

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

PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2010
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NAME OF PROVIDER OR SUPPLIER TRADEWATER POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 40408
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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 annual survey was completed 11/17/10 through 11/19/10 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "D". Additionally, an abbreviated survey (KY #15595) was conducted on 11/17/10 and concluded on 11/19/10 and was unsubstantiated with no deficiencies.	F 000	1. Corrective Action: Resident #5 Immediate inservice on peri-care was provided on 11-18-10 by Corporate Nurse Trainer for CNA #1, responsible for the care of resident #5. DON also provided re-education on 11-18-10. Follow-up education was provided by ADON on 12-3-10. (See attachment 1, 2 & 3)	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, it was determined the facility failed to ensure appropriate treatment and services to prevent urinary tract infections for one resident (#5) in the selected sample of 14. Findings include: A review of the policy/procedure, "Giving Female Perineal Care" undated, revealed during provision of incontinent care/perineal care, the caregiver should separate the labia and clean in a downward motion, front to back with one stroke,	F 315	2. ID of Others at risk: All residents listed as incontinent were reviewed for incontinent care. Incontinent care was observed by the Compliance Nurse and ADON on 11-22-10 thru 12-10-10 with no other problems noted. 3. Prevention Measures: Staff inservice was held on 12-3-10 on peri-care for the Nursing staff. Observation will continue by Administrative Nursing staff weekly during	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *12-21-10*

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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NAME OF PROVIDER OR SUPPLIER TRADEWATER POINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 42408		
(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 315	<p>Continued From page 1</p> <p>repeating until the area was clean. The policy revealed the next step included assisting the resident to lower his/her legs and turn onto his/her side away from the caregiver. The technique included completion of the incontinent care by washing from the vagina toward the rectum with one stroke, followed by rinsing and drying the area.</p> <p>A review of the policy/procedure, "Infection Control, Universal Precautions" dated 03/09/10, revealed caregivers should wash their hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves were worn.</p> <p>A record review revealed Resident #5 was admitted to the facility, on 04/22/09, with a diagnosis to include Urinary Tract Infection. A review of the annual Minimum Data Set (MDS), dated 10/25/10, revealed the facility identified the resident was always incontinent of bowel and bladder and required total assistance for bed mobility.</p> <p>An observation during the provision of incontinent care for Resident #5, on 11/18/10 at 10:05 AM, revealed Certified Nurse Aide (CNA) #1 applied gloves, prior to care. The resident had a bowel movement. CNA #1 cleansed the resident's buttocks front to back and placed a brief under the resident. The CNA did not wash her hands or change her gloves and proceeded to separate the labia with her gloved hand, cleansing the perineum front to back, while wearing the contaminated gloves.</p> <p>An interview with CNA #1, on 11/18/10 at 10:25 AM, revealed she never changed gloves during</p>	F 315	<p>the month of December 2010 and monthly for 6 months with any problems corrected immediately.</p> <p>4. Monitor: Weekly monitor by Compliance Nurse for month of December 2010 with review monthly thru June 2011 with any problems corrected immediately.</p> <p>5. Date Corrected:</p>	12-11-10	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2010
NAME OF PROVIDER OR SUPPLIER TRADEWATER POINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 42408		
(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 315	Continued From page 2 incontinent care and she normally provided the incontinent care from the buttocks to the perineal area. She verbalized understanding of how the procedure could result in a spread of contamination to the perineal area, using contaminated gloves. She stated, "I have never thought about that before." An interview with the Director of Nursing, on 11/18/10 at 10:30 AM, revealed she expected staff to change their gloves if they were soiled during incontinent care. She revealed staff should follow the policy for proper incontinent care.	F 315			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2010
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NAME OF PROVIDER OR SUPPLIER TRADEWATER POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 42408
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 11/19/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12-10-10</i>
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