

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

PRINTED: 01/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185291</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/27/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>REDBANKS COLONIAL TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>142 ROGER POWELL RD SEBREE, KY 42455</b>		
(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 000	<p><b>INITIAL COMMENTS</b></p> <p>A Recertification Survey was conducted on 12/18/13 through 12/27/13 to determine the facility's compliance with Federal requirements. Immediate Jeopardy was identified on 12/20/13 and determined to exist on 12/07/13 with deficiencies cited at 42 CFR 483.20 Resident Assessment F-282 and 42 CFR 483.25 Quality of Care F-323 at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care F-323. The facility was notified of the Immediate Jeopardy on 12/20/13.</p> <p>On 12/07/13 at 1:30 PM, a State Registered Nurse Aide (SRNA) left Resident #15 in his/her room alone, up in the shower chair without tab alarms or staff supervision. Facility staff found Resident #15 in his/her room face down on the floor, unresponsive, after an unwitnessed fall from a shower chair. Resident #15 was transferred by ambulance to the hospital and diagnosed with a Cervical One Ring Fracture and a right Frontal Scalp Hematoma. Resident #15 was then transferred to another hospital for neurosurgical consultation and expired on 12/09/13 of respiratory failure as the result of a cervical compression. The facility failed to implement the care plan and maintain adequate supervision of Resident #15 while up in a shower chair when tab alarms could not be used to alert staff if he/she tried to transfer unassisted.</p> <p>An acceptable Credible Allegation of Compliance (CAoC) was received on 12/23/13, which alleged removal of the Immediate Jeopardy on 12/11/13, prior to the initiation of the Recertification survey. The State Survey Agency determined the</p>	F 000			

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

TITLE

(X6) 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.

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F 000	Continued From page 1 deficient practice was corrected related to lack of supervision on 12/11/13 as alleged in the AOC; therefore, it was determined to be Past Immediate Jeopardy.	F 000			
F 282	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.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to provide care in accordance with the written plan of care for one (1) of fifteen sampled residents (Resident #15) for the prevention of falls.  The facility assessed Resident #15 as being at high risk for falls and care planned the resident to have tab alarms to wheelchair due to unassisted transfers. On 12/07/13 at 1:30 PM, the Certified Nursing Assistant (CNA) left Resident #15 in his/her room alone in a shower chair without tab alarms or supervision to prevent unassisted transfers. The facility staff found Resident #15 in his/her room face down on the floor, unresponsive, after an unwitnessed fall from a shower chair. Resident #15 was transferred by ambulance to the hospital and diagnosed with cervical one ring fracture and a right frontal scalp hematoma. Resident #15 was then transferred to another hospital for neurosurgical consultation. The resident expired on 12/09/13, of respiratory	F 282	Past noncompliance: no plan of correction required.		

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F 282	<p>Continued From page 2</p> <p>failure as the result of a cervical compression. The facility failed to ensure the safety of Resident #15, left the resident unattended, up in a shower chair when tab alarms could not be used to alert staff if he/she tried to transfer unassisted.</p> <p>The facility's failure to provide care in accordance with the care plan has caused or is likely to cause serious injury, harm, impairment, and/or death to the residents. Past Immediate Jeopardy was identified on 12/27/13 and determined to exist on 12/07/13, at 42 CFR 483.20 Resident Assessment. The facility was notified of the Past Immediate Jeopardy on 12/27/13.</p> <p>An acceptable Credible Allegation of Compliance (CAoC) was received on 12/23/13, which alleged removal of the Immediate Jeopardy on 12/11/13, prior to the initiation of the Recertification survey. The State Survey Agency determined the deficient practice was corrected related to lack of supervision on 12/11/13 as alleged in the AOC; therefore, it was determined to be Past Immediate Jeopardy.</p> <p>The findings include:</p> <p>Review of the facility's policy "Fall Assessment Screening Tool", dated 12/2007, revealed the purpose of the Fall Assessment Screening Tool (FAST) was to evaluate the residents for fall risks and it should be completed by a licensed nurse initially, quarterly, and as indicated by interdisciplinary review of event evaluations. A score of sixty-five (65) or greater indicted the resident was at high risk for falls.</p> <p>Record review revealed the facility admitted</p>	F 282			

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F 282	<p>Continued From page 3</p> <p>Resident #15 on 03/04/13, with diagnoses which included Heart Failure, Hypertension, Diabetes Mellitus, Cerebral Vascular Accident, Non-Alzheimer's disease, Atrial Fibrillation, Malaise, and Fatigue. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 12/04/13, revealed the facility assessed Resident #15 as requiring total assistance of two (2) staff members with transfers, extensive assistance of one (1) staff member for locomotion in a wheelchair, extensive assistance of two (2) staff members for toilet use, and total assistance of two (2) staff members for bathing. Review of the FAST, dated 09/18/13, revealed the facility assessed Resident #15 as high risk for falls with a score of one hundred and five (105).</p> <p>Review of Resident #15's Comprehensive Care Plan for Falls Risk, dated 09/17/13, revealed , interventions for staff to provide sensor alarms while in bed and a tab alarm and dycem to wheelchair. Review of the Comprehensive Care Plan for assistance with Activities of Daily Living (ADLs), dated 09/17/13, revealed interventions for two (2) staff to transfer Resident #15 with a mechanical lift; and the resident was totally dependent on one (1) staff for bathing and dressing.</p> <p>Review of the Event Report Investigation, dated 12/07/13, revealed on 12/07/13 at 1:30 PM, Resident #15 was left unsupervised in his/her room after a shower by State Registered Nurse Aide (SRNA) #1. The resident fell from the shower chair while SRNA #1 went to get assistance to use the mechanical lift to transfer him/her. SRNA #1 returned to the room to find Resident #15 lying on the floor face down. After an assessment by Registered Nurse (RN) #1, the</p>	F 282			

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F 282	<p>Continued From page 4</p> <p>physician was notified and the resident was transferred to the local hospital. The facility determined the causative factor for the fall to be resident left unassisted and tried to get up.</p> <p>Review of Hospital Emergency Department Records, dated 12/07/13, revealed Resident #15 was determined to have sustained a Cervical One Ring Fracture. Review of the Neurosurgery Consult Notes, dictated on 12/10/13, revealed the resident expired two (2) days later related to Respiratory Failure secondary to Cervical Compression.</p> <p>Interview with SRNA #1, on 12/19/13 at 5:12 PM, revealed while transporting Resident #15 to his/her room after a shower, she saw SRNA #2 in the hallway. She stated she positioned the resident near the end of his/her bed in front of the television and locked the wheels on the shower chair. Further interview revealed she then stepped out of the room, into the hallway away from the resident to call for staff assistance to use a mechanical lift to transfer the resident. SRNA #1 stated when she turned around to go back into the room, the resident was lying on the floor face down. She denied hearing anything to alert her that the resident was trying to transfer or that he/she had fallen. The SRNA stated the shower chair was still in the same place, but she had to move it to get to Resident #15. SRNA #1 stated she could not remember giving the call light to Resident #15, but she did not recall the resident ever using a call light to call for assistance. The SRNA stated there was no alarm on the shower chair and the one from the wheelchair would not work because there was no bottom in the shower chair for the alarm to be placed.</p>	F 282			

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F 282	<p>Continued From page 5</p> <p>Interview with SRNA #2, on 12/20/13 at 1:42 PM, revealed she was going to Resident #15's room when SRNA #1 called her for help to transfer the resident from the shower chair to the bed with the mechanical lift. SRNA #2 stated SRNA #1's back was to the resident. She indicated she would have not felt comfortable leaving the resident unattended in a shower chair. SRNA #2 stated when she walked into the room, the resident was on the floor with his/her back up and the resident did not respond when they first got to him/her.</p> <p>Interview with RN #1, on 12/20/13 at 11:22 AM, revealed she was at the nurses' station when the resident was transported back to his/her room from the shower room in a shower chair. She heard the SRNAs yell her name, and she ran down the hallway to Resident #15's room. The RN stated it had only been a few seconds from the time she heard her name called until she arrived to the resident's room. When she arrived to the room the resident was conscious. RN #1 stated they had been using the shower chair as a transfer chair and there was no plan to use an alarm with the shower chair. Further interview revealed she thought it was poor judgement to leave the resident unattended in the shower chair.</p> <p>Interview with LPN #1, a floor nurse, on 12/19/13 at 4:13 PM, revealed Resident #15 had dementia and was unaware of his/her limitations, and was unable to reposition himself/herself in a wheelchair. LPN #1 stated he would not have left Resident #15 out of his line of sight in a shower chair. He further stated he would not leave anyone with dementia in a shower chair unattended.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 282			

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F 282	<p>Continued From page 6</p> <p>12/19/13 at 3:15 PM, revealed Resident #15 was reassessed on 09/18/13, using a Falls Assessment Screening Tool (FAST) and the facility determined the resident was at high risk for falls. The DON further stated alarms were placed on the resident's wheelchair and bed to alert staff of attempted unassisted transfers. She stated Resident #15 had two (2) falls since his/her admission to the facility. She stated on 12/02/13, when staff responded to a bed alarm in Resident #15's room he/she was found with his/her shoulders on the floor and the lower half of his/her body still on the bed. She stated it was determined his/her bedside table was just out of reach on the other side of the fall mat. The mat and bedside table were rearranged to get the table in the resident's reach while in bed. Continued interview revealed the second fall occurred, on 12/07/13, when SRNA #1 left the resident unattended in a shower chair in his/her room to get help to use a mechanical lift to transfer the resident from the shower chair to his/her bed. She stated Resident #15 did not have a care plan related to the shower chair, and the care plan was revised for the resident not to be left alone in a shower chair.</p> <p><b>**The facility implemented the following actions to correct the deficiency:</b></p> <p>On 12/07/13, the DON, Assistant Director of Nursing (ADON), and LPN #2 initiated education to all nurses and SRNAs that no residents would be left unattended in a shower chair. Education started with staff that were present in the facility, and the call list was initiated to educate the staff who were not present in the facility. This continued until all staff was educated on 12/09/13.</p>	F 282			

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F 282	<p>Continued From page 7</p> <p>The facility ordered a shower bed for the residents who would benefit from it and ordered safety straps to be placed on the shower chairs already in the facility.</p> <p>The facility implemented monitoring of the shower rooms five (5) time a week to include weekends on 12/07/13 to ensure safety belts were being used on shower chairs, correct positioning of the residents, and no residents were left unattended in the shower chairs.</p> <p>The Minimum Data Set (MDS) Coordinator updated all the care plans as well as SRNA care plans on every resident in the facility on 12/10/13 to state "not to leave a resident alone in a shower chair".</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>Interviews with RN #2, LPN #5, LPN #3, LPN #8, KMA #6, KMA #3, SRNA #14, SRNA #5, SRNA #6, SRNA #7, SRNA #8, SRNA #19, and SRNA #3, on 12/26/13 at 5:16 PM, 5:20 PM, 5:21 PM, 5:31 PM, 5:40 PM, 5:49 PM, 6:25 PM, 6:28 PM, 6:38 PM, 6:40 PM, 6:43 PM, 6:55 PM, and 7:00 PM, respectively, and LPN #1, LPN #2, LPN #4, KMA #5, SRNA #9, SRNA #10, SRNA #11, SRNA #12, and SRNA #13, on 12/27/13 at 9:15 AM, 9:25 AM, 9:30 AM, 9:35 AM, 9:43 AM, 9:50 AM, 9:52 AM, 9:58 AM, and 10:02 AM, respectively, revealed they were educated in regard to not leaving residents unattended in shower chairs.</p> <p>An interview with the Minimum Data Set (MDS) Coordinator, on 12/27/13 at 1:25 PM, revealed she updated all the care plans as well as SRNA</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>care plans on every resident in the facility on 12/10/13 to not leave the resident alone in a shower chair. Review of the expanded sample of eight (8) residents revealed each care plan and SRNA care plan had been updated on 12/10/13.</p> <p>Observation of the use of a shower room chair, on 12/26/13 at 6:36 PM, by SRNA #8 and SRNA #26, revealed they used the lift to transfer a resident from his/her bed to a wheelchair, transported to the shower room, then transferred the resident to the shower bed in the shower room. While in the shower room, shower chairs were observed with safety straps in place. SRNA #26 stated since got the shower bed most of the residents who required a mechanical lift used the shower bed, but she used the safety straps on all residents while in the shower chairs.</p> <p>On 12/27/13, review of the facility's documentation, related to monitoring of the shower room, revealed staff were monitoring the shower rooms five (5) times per week to include weekends to ensure safety belts were being used on shower chairs, correct positioning of the residents, and no residents were left unattended in the shower chairs.</p> <p>Interviews with LPN #1 and Kentucky Medication Aide #5, on 12/27/13 at 9:25 AM and 9:58 AM respectively, revealed they had been in the shower rooms to observe for the use of safety belts on the shower chairs and had not observed any shower chairs used for transport outside the shower rooms. Interviews with SRNA #5 and SRNA #8, on 12/26/13 at 5:21 PM and 5:49 PM respectively, revealed they had been observed in the shower room by supervisory staff for use of safety belts on shower chairs and both denied</p>	F 282			

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F 282	Continued From page 9 use of a shower chair for transport outside the shower rooms.	F 282			
F 323 SS=J	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 and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent falls for one (1) of fifteen (15) sampled residents (Resident #15).  On 12/07/13 at 1:30 PM, after completing the resident's shower, the State Registered Nurse Aide (SRNA) left Resident #15 in his/her room alone to get a mechanical lift and assistance to transfer the resident. Resident #15 was left unattended, in a shower chair with no tab alarms or supervision to ensure staff would be aware if the resident attempted to transfer unassisted. Upon return to the room, the SRNA found Resident #15 face down on the floor, unresponsive. Resident #15 was transferred by ambulance to the hospital and diagnosed with Cervical One Ring Fracture and a right Frontal Scalp Hematoma. Resident #15 was then transferred to another hospital for neurosurgical	F 323	Past noncompliance: no plan of correction required.		

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F 323	<p>Continued From page 10</p> <p>consultation and expired on 12/09/13 of respiratory failure as the result of a cervical compression. The facility failed to provide adequate supervision of Resident #15 while up in a shower chair, when tab alarms could not be used to alert staff if he/she tried to transfer unassisted. Refer to F282</p> <p>Immediate Jeopardy was identified on 12/20/13 and determined to exist on 12/07/13 with deficiencies cited at 42 CFR 483.20 Resident Assessment F-282 and 42 CFR 483.25 Quality of Care F-323 at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care F-323. The facility was notified of the Immediate Jeopardy on 12/20/13.</p> <p>An acceptable Credible Allegation of Compliance (CAoC) was received on 12/23/13, which alleged removal of the Immediate Jeopardy on 12/11/13, prior to the initiation of the Recertification Survey. The State Survey Agency determined the deficient practice was corrected related to lack of supervision on 12/11/13 as alleged in the AOC; therefore, it was determined to be Past Immediate Jeopardy.</p> <p>The findings include:</p> <p>Review of the facility's policy "Fall Assessment Screening Tool", dated 12/2007, revealed the purpose of the Fall Assessment Screening Tool (FAST) was to evaluate the residents for fall risks. The FAST should be completed by a licensed nurse initially, quarterly, and as indicated by interdisciplinary review of event evaluations. High risk for falls was indicated by a score greater than sixty-five (65).</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  <b>REDBANKS COLONIAL TERRACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>142 ROGER POWELL RD SEBREE, KY 42455</b>
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F 323	<p>Continued From page 11</p> <p>Record review revealed the facility admitted Resident #15 on 03/04/13 with diagnoses which included Heart Failure, Hypertension, Diabetes Mellitus, Cerebral Vascular Accident, Non-Alzheimer's disease, Atrial Fibrillation, Malaise and Fatigue. Review of the FAST, dated 09/18/13, revealed the facility assessed Resident #15 as high risk for falls with a score of one hundred and five (105).</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 12/04/13, revealed the facility assessed Resident #15 as requiring the total assistance of two (2) staff members with transfers, and total assistance of two (2) staff members for bathing.</p> <p>Review of Resident #15's Comprehensive Care Plan for Falls Risk, dated 09/17/13, revealed interventions for a working and reachable call light, all personal items within reach, use of sensor alarms while in bed, and a tab alarm while up in the wheelchair. Review of the Comprehensive Care Plan for assistance with Activities of Daily Living (ADLs) revealed an intervention for two (2) staff to transfer Resident #15 with a mechanical lift.</p> <p>Review of an Event Report Investigation, dated 12/02/13 revealed on 12/04/13 at 7:00 PM, Resident #15's bed alarm sounded and staff found the upper half of the resident's body on the floor with his/her legs still on the bed. There were no injuries noted. The causative factor was determined to be that the resident was trying to reach his/her bedside table. The facility implemented an intervention to keep the resident's bedside table within reach</p>	F 323		
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F 323	Continued From page 12  Review of the Event Report Investigation, dated 12/07/13, revealed on 12/07/13 at 1:30 PM, Resident #15 was left unsupervised, sitting up in a shower chair, in his/her room after State Registered Nurse Aide (SRNA) #1 had completed his/her shower. The resident fell from the shower chair while SRNA #1 went to get assistance to use the mechanical lift to transfer him/her. SRNA #1 returned to the room to find Resident #15 lying on the floor face down. After an assessment by Registered Nurse (RN) #1, the physician was notified and the resident was transferred to the local hospital. The facility determined the causative factor to be an unassisted transfer from a shower chair.  Review of the Hospital Emergency Department Records, dated 12/07/13, revealed Resident #15 had sustained a Cervical One Ring Fracture. Review of the Neurosurgery Consult Notes, dictated on 12/10/13, revealed the resident expired two (2) days later related to Respiratory Failure secondary to Cervical Compression.  Interview with SRNA #1, on 12/19/13 at 5:12 PM, revealed after she completed the resident's shower, she transported Resident #15 back to his/her room. She stated she positioned the resident near the end of his/her bed in front of the television and locked the wheels on the shower chair. Continued interview revealed she stepped back into the hallway to call for staff assistance to use a mechanical lift to transfer the resident because it required two (2) staff to assist when using a mechanical lift to transfer. SRNA #1 stated when she turned around to go back into the room, the resident was lying on the floor face down. The SRNA indicated the shower chair was	F 323			

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F 323	<p>Continued From page 13</p> <p>still in the same place, but she had to move it to get to Resident #15. SRNA #1 notified the nurse for assistance. Registered Nurse (RN) #1 came to the resident's room and immediately started assessing the resident and obtained vital signs.</p> <p>Interview with SRNA #2, on 12/20/13 at 1:42 PM, revealed she was going to Resident #15's room when SRNA #1 called her for help to transfer the resident from the shower chair to the bed with the mechanical lift. SRNA #2 stated when she walked into the room, the resident was on the floor with his/her back up; the resident did not respond when they first got to him/her. The SRNA revealed they rolled the resident to his/her back while she supported the resident's head. Further interview with SRNA #2 revealed she stayed on the floor with the resident's head supported in her lap until the paramedics arrived. SRNA #2 stated there was a red raised area on the right side of the resident's forehead and skin tears on his/her right hand and elbow. The SRNA revealed when Resident #15 began talking and responding to questions, he/she reported right hip and back pain.</p> <p>Interview with RN #1, on 12/20/13 at 11:22 AM, revealed she was at the nurses' station when the resident was transported back to his/her room from the shower room. She heard the SRNAs yell her name, and she ran down the hallway to Resident #15's room. RN #1 stated when she arrived to the room the resident was conscious and it had only been a few seconds from the time she heard her name called until she arrived to the room. She continued, stating that the resident was lying on his/her right side with a sheet over him/her, and there was blood on his/her right hand and arm. The RN stated she assessed the</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>resident, cleaned and covered the wounds, started neurological checks, and monitored the resident's vital signs. She stated when Resident #15 started complaining of pain to his/her right hip, she instructed Kentucky Medication Aide (KMA) #1 to start monitoring the vital signs. RN #1 notified the physician for orders to transport the resident to the hospital. She notified the family that the resident was going to the hospital for an evaluation and treatment.</p> <p>Interview with KMA #1, on 12/19/13 at 4:30 PM, revealed she observed Resident #15 being transported down the hallway in the shower chair to his/her room. She stated she heard SRNA #1 call from the hallway for assistance from SRNA #2, then heard both SRNAs call for RN #1. The KMA stated she arrived to the room just behind RN #1 and saw Resident #15 lying on his/her back on the floor with the SRNAs kneeled beside him/her. She stated she was instructed to get equipment to monitor vital signs. She came back to the room and continued to monitor the resident, while RN #1 spoke to the family and contacted the physician to get orders to transfer the resident to the hospital.</p> <p>Interview with Paramedic #1, on 12/20/13 at 8:58 AM, revealed when he arrived to the room the resident was supine on the floor with his/her head in SRNA #2's lap. The Parametric stated Resident #15 complained about right hip pain during the assessment, and they suspected a head injury due to the report that the resident had been unconscious. The Paramedic revealed he attempted to place a cervical collar on the resident while he/she was on the floor, but was unable to place the cervical collar on until his/her head was flat on the spine board. He stated the</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>resident did not complain of neck or head pain, but experienced some respiratory distress, so they provided cervical immobilization and oxygen for transport to the hospital.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 12/19/13 at 5:27 PM, and on 12/20/13 at 3:00 PM, revealed transporting a resident in a shower chair to his/her room for transfer by mechanical lift had been common practice since she worked there and she could not recall any falls from a shower chair. She stated when a fall was reported, an assessment on the resident was completed and if no injury or complaints of pain were identified, they assisted the resident to get up and initiated neurological checks, notified the family and physician, initiated any physician's orders, and began an investigation to determine the probable cause. If there were injuries, they would leave the resident in the position found, call 911, and notify the family and physician. She revealed she initiated an investigation and interviewed RN #1 and SRNA #1; however, the resident had already been transferred before she was notified to initiate an investigation.</p> <p>Interview with LPN #1 Charge Nurse/Floor Nurse, on 12/19/13 at 4:13 PM, revealed Resident #15 had dementia and was unaware of his/her limitations, and was unable to safely reposition himself/herself in a wheelchair.</p> <p>Interview with the Director of Nursing (DON), on 12/19/13 at 3:15 PM, revealed Resident #15 was reassessed, on 09/18/13, using a Falls Assessment Screening Tool (FAST) and was determined to be at high risk for falls, so alarms were placed on his/her wheelchair and the bed to alert staff of unassisted transfers. She stated</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>Resident #15 had two (2) falls since his/her admission to the facility. The DON stated on 12/02/13, staff responded to a bed alarm in Resident #15's room. The resident was found with his/her shoulders on the floor and the lower half of his/her body still on the bed. She stated it was determined the resident's bedside table was just out of reach on the other side of the fall mat. The mat and bedside table were rearranged to get the table in the resident's reach while in bed. Continued interview revealed the second fall occurred, on 12/07/13, when SRNA #1 left the resident unattended in a shower chair in his/her room to get help to use a mechanical lift to transfer Resident #15 from the shower chair to his/her bed. She stated Resident #15 did not have a care plan related to the shower chair; after the fall the care plan was revised for the resident not to be left alone in a shower chair.</p> <p>**The facility implemented the following actions to correct the deficiency:</p> <p>On 12/07/13, the DON, Assistant Director of Nursing (ADON), and LPN #2 initiated education to all nurses and SRNAs that no residents would be left unattended in a shower chair. Education started with staff that was present in the facility, and the call list was initiated to educate the staff who were not present in the facility. This continued until all staff was educated on 12/09/13.</p> <p>The facility ordered a shower bed for those residents who would benefit from it and ordered safety straps to be placed on shower chairs already in the facility.</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>The facility implemented monitoring of the shower rooms five (5) time a week to include weekends on 12/07/13 to ensure safety belts were being used on shower chairs, correct positioning of the residents, and no residents were left unattended in the shower chairs.</p> <p>The Minimum Data Set (MDS) Coordinator updated all the care plans as well as SRNA care plans on every resident in the facility on 12/10/13 to state "not to leave a resident alone in a shower chair".</p> <p>Review of the Credible Allegation of Compliance (CAoC), dated 12/07/13, revealed the facility ordered a shower bed for those residents who would benefit from it and ordered safety straps to be placed on shower chairs already in the facility.</p> <p>**The SSA validated the corrective action taken by the facility as follows:</p> <p>Interviews with RN #2, LPN #5, LPN #3, LPN #8, KMA #6, KMA #3, SRNA #14, SRNA #5, SRNA #6, SRNA #7, SRNA #8, SRNA #19, and SRNA #3, on 12/26/13 at 5:16 PM, 5:20 PM, 5:21 PM, 5:31 PM, 5:40 PM, 5:49 PM, 6:25 PM, 6:28 PM, 6:38 PM, 6:40 PM, 6:43 PM, 6:55 PM, and 7:00 PM, respectively, and LPN #1, LPN #2, LPN #4, KMA #5, SRNA #9, SRNA #10, SRNA #11, SRNA #12, and SRNA #13, on 12/27/13 at 9:15 AM, 9:25 AM, 9:30 AM, 9:35 AM, 9:43 AM, 9:50 AM, 9:52 AM, 9:58 AM, and 10:02 AM, respectively, revealed they were educated in regard to never leaving anyone in a shower chair unattended.</p> <p>An interview with the Minimum Data Set (MDS) Coordinator, on 12/27/13 at 1:25 PM, revealed she updated all the care plans as well as SRNA</p>	F 323		

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F 323	<p>Continued From page 18</p> <p>care plans on every resident in the facility on 12/10/13 to state not to leave a resident alone in a shower chair. Review of the expanded sample of eight (8) residents revealed each care plan and SRNA care plan had been updated on 12/10/13.</p> <p>Observation of the use of a shower room chair, on 12/26/13 at 6:36 PM, by SRNA #8 and SRNA #26, revealed they used the lift to transfer a resident from his/her bed to a wheelchair, transported to the shower room, then transferred the resident to the shower bed in the shower room. While in the shower room, shower chairs were observed with safety straps in place. SRNA #26 stated since they have gotten the shower bed most of the residents who required a mechanical lift used the shower bed, but she used the safety straps on all residents while in the shower chairs.</p> <p>On 12/27/13, review of the facility's documentation, related to monitoring of the shower room, revealed staff was monitoring the shower rooms five (5) times per week to include weekends to ensure safety belts were being used on the shower chairs, correct positioning of the residents, and no residents were left unattended in the shower chairs.</p> <p>Interviews with LPN #1, and KMA #5, on 12/27/13 at 9:25 AM, and 9:58 AM respectively, revealed they had been in shower rooms to observe the use of safety belts on the shower chairs and had not observed any shower chairs used for transport outside the shower rooms. Interviews with SRNA #5, and SRNA #8 on 12/26/13 at 5:21 PM, and 5:49 PM, respectively, revealed they had been observed in shower room by supervisory staff for use of safety belts on shower chairs and both denied use of a shower chair for transport</p>	F 323		

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F 323	<p>Continued From page 19 outside the shower rooms.</p> <p>Interview with LPN #2, on 12/27/13 at 9:52 AM, revealed she talked to the DON on the phone and the DON advised her on what to include in the training for the staff. The training included to not leave residents unattended in the shower room/bathroom, or on a bedside commode and to not transport any residents in a shower chair. She then utilized the call list to call staff who was not able to receive the training at the facility and provided the training over the phone.</p> <p>Interview with the ADON, on 12/27/13 at 10:06 AM, revealed she worked with the DON on what the contents of the training. Staff who was not present to get training in person were contacted by phone on 12/09/12. She stated she contacted the Medical Director on 12/09/13 to let him know what training had been done and to go over the allegation of compliance and update him.</p>	F 323			

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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1973.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1973 and upgraded in 2008, with 31 smoke detectors and 4 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1973.</p> <p>GENERATOR: Type II generator installed in 2008. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 12-18-13. Redbanks Colonial Terrace was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for eighty-seven (87) beds with a census of sixty-nine (69) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>			

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

*Rick Handrick*

TITLE

*Administrator*

(X6) DATE

*1-17-14*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to 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  REDBANKS COLONIAL TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 142 ROGER POWELL RD SEBREE, KY 42455		
(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	Continued From page 1 (Fire).	K 000	Regarding K052, the Facility took corrective action at the time the deficient practice was discovered, calling the contractor to schedule correction action. Correction has been made of the deficient practice by the fire inspection contractor as related to the issue of smoke detector sensitivity testing.	12/21/13	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4  This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for eighty-seven (87) beds with a census of sixty-nine (69) on the day of the survey. The facility failed to ensure all smoke detectors at the facility were properly tested at least once in the last two (2) years.	K 052	The deficient practice has been addressed, with no residents found to be affected by the deficient practice, and measures put in place to identify any deficient practice, so as to not impact any resident, as regards the same deficient practice.  Specifically, regarding measures taken to correct the deficient practice, and thus, place into practice measures to address systemic changes, the following has been done:  The Facility had a bi-annual sensitivity test completed by the contractor on 12-20-13, now showing all detectors are in compliance with 7-3.2.1. This report is on file at the Facility.  All future testing will be conducted as specified by 7-3.2.1.  The fire alarm maintenance contractor will be required to check in with the maintenance department upon their arrival. The contractor will identify the type test to be conducted. Upon completion, the contractor will personally address findings with the maintenance staff or designee, for verification.  The maintenance staff or designee will then sign off on the verification, ensuring compliance, to provide validation that solutions are sustained.  Additionally, to ensure the deficient practice does not re-occur, a monthly maintenance documentation sheet will include the date of the most recent sensitivity test AND the date of the next scheduled sensitivity test due. The maintenance department will contact the designated contractor in advance, to advise them when the next bi-annual sensitivity test is due. Training was provided to staff on 12-21-13 as regards the requirements for compliance and testing for smoke detector sensitivity testing. Staff trained were the Environmental Services Director; his assistant; Housekeeping/Laundry Supervisor; Director of Nursing; Assistant Director of Nursing; Administrator.		

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K 052	Continued From page 2  The findings include:  Review of the Fire Alarm Inspection, on 12/18/13 at 3:19 PM with the Maintenance Supervisor, revealed a Smoke Detector Sensitivity Test had been performed on the fire alarm smoke detectors on 10/04/11. The January report noted the last sensitivity test was performed on 10/04/11; and, the October report noted the testing was completed on 01/16/13. Smoke detectors must be tested according to NFPA 72 (1999 edition) to ensure their reliability.  Interview, on 12/18/13 at 3:19 PM with the Maintenance Supervisor, revealed he was unaware the facility did not have a current sensitivity test on all fire alarm smoke detectors. He stated he documented in his notes that the fire inspection company conducted the test on 01/16/13 per the company's report. He stated he contacted the fire inspection company and they stated they must have made a typo on the report and the testing wasn't completed.  Interview, on 12/18/13 at 5:35 PM with the Administrator, revealed he was unaware the proper testing of the smoke detectors had not been completed. He was under the impression that the testing was required annually and was unaware of when the last test was performed. He stated he was ultimately responsible to ensure the testing on the smoke detectors was completed at the appropriate time.  Reference: NFPA 72 (1999 edition)  7-3.2.1* Detector sensitivity shall be checked within 1 year after	K 052		

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K 052	Continued From page 3 installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the	K 052			

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K 052	Continued From page 4 listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.  Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.  Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2.  The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.	K 052			