

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

PRINTED: 04/06/2012
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 C 03/23/2012
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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055
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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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F 000	INITIAL COMMENTS An abbreviated survey (KY #18006) was conducted on 03/23/12 to determine the facility's compliance with Federal requirements. KY #18006 was substantiated with deficiencies cited at the highest scope and severity of a "G."	F 000	F224 Criteria #1 Resident #1 has returned to the facility after receiving treatment for the right hip fracture. Staff members were inserviced on Resident #1's toileting needs on 3/5/2012, 3/6/2012, 3/7/2012, 3/28/2012, 4/2/2012, 4/11/2012, 4/18/2012, and 4/19/2012. This training was completed by Administrative Nursing.	
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policies and procedures, and the Final Investigative Report, it was determined the facility failed to ensure one resident (#1) was free from neglect, in the selected sample of four residents. On 03/04/12 at 3:30 PM, Resident #1 sustained a fall from the wheelchair. The resident was found in front of the nurse's station with his/her pants down and urine on the floor. Certified Nurse Aide (CNA) #5 started her shift at 6:00 AM, with CNA #3 starting her shift at approximately 9:30 AM. Both CNAs were responsible for the resident's care, on 03/04/12, but failed to ensure the resident was changed or toileted the entire shift prior to the fall. Additionally, it was determined the resident's sensor pad alarm was not turned on or functioning at the time of the fall. The resident sustained an intertrochanteric right femoral neck (right hip) fracture as a result of the fall.	F 224	Staff members were also inserviced on the personal safety alarms that are used in fall management for Resident #1, and that these are to be checked for function and placement every 2 hours on 3/5/2012, 3/6/2012, 3/7/2012, 3/28/2012, 4/2/2012, 4/11/2012, 4/18/2012, and 4/19/2012. This training was completed by Administrative Nursing. Certified Medication Techs. were inserviced on the expectation that they are to check alarms at the beginning of each shift to ensure that it is functioning appropriately. This was completed on 3/23/2012 and 5/2/2012. This inservice was completed by Administrative Nursing.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Glenn Wedder, Administrator May 3, 2012

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 224	<p>Continued From page 1</p> <p>Findings Include:</p> <p>A review of the facility's "Resident Abuse and Neglect" policy, undated, revealed neglect was defined "as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."</p> <p>A record review revealed the facility admitted Resident #1 on 11/03/10 with diagnoses to include Alzheimer's Dementia. A review of the quarterly Minimum Data Set (MDS), dated 01/20/12, revealed the facility identified the resident as severely cognitively impaired, required extensive assistance of two staff for toilet use, and was incontinent of bowel and bladder. A review of the Comprehensive Device Assessment, dated 10/21/11, and the Resident Care Guide, undated, revealed the resident had a sensor alarm pad and a self release belt to the wheelchair for safety. A review of the Comprehensive Care Plan, dated 01/12/12, revealed the resident should be toileted every two hours and as needed. A review of the Fall Assessment Screening Tool, dated 01/12/12, revealed the facility identified the resident as a high risk for falls.</p> <p>A review of the Final Investigative Report, dated 03/08/12, revealed CNA #3 and CNA #5 did not toilet Resident #1, on 03/04/12, from 6:00 AM to approximately 4:00 PM. The report revealed Resident #1 was found in the floor with his/her pants pulled down and urine on the floor. The resident's sensor pad alarm was turned off and was not sounding prior to the fall. The resident sustained an intertrochanteric right femoral neck</p>	F 224	<p>Criteria #2 In order to identify other residents having the potential to be affected by same deficient practice residents whose BIMS score is between 13-15 will be interviewed by the Social Services Director to ensure that their care is being provided as indicated, and that they are being provided with appropriate care. This will be completed by May 6, 2012.</p>	
			<p>Criteria #3 The two Certified Nurse Aides (Certified Nurse Aide #3 and Certified Nurse #5) that failed to provide care were terminated for neglect of Resident #1 on 3/8/2012. The responsible Certified Medication Tech. (CMT) was provided corrective action on 3/5/2012 related to the incident. Certified Nurse Aide #1 was also provided with corrective action in relation to the incident on 3/5/2012. Corrective actions were provided by Administrative Nursing.</p>	

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F 224	<p>Continued From page 2</p> <p>(right hip) fracture, per the report. CNA #3 and CNA #5 were suspended on 03/05/12 and terminated on 03/08/12 for neglect.</p> <p>An interview with Registered Nurse (RN) #1, on 03/23/12 at 1:25 PM, revealed she was the nurse who worked on 03/04/12. She revealed she did not witness Resident #1's fall; however, she examined the resident afterwards. She revealed the resident was lying on his/her right side with his/her pants pulled slightly down, and there was urine on the floor. She further revealed CNA #5 admitted she had not toileted the resident the entire shift.</p>	F 224	<p>The Facility/Administrative Nursing will also implement staffing sheets that are completed for each shift that indicates the residents that the Certified Nurse Aides are responsible for. Implementation of these sheets will be May 6, 2012</p> <p>The Assistant Director of Nursing and the Director of Nursing will monitor for completion of the staffing sheets on a weekly basis to ensure that they are being completed.</p>	
	<p>An interview with Certified Medication Tech (CMT) #1, on 03/23/12 at 10:30 AM, revealed she was passing medications when Resident #1 fell, on 03/04/12. She revealed CNA #3 and CNA #5 verified they had not provided care for the resident all day, as the resident was already up in the wheelchair when their shift began. She revealed CNA #3 and CNA #5 stated that the resident was "next on their list," but the resident fell before care was provided.</p> <p>An interview with CNA #3, on 03/23/12 at 10:40 AM, revealed she started her shift, on 03/04/12 at 9:30 AM. She stated that Resident #1 was already up in the wheelchair, so she "assumed" the resident had already been provided care. She revealed the resident was supposed to be toileted every two hours, but it had been a "hectic" day.</p> <p>An attempted interview with CNA #5, on 03/23/12 at 10:20 AM, 12:50 PM, and 3:00 PM, was unsuccessful; however, a review of the Final Investigative Report, dated 03/08/12, revealed</p>		<p>Staff members were also provided education on the Resident Abuse/Neglect Policy by the Administrator/Director of Nursing on 3/5/2012, 3/6/2012, 3/7/2012, 3/11/2012, 3/21/2012, 3/28/2012, 3/30/2012, 4/2/2012, 4/4/2012, 4/11/2012, 4/16/2012, 4/18/2012, 4/19/2012, and 4/25/2012.</p>	

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F 224	<p>Continued From page 3</p> <p>CNA #5 admitted the resident was not toileted prior to 4:00 PM, as she had "forgotten."</p> <p>An interview with the DON, on 03/23/12 at 3:25 PM, revealed she conducted an interview with CNA #5, on 03/05/12. CNA #5 admitted she did not provide care for Resident #1 on 03/04/12, prior to the fall. She revealed CNA #5 stated she "was busy." She expected CNA #3 and CNA #5 to follow the resident's care guide, providing</p>	F 224	<p>Inservicing was provided to staff on ensuring Resident Care Guides are to be followed by Administrative Nursing on 3/5/2012, 3/8/2012, 3/7/2012, 3/11/2012, 3/28/2012, 4/4/2012, 4/11/2012, 4/18/2012, 4/19/2012, and 4/25/2012. Administrative Nursing completed this training.</p>	
	<p>incontinent care/toileting every two hours and as needed.</p> <p>An interview with the Risk Manager, on 03/23/12 at 5:15 PM, revealed she witnessed the interview with the Director of Nursing (DON) and CNA #5, on 03/05/12. She revealed CNA #5 admitted she did not toilet the resident her entire shift on 03/04/12.</p> <p>Additionally, the resident's sensor pad alarm on the wheelchair was not turned on prior to the fall.</p> <p>A review of the "Personal Safety Alarms" policy, undated, revealed "personal safety alarms would be checked at least every two hours for proper functioning by direct care staff. Alarms should be checked for proper placement, to ensure they are functioning or in good working order. Ongoing surveillance of proper device use would be done during routine care and compliance rounds."</p> <p>A review of the "Alarms Monitoring" policy, undated, revealed "the Certified Medication Aide was to access each resident alarm at the beginning of the shift by sounding the alarm and ensuring it functioned correctly."</p>		<p>Criteria #4 A Continuous Quality Improvement Tool will be utilized x3 months and then quarterly to ensure that staff can identify examples of abuse/neglect and knowledge of the abuse neglect policy. This will be completed by the Administrator. Administrator will interview staff and ask them to identify types of Abuse and Neglect, and repercussions of Abuse and Neglect.</p> <p>The abuse policy will also be inserviced by the Administrator x2 months and then quarterly after this to ensure compliance and knowledge of the policy.</p>	Criteria #5 5/7/2012

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F 224	Continued From page 4 An interview with Registered Nurse (RN) #1, on 03/23/12 at 1:25 PM, revealed the resident was sitting at the nurse's desk prior to the fall, and she noticed the self-release belt attached to the resident; however, she did not ensure the resident's sensor alarm was turned on and functioning. She revealed the Certified Medication Tech (CMT) was responsible for ensuring the alarm was turned on and functioning.	F 224	F226 Criteria #1 The Certified Nurse Aides that neglect was substantiated against were terminated from employment on 3/8/2012. They will no longer provide care to residents at River's Bend Retirement Community, which includes Resident #1.	
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	<p>An interview with Certified Medication Tech (CMT) #1, on 03/23/12 at 10:30 AM, revealed she worked on 03/04/12 from 6:00 AM to 6:00 PM. She revealed it was the responsibility of "all staff" to ensure alarms were on and functioning. She revealed she checked to ensure the self-release belt was attached to the resident, but could not recall if the sensor alarm was turned on and functioning.</p> <p>An interview with CNA #3, on 03/23/12 at 10:40 AM, revealed she started the shift on 03/04/12 at 9:30 AM. She revealed she did not ensure the resident's sensor alarm was on and functioning prior to the fall. She further revealed the resident was ambulated by restorative prior to the fall and it should have been checked at that time.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 03/23/12 at 9:35 AM, revealed she provided level 2 restorative care for Resident #1 on 03/04/12. She revealed she ambulated the resident between 10:00 AM and 11:00 AM. She revealed when she stood the resident up, the alarm did not sound. After ambulating the resident, she ensured the self-release belt was attached, but did not turn on the resident's sensor pad alarm.</p>		<p>Criteria #2 In order to identify other residents having the potential to be affected by same deficient practice residents with a BIMS score of 13-15 will be interviewed by the Social Services Director to ensure that Resident care is being provided as indicated, and that they are being provided with appropriate care. This will be completed by May 6, 2012.</p> <p>Criteria #3 The Director of Nursing and Assistant Director of Nursing were provided education on the Abuse/Neglect Policy, which includes suspension of alleged staff, on 3/28/2012. This was completed by the Administrator.</p>	
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F 224	<p>Continued From page 5</p> <p>An attempted interview with CNA #5, on 03/23/12 at 10:20 AM, 12:50 AM, and 3:00 PM, was unsuccessful; however, a review of the Final Investigative Report, dated 03/08/12, revealed she did not ensure the resident's alarm was turned on and functioning prior to the fall.</p> <p>Interview with the Director of Nursing (DON), on 03/23/12 at 3:25 PM and at 5:20 PM, revealed she expected the staff to ensure the residents' alarms were placed, according to the resident care guide.</p>	F 224	<p>Staff were provided education on Abuse/Neglect Policy by Administrative Nursing or Administrator on 3/5/2012, 3/6/2012, 3/7/2012, 3/11/2012, 3/21/2012, 3/28/2012, 3/30/2012, 4/4/2012, 4/11/2012, 4/16/2012, 4/18/2012, 4/19/2012, and 4/25/2012.</p>	
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F 226 SS=G	<p>483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's policy/procedures, and the Final Investigative Report, it was determined the facility failed to ensure written policies and procedures were implemented that prohibit neglect for one resident (#1) in the selected sample of four residents. Certified Nurse Aide (CNA) #3 and CNA #5 failed to toilet Resident #1, on 03/04/12, from 6:00 AM to approximately 4:00 PM. Resident #1 was found in the floor, at 3:30 PM, with his/her pants pulled down and urine on the floor. The resident's sensor pad alarm was not turned on prior to the fall. The resident sustained a intertrochanteric right femoral neck (right hip) fracture, as a result</p>	F 226	<p>Criteria #4 A Continuous Quality Improvement Tool will be utilized x3 months and then quarterly to ensure that staff can identify examples of abuse/neglect and knowledge of the abuse neglect policy. As part of this tool staff will be interviewed and asked types of abuse/neglect and the repercussions of being convicted of abuse and neglect. This will be completed by the Administrator.</p>	<p>Criteria #5 5/7/2012</p>
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F 226	<p>Continued From page 6 of the fall. (Refer to F224) CNA #3 and CNA #5 were not removed from resident care, on 03/04/12, and were allowed to work a partial shift, on 03/05/12, before suspension was initiated.</p> <p>Findings Include:</p> <p>A review of the facility's policy/procedure, "Resident Abuse and Neglect," undated, revealed "the resident's safety and protection would be assured. If an incident involved an employee, the employee would immediately be placed on suspension until the investigation was completed."</p> <p>A review of CNA #3's timesheet, dated 03/04/12, revealed she worked from 9:24 AM to 6:30 PM, and on 03/05/12, she worked from 5:57 AM to 12:28 PM.</p> <p>An interview with CNA #3, on 03/23/12 at 10:40 AM, revealed she did not provide incontinent care/toileting for Resident #1, on 03/04/12, prior to the resident's fall at 3:30 PM. She revealed she did not ensure the resident's sensor alarm pad was turned on and functioning. She was issued a written disciplinary action after the events by Certified Medication Tech (CMT) #1, but she was allowed to continue with resident care for the remainder of the shift. She revealed she was supposed to report to the Director of Nursing (DON) at 11:00 AM, on 03/05/12; however, she was not aware she could not complete her shift as scheduled, on 03/05/12.</p> <p>A review of CNA #5's timesheet, dated 03/04/12, revealed she worked from 5:58 AM to 6:28 PM, and on 03/05/12, she worked from 6:01 AM to</p>	F 226		
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F 226	<p>Continued From page 7 12:40 PM.</p> <p>An attempted interview with CNA #5, on 03/23/12 at 10:20 AM, 12:50 PM, and 3:00 PM, was unsuccessful; however, an interview with Registered Nurse (RN) #1, on 03/23/12 at 2:35 PM, revealed CNA #5 completed her shift on 03/04/12, and worked 03/05/12, until she was suspended by the DON.</p>	F 226		
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	<p>An interview with CMT #1, on 03/23/12 at 10:30 AM and at 2:30 PM, revealed CNA #3 and CNA #5 reported to her that they had not toileted Resident #1 prior to the fall, on 03/04/12 at 3:30 PM. She reported the allegation of neglect to RN #1 immediately. She revealed the DON instructed her to inservice CNA #3 and CNA #5 about neglect. They received disciplinary action at that time; however, the DON did not instruct her to send the two staff members home. She revealed she would remove a staff member from resident care if there was an allegation of physical or verbal abuse; however, she was "not sure" about a neglect allegation.</p> <p>An interview with RN #1, on 03/23/12 at 1:25 PM, revealed she first reported the resident's fall (with no alarm sounding) to the Assistant Director of Nursing (ADON), as she was on call. It was later in the shift when it was discovered the resident had not been checked for incontinence/toileting the entire shift. She revealed the ADON was notified immediately after the allegation of neglect. CMT #1 was instructed by the DON to inservice CNA #3 and CNA #5, and issue disciplinary action. She revealed the CNAs were not removed from resident care, as she was not instructed to remove them. She revealed she did</p>			
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F 226	<p>Continued From page 8</p> <p>not know what the policy stated. She stated "I didn't even think about removing them."</p> <p>An interview with the ADON, on 03/23/12 at 3:10 PM, revealed she was made aware of the allegation of neglect, as she was on call for the facility, on 03/04/12. She revealed she made the Administrator aware and the Administrator took over the investigation.</p>	F 226		
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	<p>An interview with the DON, on 03/23/12 at 3:25 PM, revealed she instructed CMT #1, on 03/04/12, to inservice CNA #3 and CNA #5 related to "alarms" and "providing care to their residents." She revealed CMT #1 was to issue written disciplinary action at that time. CNA #3 and CNA #5 were supposed to meet in her office the next morning at specific scheduled times. She revealed they were not supposed to provide resident care, on 03/05/12. She stated that she was not aware they worked the floor prior to meeting with her.</p> <p>An interview with the Administrator, on 03/23/12 at 4:00 PM, revealed she did not speak with CNA #3 and CNA #5 specifically, but gave direction to the ADON and DON. She revealed CNA #3 and CNA #5 were suppose to report to the DON's office at specific times, on 03/05/12. They were not suppose to provide resident care, as an investigation would be conducted for possible neglect. She was not aware CNA #3 and CNA #5 worked the floor, on 03/05/12; however, she did recall CNA #3 had "scrubs" on during the interview process.</p> <p>A review of the Final Investigative Report, dated 03/08/12, revealed CNA #3 and #5 were</p>			
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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055
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F 226	Continued From page 9 terminated as of 03/08/12 for neglect.	F 226		
F 282 SS=G	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F282 Criteria #1 Resident #1 has returned to the facility after receiving treatment for the right hip fracture. Staff members were inserviced that Resident #1 is to be toileted as indicated on Resident #1's resident care guide this was completed on 3/5/2012, 3/6/2012, 3/7/2012, 3/28/2012, 4/4/2012, 4/18/2012, 4/19/2012, and 4/25/2012. This was completed by Administrative Nursing.	

	This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure, and the Final Investigative Report, it was determined the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care for one resident (#1), in the selected sample of four residents. The Comprehensive Care Plan indicated Resident #1 should be toileted every two hours and as needed. Certified Nurse Aide (CNA) #3 and CNA #5 did not follow the Comprehensive Care Guide related to toileting, as the resident was not toileted on 03/04/12, from 6:00 AM to 4:00 PM. The Resident Care Guide indicated Resident #1 required a sensor pad alarm to the wheelchair for safety. Resident #1 fell from the wheelchair, on 03/04/12. The resident was found with his/her pants pulled down and urine on the floor. CNA #1, CNA #3, and CNA #5 failed to ensure the resident's sensor pad alarm was turned on and functioning, according to the Resident Care Guide. Resident #1 sustained an intertrochanteric right femoral neck (right hip) fracture as a result from the fall. Findings include:		Staff were also inserviced by the Director of Nursing on the personal safety alarms that are used in fall management for Resident #1 this was completed on 3/5/2012, 3/6/2012, 3/7/2012, 3/28/2012, 4/4/2012, 4/18/2012, 4/19/2012, and 4/25/2012. During this inservice staff were also trained that these are to be checked for function and placement every 2 hours.	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 C 03/23/2012
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F 282	Continued From page 10 A review of the facility's "Comprehensive Care Plan" policy/procedure, undated, revealed "the CNA care plan would be provided to strive to ensure that nursing staff were aware of supports that were to be provided for the resident." A record review revealed the facility admitted Resident #1 on 11/03/10 with diagnoses to include Alzheimer's Disease. A review of the quarterly Minimum Data Set (MDS), dated 01/20/12, revealed the facility identified the resident as severely cognitively impaired and required extensive assist for toilet use and transfers. The MDS revealed the resident was incontinent of bowel and bladder. A review of the Comprehensive Care Plan, dated 01/12/12, revealed the resident should be toileted every two hours and as needed. A review of the Resident Care Guide, undated, revealed the resident should have a sensor pad alarm to the wheelchair for safety.	F 282	Criteria #2 Administrative Nursing will do a one time compliance round which includes visually observing at least 50% of the residents and ensuring they are being provided alarms/devices that they are care planned for in relation to fall management. This will occur x1 month and then quarterly after this to ensure that we are maintaining compliance. This will be done by May 6 2012.	
	A review of the Final Investigative Report, dated 03/08/12, revealed Resident #1 fell from the wheelchair, on 03/04/12 at 3:30 PM, with his/her pants pulled down and urine on the floor. The resident's sensor alarm pad was turned off and not sounding at the time of the fall. The resident sustained an intertrochanteric right femoral neck (right hip) fracture as a result of the fall. An interview with CNA #1, on 03/23/12 at 9:35 AM, revealed she ambulated the resident between 10:00 AM and 11:00 AM, on 03/04/12. She revealed the sensor alarm pad was not sounding when the resident stood up, and she did not turn it on after assisting the resident back into		In order to identify other residents having the potential to be affected by same deficient practice residents with a BIMS score of 13-15 will be interviewed by the Social Services Director to ensure that their care is being provided as indicated, and that they are being provided with appropriate care. This will be completed by May 6 2012.	6

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

PRINTED: 04/06/2012
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 C 03/23/2012
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RIVER'S BEND RETIREMENT COMMUNITY

300 BEECH ST,
KUTTAWA, KY 42055

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F 282

Continued From page 11
the wheelchair.

An interview with CNA #3, on 03/23/12 at 10:40 AM, revealed she clocked in at 9:30 AM, on 03/04/12, and did not toilet Resident #1 her entire shift. She revealed the resident should have been toileted every two hours and as needed. She also revealed she did not ensure the resident's sensor alarm pad was turned on and functioning.

F 282

Criteria #3
Staff were provided education by Administrative Nursing/Administrator that they are to be following the Resident Care Guides and ensuring that the supports listed are being provided for each resident. This was completed on 3/5/2012, 3/6/2012, 3/7/2012, 3/11/2012, 3/21/2012, 3/28/2012, 4/4/2012, 4/11/2012, 4/19/2012, and 4/25/2012.

F 323
SS=G

Attempted interview with CNA #5, on 03/23/12 at 10:20 AM, 12:50 PM, and 3:00 PM, was unsuccessful; however, a review of the Final Investigative Report revealed she did not toilet the resident from 6:00 AM to 4:00 PM, on 03/04/12. The report also revealed she did not ensure the resident's alarm sensor pad was on and functioning.

An interview with the Director of Nursing (DON), on 03/23/12 at 5:20 PM, revealed she expected the staff to follow the care plan for each resident.

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of the

F 323

Certified Medication Techs. were provided education by Administrative Nursing that they are to be doing compliance rounds each shift, which includes ensuring that alarms/devices are provided to the resident as the care plan indicates. This was completed on 3/23/2012.

The Director of Nursing also provided training on ensuring completion of compliance rounds on 4/11/2012, and 5/2/2012. This was provided to Certified Medication Techs.

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

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 C 03/23/2012
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F 323	Continued From page 12 facility's policy and procedures, and the Final Investigative Report, it was determined the facility failed to ensure each resident received adequate supervision and assistance device to prevent accidents for one resident (#1), in the selected sample of four residents. On 03/04/12 at 3:30 PM, Resident #1 fell from the wheelchair. It was determined the resident's sensor pad alarm was not turned on and functioning at the time of the fall. The resident sustained a Intertrochanteric right femoral neck (right hip) fracture as a result of the fall.	F 323	Staff members were also provided education that they are to be following the Resident Care Guide and ensuring the supports listed are being provided as indicated. This education was provided by Administrative Nursing and was completed on 3/5/2012, 3/8/2012, 3/7/2012, 3/11/2012, 3/21/2012, 3/28/2012, 4/4/2012, 4/11/2012, 4/19/2012, and 4/25/2012.	
	Findings include: A review of the facility's "Personal Safety Alarms" policy, undated, revealed "personal safety alarms would be checked at least every two hours for proper functioning by direct care staff. Alarms should be checked for proper placement, to ensure they are functioning or in good working order. Ongoing surveillance of proper device use would be done during routine care and compliance rounds." A review of the facility's "Alarms Monitoring" policy, undated, revealed "the Certified Medication Aide would access each resident alarm at the beginning of the shift by sounding the alarm and ensuring it functioned correctly." A record review revealed the facility admitted Resident #1 on 11/03/10 with diagnoses to include Alzheimer's Dementia. A review of the quarterly Minimum Data Set (MDS), dated 01/20/12, revealed the facility identified the resident as severely cognitively impaired, required extensive assistance of two staff for		Criteria #4 The facility plans to monitor it's performance by Administrative Nursing receiving compliance rounds/alarm checks that are completed by Certified Medication Techs. 2X's a month This will ensure that that this monitoring tool is being completed. This will be done for one month and then every quarter after this. Administrative nursing will also pick a sample of 50% of residents and visually observe supports that are being provided in comparison to the care plan to ensure that they are being provided as indicated. This will occur one month and then every quarter after that to ensure that compliance is achieved and maintained.	Criteria #5 5/7/2012

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

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F 323	<p>Continued From page 13</p> <p>transfers. A review of the Comprehensive Device Assessment, dated 10/21/11, and the Resident Care Guide, undated, revealed the resident had a sensor alarm pad and a self-release belt to the wheelchair for safety. A review of the Fall Assessment Screening Tool, dated 01/12/12, revealed the facility identified the resident as a high risk for falls.</p> <p>A review of the Final Investigative Report, dated 03/08/12, revealed Resident #1 was found in the floor with his/her pants pulled down and urine on the floor. The resident's sensor pad alarm was turned off and not sounding prior to the fall. The resident sustained an intertrochanteric right femoral neck (right hip) fracture, according to the report.</p>	F 323	<p>F323 Criteria #1 Resident #1 has returned to the facility after receiving treatment for the right hip fracture. Staff members were inserviced on 3/5/2012, 3/06/2012, 3/7/2012, 3/28/2012, 4/4/2012, 4/18/2012, 4/19/2012, and 4/25/2012 that Resident #1 is to be toileted as indicated on Resident #1's resident care guide. This training was provided by Administrative Nursing.</p>	
	<p>An interview with Registered Nurse (RN) #1, on 03/23/12 at 1:25 PM, revealed she was the nurse who worked on 03/04/12. She revealed she did not witness Resident #1's fall; however, she examined the resident afterwards. She revealed the resident's sensor pad alarm was not turned on at the time of the fall.</p> <p>She further revealed the resident was sitting near the nurse's desk that day, and she noticed the self-release belt was attached to the resident; however, she did not ensure the resident's sensor alarm was turned on and functioning. She revealed the Certified Medication Tech (CMT) was responsible for ensuring the alarm was turned on and functioning.</p> <p>An interview with Certified Medication Tech (CMT) #1, on 03/23/12 at 10:30 AM, revealed she worked on 03/04/12 from 6:00 AM to 6:00 PM. She revealed it was the responsibility of "all staff"</p>		<p>Staff were also inserviced on the personal safety alarms that are used in fall management for Resident #1, and that these are to be checked for function and placement every 2 hours. This was done by Director of Nursing on 3/5/2012, 3/6/2012, 3/7/2012, 3/28/2012, 4/18/2012, and 4/19/2012.</p>	

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

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F 323	<p>Continued From page 14</p> <p>to ensure alarms were on and functioning. She revealed she checked to ensure the self-release belt was attached to the resident, but could not recall if the sensor alarm was turned on and functioning.</p> <p>An interview with CNA #3, on 03/23/12 at 10:40 AM, revealed she started the shift on 03/04/12 at 9:30 AM. She revealed she did not ensure the resident's sensor alarm was on and functioning prior to the fall. She further revealed the</p>	F 323	<p>Criteria #2</p> <p>Administrative Nursing will do a one time compliance round which includes visually observing at least 50% of the residents and ensuring they are being provided alarms/devices that they are care planned for in relation to fall management. This will be completed x1 month and then quarterly after this to ensure maintained compliance.</p> <p>This will be done by May 6, 2012.</p>	
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	<p>Restorative CNA ambulated the resident earlier in the shift, and she should have ensured the sensor pad alarm was turned on at that time.</p> <p>An interview with CNA #1, on 03/23/12 at 9:35 AM, revealed she provided Level 2 Restorative for Resident #1 on 03/04/12. She revealed she ambulated the resident between 10:00 AM and 11:00 AM. She revealed when she assisted the resident to stand up, the alarm did not sound. After ambulating the resident, she ensured the self-release belt was attached, but she did not turn on the resident's sensor pad alarm.</p> <p>An attempted interview with CNA #5, on 03/23/12 at 10:20 AM, 12:50 AM, and 3:00 PM, was unsuccessful; however, a review of the Final Investigative Report, dated 03/08/12, revealed she did not ensure the resident's alarm was turned on and functioning prior to the fall.</p> <p>Interview with the Director of Nursing (DON), on 03/23/12 at 3:25 PM and 5:20 PM, revealed she expected the staff to ensure the residents' alarms were placed, according to the resident care guide.</p>		<p>In order to identify other residents having the potential to be affected by same deficient practice residents with a BIMS score of 13-15 will be interviewed by the Social Services Director to ensure that their care is being provided as indicated, and that they are being provided with appropriate care. This will be completed by May 6, 2012.</p>	
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