

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

PRINTED: 01/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ JAN 2012 B. WING _____		(X3) DATE SURVEY COMPLETED  12/16/2011
NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055		
(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)	(X6) COMPLETION DATE	
F 000	INITIAL COMMENTS  An annual survey and abbreviated survey (KY #17324, KY #17380 and KY #17507) were conducted on 12/14/11 through 12/16/11, and a Life Safety Code survey was conducted on 12/15/11 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E." KY #17324, KY# 17380 and KY #17507 were unsubstantiated with no deficiencies cited.		F 000 The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth or fact alleged or conclusions set forth in statement of deficiency. The Plan of Correction is prepared and executed solely because it is required by federal and state law.  F280  Criteria #1 A comprehensive care plan identifying anticoagulant/antiplatelet blood thinning medications will be developed for resident #3, by the LPN/MDS Coordinator. This will be completed by January 25, 2012.		
F 280 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.		F 280  Criteria #2 A comprehensive care plan audit will be conducted for those residents utilizing anticoagulant/antiplatelet blood thinning medications. This will be completed by the LPN/MDS Coordinator. This will be completed by January 25, 2012.  Criteria #3 Upon receipt of a physician's order to initiate an anticoagulant/antiplatelet blood thinning medication, an acute care plan targeting anticoagulant/antiplatelets medications will be developed by the licensed nurse receiving the order or by Administrative Nursing. Administrative Nursing and licensed nurses will be provided training on this by 1/25/2012.  Criteria #4 A comprehensive care plan audit will be conducted quarterly for those residents utilizing anticoagulant/antiplatelet blood thinning medications. This will be conducted by Administrative Nursing.		
	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 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.			Criteria #5 1/25/2012 dt  1-26-12 dt	
	This REQUIREMENT is not met as evidenced by:				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Dawn Jeddler*

TITLE

*Administrator 1-9-12*

(X8) DATE

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.

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

PRINTED: 01/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/16/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055
---	---

(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 260	<p>Continued From page 1</p> <p>Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to develop a comprehensive care plan, for one resident (#3), in the selected sample of ten, related to monitoring and prevention of bruising, as well as other complications related to Anticoagulation Therapy.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Comprehensive Care Plan," undated, revealed "upon admission, an initial care plan was to be developed by nursing staff to strive to ensure that nursing staff were aware of the support the resident needed to provide care."</p> <p>A record review revealed Resident #3 was admitted to the facility on 08/25/11 with diagnosis to include Congestive Heart Failure, Atrial Fibration, Respiratory Failure, Depressive Disorder and Anxiety.</p> <p>A review of Resident #3's interim care plan and the comprehensive care plan, dated 09/07-27/11, did not address Anticoagulation Therapy or the need to monitor for the prevention of bruising or other complications related to the use of blood thinners.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 12/01/11, revealed the resident to be moderately cognitively impaired, frequently incontinent of urine with occasional bowel incontinence. He/she required extensive assistance with transfers, bed mobility and most activities of daily living (ADLs).</p>	F 260		
-------	---	-------	--	--

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

PRINTED: 01/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/16/2011
NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055		
(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)	(X6) COMPLETION DATE	
F 280	Continued From page 2  A review of the physician's orders, dated 12/01-31/11 revealed "Aspirin 81 milligrams (mg) by mouth (po) once daily and Plavix 75 mg po once daily" with a start date of 08/25/11. (Both medications are anticoagulants or blood thinners).  An observation, on 12/15/11 at 10:00 AM, revealed Licensed Practical Nurse (LPN)/MDS Coordinator completed Resident #3's skin assessment. Observation revealed there was scattered fading discolorations on all extremities.  An interview with the LPN/MDS Coordinator, on 12/16/11 at 11:10 AM, revealed a care plan related to anticoagulation therapy should be initiated, and she stated she was responsible to initiate the care plan; however, she was unable to provide a care plan for Resident #3. She could provide no explanation as to why a care plan was not in place.	F 280	F309  Criteria #1 A comprehensive care plan identifying anticoagulant/antiplatelet blood thinning medications will be developed for resident #3, by the LPN/MDS Coordinator. This will be completed by January 25, 2012.  Criteria #2 A comprehensive care plan audit will be conducted for those residents utilizing anticoagulant/antiplatelet blood thinning medications. This will be completed by the LPN/MDS Coordinator. This will be completed by January 25, 2012.  Criteria #3 Upon receipt of a physician's order to initiate an anticoagulant/antiplatelet blood thinning medication, an acute care plan targeting anticoagulant/antiplatelets medications will be developed by the licensed nurse receiving the order or by Administrative Nursing. Administrative Nursing and licensed nurses will be provided training on this by 1/25/2012.  Criteria #4 A comprehensive care plan audit will be conducted quarterly for those residents utilizing anticoagulant/antiplatelet blood thinning medications. This will be conducted by Administrative Nursing.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Criteria #5 1/25/2012  1.26.12 dia		

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

PRINTED: 01/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/16/2011
NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055		
(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 309	Continued From page 3  This REQUIREMENT Is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to provide the necessary care and services to maintain the highest practical physical well being for one resident (#3), in the selected sample of ten, related to the failure to implement interventions to monitor for or prevent bruising, and other complications related to Anticoagulation Therapy.  Findings include:  A review of the facility's policy/procedure, "Comprehensive Care Plan," undated, revealed "upon admission, an initial care plan was to be developed by nursing staff to strive to ensure that nursing staff were aware of the support the resident needed to provide care."  A record review revealed Resident #3 was admitted to the facility on 08/25/11 with diagnoses to include Congestive Heart Failure, Atrial Fibulation, Respiratory Failure, Depressive Disorder and Anxiety.  A review of Resident #3's interim care plan and the comprehensive care plan, dated 09/07-27/11, did not address Anticoagulation Therapy or the need to monitor for the prevention of bruising or other complications related to the use of blood thinners.  A review of the quarterly Minimum Data Set	F 309			

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

PRINTED: 01/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/16/2011
NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055		
(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 309	<p>Continued From page 4</p> <p>(MDS), dated 12/01/11, revealed the resident to be moderately cognitively impaired, frequently incontinent of urine with occasional bowel incontinence. He/she required extensive assistance with transfers, bed mobility and most activities of daily living (ADLs).</p> <p>A review of the physician's orders, dated 12/01-31/11 revealed "Aspirin 81 milligrams (mg) by mouth (po) once daily and Plavix 75 mg po once daily" with a start date of 08/25/11. (Both medications are anticoagulants or blood thinners).</p> <p>An observation, on 12/15/11 at 10:00 AM, revealed Licensed Practical Nurse (LPN)/MDS Coordinator completed Resident #3's skin assessment. Observation revealed there was scattered fading discolorations on all extremities.</p>	F 309			
	<p>An interview with the LPN/MDS Coordinator, on 12/16/11 at 11:10 AM, revealed a care plan related to anticoagulation therapy should be initiated, and she stated she was responsible to initiate the care plan; however, she was unable to provide a care plan for Resident #3. She could provide no explanation as to why a care plan was not in place.</p> <p>An interview with the Director of Nursing (DON), on 12/16/11 at 3:50 PM, revealed she expected a care plan for anticoagulant therapy to be initiated and implemented, as well as staff to be educated on safety precautions. She provided no explanation as to why this did not occur.</p>				

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

RECEIVED

PRINTED: 01/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

JAN 12 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/15/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055
---	---

(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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1995</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator installed in 1996. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/15/11. Rivers Bend Retirement Community was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for forty (40) beds and the census was thirty eight (38) 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 Fire)</p>	K 000	<p>K147</p> <p>Criteria #1 Extension chord in use in room #224 has been removed. Extension chord in room #213 has been removed. The refrigerator in the Risk Manager's Office is no longer plugged into the power strip. The refrigerator plugged into a power strip located in the Director of Nursing's office has been removed. This was completed by the Maintenance Director.</p> <p>Criteria #2 The Maintenance Director will do a facility walk through by January 25, 2012 to ensure that extension chords are not being utilized or that power strips are not being inappropriately used.</p> <p>Criteria #3 Department Heads, residents, and family members will be notified that refrigerators are not to be plugged into power strips, and that extension chords are not to be utilized. This will be completed by the Maintenance Director and Administrator. This will be completed by January 25, 2012.</p> <p>Criteria #4 The Maintenance Director will do a monthly walk through for three months, and then this will be completed quarterly. If extension chords are present or inappropriate items plugged into power strip it will be removed immediately. Documentation of walkthrough will be documented on preventive maintenance form and reviewed during monthly Safety Committee Meeting.</p> <p>Criteria #5 1/26/2012</p>	

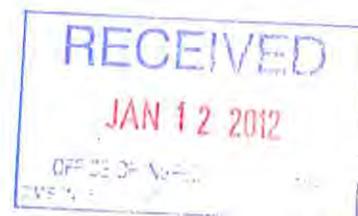
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lawrence J. Jordan ADMINISTRATOR 1-12-12

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

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

PRINTED: 01/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/15/2011
NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055	
(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)	(X6) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 147 SS=E	<p>Deficiencies were cited with the highest deficiency identified at " F " level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff, and visitors. The facility is licensed for forty (40) beds with a census of thirty eight (38) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/15/11 between 8:00 AM and 11:00 AM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> <li>1) An extension cord in use located in room #224.</li> <li>2) An extension cord plugged into another extension cord, plugged into a power strip located in room #213.</li> <li>3) A refrigerator plugged into a power strip located in the Risk Management Office.</li> <li>4) A refrigerator plugged into a power strip located in the Director of Nursing Office.</li> </ol>	K 147		



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

PRINTED: 01/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/15/2011
NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055	
(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
K 147	Continued From page 2 Interview, on 12/15/11 between 8:00 AM and 11:00 AM, with the Maintenance Director revealed he was not aware power strips were being misused. He was aware extension cords were prohibited and stated family members bring them in without his knowledge.  Reference: NFPA 99 (1999 edition)  3-3.2.1.2 D  Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

