closing device.</p> <p>Interview, on 06/25/13 at 2:11 PM, with the Maintenance Supervisor revealed he was aware staff used the bungee cord to hold the door while inventory was delivered but not aware the bungee cord was not removed when the delivery was completed.</p> <p>2. Observation, on 06/25/13 between 10:00 AM and 3:00 PM, with the Maintenance Supervisor revealed rooms required being self-closing or containing a hazardous amount of combustibles did not have self-closing device to keep the door closed. The rooms identified as hazardous requiring a rated door with a self-closing device were located in the following areas: Receptionist Office, Copy Room, and the Staff Development Office.</p> <p>Interview, on 06/25/13 between 10:00 AM and 3:00 PM, with the Maintenance Supervisor revealed he was not aware the doors to these rooms did not meet the requirements for protection from hazards.</p> <p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>Reference: NFPA 101 (2000 Edition).</p>	K 029	<p>3. All doors shall be inspected quarterly for functionality and code compliance per Kindred Preventive Maintenance policy. The Maintenance director will do inspections. Dietary staff was in-serviced on 7/25/2013 and 7/26/2013 by the Administrator /Maintenance director on the protocol for doors with closing devices and why they must stay free from objects that would keep them from closing properly.</p> <p>4. The Maintenance Director will report any doors not in compliance with door closing code to Administrator immediately, with appropriate action taken. The Administrator will track and trend monthly for 3 months and report findings to PI committee with appropriate action taken.</p> <p>5. Completion date 8/9/2013</p>	8/9/13



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K 029 Continued From page 3

K 029

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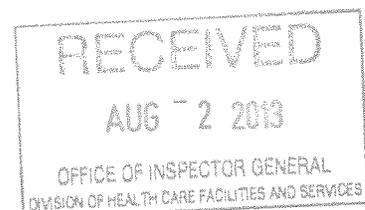
19.3.2 Protection from Hazards.
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:

- (1) Boiler and fuel-fired heater rooms
- (2) Central/bulk laundries larger than 100 ft² (9.3 m²)
- (3) Paint shops
- (4) Repair shops
- (5) Soiled linen rooms
- (6) Trash collection rooms
- (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction
- (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.

Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

K 056 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
If there is an automatic sprinkler system, it is

K 056



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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 056 Continued From page 4
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

This STANDARD is not met as evidenced by:
Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for seventy nine (79) beds with a census of seventy nine (79) on the day of the survey. The facility failed to ensure the facility had complete sprinkler coverage.

The findings include:

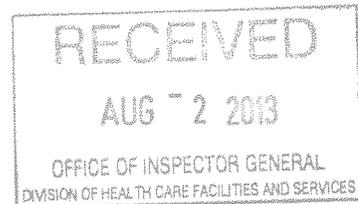
Observation, on 06/25/13 between 10:00 AM and 3:00 PM, with the Maintenance Supervisor revealed light fixtures installed within twelve (12) inches of a sprinkler head located in room #14, the Bath of rooms #17, 8, 6, and 4, the Bath of room #5, one (1) in the corridor of the 100 Hall, five (5) light fixtures in the Dining Room, the

K 056

K056

1. The maintenance director is replacing, moving or removing light fixtures by 8/9/2013 in all areas of non-compliance as specified on the 2013 Life Safety 2567.
2. The Maintenance director will monitor for sprinkler head obstructions through out the building during his routine monthly Preventive Maintenance checks. The checks will be documented in Preventive Maintenance log with the first inspection documented on 6/28/2013.
3. The sprinkler contractor will do quarterly inspections of the sprinkler system for functionality and code compliance and report any non-compliance to the Maintenance Director. The 1st inspection was done on 7/12/2013.
4. The Maintenance director will report any non-compliance findings to Administrator with immediate action taken. The Administrator will track and trend findings monthly for 3 months and report to PI meeting with appropriate action taken.
5. Completion date 8/9/2013

8/9/13



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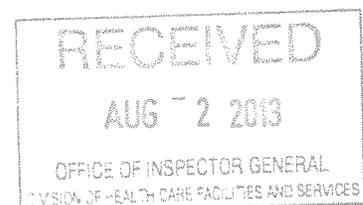
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-RIVERSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327
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K 056	Continued From page 5 Oxygen Room, rooms #22, 24, 23, 25, 28, 30, 31, 33, the Medical Records Storage, the Enteral Supplies, the Bath of room #41, and five (5) light fixtures in the Rehab Department. Interview, on 06/25/13 between 10:00 AM and 3:00 PM, with the Maintenance Supervisor revealed he had just become aware of the sprinkler head requirement. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. Reference: NFPA 13 (1999 ed.)	K 056		8/9/13
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K 056 Continued From page 6
5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.
Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)

K 056

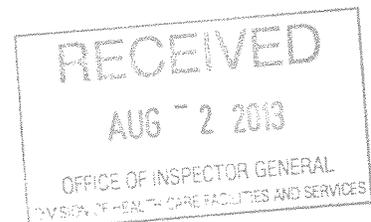
8/9/13

Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	2 1/2
1 ft 6 in. to less than 2 ft	3 1/2
2 ft to less than 2 ft 6 in.	5 1/2
2 ft 6 in. to less than 3 ft	7 1/2
3 ft to less than 3 ft 6 in.	9 1/2
3 ft 6 in. to less than 4 ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	16 1/2
5 ft and greater	18

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).
Reference: NFPA 13 (1999 ed.)
5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.

Reference: NFPA 13 (1999 Edition)

7-2.3.2.4 Where listed quick-response sprinklers



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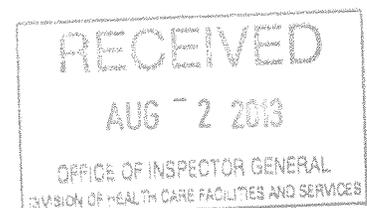
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K 056	<p>Continued From page 7</p> <p>are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <p>(1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</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),</p>	K 056		8/9/13
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K 056 Continued From page 8
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:
(a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.
(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.
(c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.

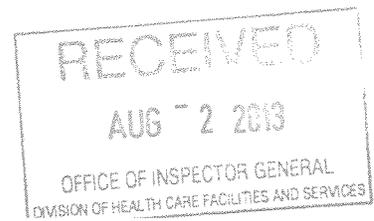
K 056

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K 144 SS=F
NFPA 101 LIFE SAFETY CODE STANDARD
Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

K 144

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency



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K 144 Continued From page 9
had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for seventy nine (79) beds with a census of seventy nine (79) on the day of the survey. The facility failed to ensure the battery charger for the emergency generator was not connected directly to the battery.

The findings include:

Observation, on 06/25/13 at 2:44 PM, with the Maintenance Supervisor revealed the battery charger for the facilities emergency generator was connected directly to the battery.

Interview, on 06/25/13 at 2:44 PM, with the Maintenance Supervisor revealed he was not aware the battery charger could not connect directly to the battery of the generator.

Reference: NFPA 110 (1999 Edition).

5-12.6
The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers ' recommendations and accepted engineering practices.
Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.

K 144

K144

1. The Generator Contractor moved battery charger to the prime mover starter to minimize voltage drop on 7/3/2013.
2. The Maintenance director will do weekly generator testing to ensure facility generator starts properly in the event of an emergency.
3. The Generator contractor will inspect and test generator annually for functionality and code compliance per Kindred Preventive Maintenance policy. The 1st inspection was completed on 7/3/2013. The Maintenance director was in-serviced by the Administrator on 7/25/2013 of the NFPA requirement of the battery charger wiring of the generator.
4. The Maintenance director will report any non-compliance findings to Administrator. The Administrator will track and trend findings monthly for 3 months and report to PI meeting with appropriate action taken
5. Completion date 8/9/2013

8/9/13

