

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

PRINTED: 11/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2013
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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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 A standard health survey was initiated on 10/22/13 and concluded on 10/24/13 with deficiencies cited at the highest scope and severity of an "F". A Life Safety Code survey was initiated and concluded on 10/22/13 with deficiencies cited at the highest scope and severity of a "D" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.	F 000	Rivers Edge Nursing & Rehab acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	
F 282 SS=D	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 observation, interview, record review and facility policy reviews, it was determined the facility failed to follow the comprehensive care plan in regard to contact precautions for Clostridium Difficile (C. Difficile) Colitis for one (1) of seventeen (17) sampled residents, Resident #11. The findings include: Review of the facility's Infection Control policy regarding Contact Isolation (dated August 2005, revealed there were bulleted steps for maintaining contact isolation. Specifically, staff were to utilize clean gloves when entering the	F 282	Rivers Edge Nursing & Rehab's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Rivers Edge Nursing & Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Rachel Carter* TITLE *X Administrator* (X6) DATE *11/12/13*

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

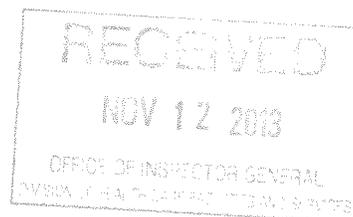
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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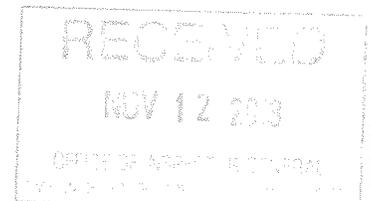
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F 282	Continued From page 1 resident's room, remove gloves and wash hands before leaving the resident's area, if the caregiver anticipated soiling his/her clothing he/she should wear a gown when caring for the resident, and remove/dispose of the gown before leaving the room. Review of the clinical record for Resident #11, revealed the facility admitted the resident on 04/03/13 with diagnoses of Spinal Stenosis, Paralytic Ileus, Anemia (unspecified), Asthma, Vitamin D Deficiency (unspecified), Osteoarthritis, Depressive Disorder, and Lack of Coordination. Review of the Quarterly Minimum Data Set (MDS), Section H, Bowel and Bladder Continence, completed on 09/21/13, revealed Resident #11 was always incontinent of bowel (no episodes of continent bowel movements). Further review of the clinical record revealed Resident #11 was diagnosed with C. Difficile Colitis on 10/07/13, and the physician prescribed an antibiotic. In addition, Resident #11's interdisciplinary care plan included a focus area for actual infection related to C-Difficile with contact isolation as an intervention, and the Certified Nursing Assistant (CNA) Care Guide listed contact isolation as a special precaution when caring for Resident #11. Observation on initial tour of the facility, on 10/22/13 at 8:25 AM, revealed contact isolation equipment including disposable gowns and gloves were available at the entrance to Resident #11's room. A sign was posted on Resident #11's door which read, gloves were to be worn when entering the room, gowns were to be worn if it was anticipated one's clothing would come in	F 282	F282 Services by qualified person/per care plan 1. Resident # 11 room was deep cleaned by the Housekeeping department on 10/24/2013 in an effort to prevent the spread of infection. Resident #11 was moved to a private room on 10/25/13. Resident #11 care plan was reviewed by the Interdisciplinary team there were no changes made to the plan of care. 2. All resident have the potential to be affected by cited deficiency. No other residents were identified to be under contact precautions. 3. Residents identified as needing contact precautions will be put in a private room if one is available. All staff were re-educated on 10/31/2013 and 11/8/13 by the Director of Nursing to include Resident #11 Comprehensive care plan including infection control/contact precautions for Clostridium Difficile	



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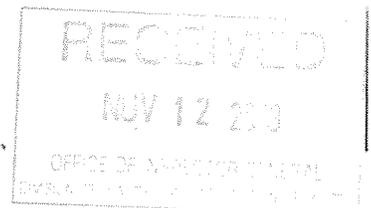
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F 282	<p>Continued From page 2</p> <p>contact with the resident, and hands were to be washed before leaving the room.</p> <p>Observation, on 10/22/13 at 12:14 PM during lunch meal tray pass, revealed CNA #1 delivered Resident #11's meal tray, used hand sanitizer, but did not don gloves upon entering the room. Resident #11 was seated in a wheelchair in the room, CNA #1 placed the tray on a counter top, assisted Resident #11 with set up of the tray, placed a clothing protector on Resident #11, and positioned the resident closer to the tray touching the handles of his/her wheelchair. Resident #11 requested iced tea which was not on the tray, and CNA #1 stated she would go get the tea, washed her hands, and left the room.</p> <p>Observation, on 10/22/13 at 12:26 PM, revealed CNA #1 returned to Resident #11's room with two (2) cups of iced tea, entered the room, did not don disposable gloves, placed the cups of tea on the resident's tray and removed the cups' lids. CNA #1 washed her hands prior to leaving the room.</p> <p>Interview, on 10/24/13 at 2:15 PM, with CNA #1 revealed she should have worn disposable gloves when assisting Resident #11 because she touched the resident's wheel chair and placed a clothing protector on Resident #11. In addition, CNA #1 stated her uniform could have been in contact with surfaces in the room while giving care to Resident #11. CNA #1 stated she was not certain, but thought she was last in-serviced on isolation precautions one week ago.</p>	F 282	<p>and infection control policies and procedures.</p> <p>All Licensed staff including the MDS coordinators have been re-educated by the Director of nursing on 10/31/2013 and 11/8/13 related to following the residents plan of care and infection control policies and procedures.</p> <p>All housekeeping and dietary staff have been educated on following infection control policy and procedures including putting on gloves when required and hand washing by Staff Facilitator and DON on 10/31/2013 and 11/8/13.</p> <p>All facility in-service training will be completed by 11/17/13.</p> <p>4. The MDS coordinator will review any resident , including the Care Plan, identified as being in isolation or contact precautions care plan upon implementation of isolation precautions and then weekly until the</p>		



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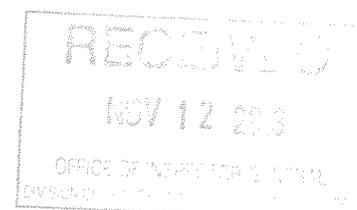
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F 282	<p>Continued From page 3</p> <p>Observation, on 10/24/13 at 11:15 AM, revealed Housekeeper #12 removed her disposable gown and gloves in the hallway after exiting Resident #11's room, and stuffed them in the biohazard bag she was carrying. Housekeeper #12 closed the bag, carried it down the hall, deposited the bag in the soiled utility room, and then went to a sink at the centrally located nurses' station to wash her hands.</p> <p>Interview, on 10/24/13 at 2:20 PM, with Housekeeper #12 revealed she should have washed her hands prior to leaving Resident #11's room, and she should not have carried the biohazard bag to the soiled utility with an un-gloved hand. Housekeeper #12 said she thought in her haste to get some help for Resident #11, who had just vomited, she forgot to utilize proper contact isolation procedures, and the risk could be the potential spread of infection to other residents and staff members. Housekeeper #12 stated her supervisor and/or the Director of Nursing (DON) reviewed isolation precautions with housekeeping staff twice per year.</p> <p>Interview, on 10/24/13 at 2:45 PM, with the Unit Manager (UM) revealed Resident #11 was placed in contact isolation and his/her care plan was revised to include contact isolation precautions as soon as the lab reported the stool positive for C-Difficile. If contact isolation precautions were consistently in effect as planned, and were practiced by all caregivers who performed care for Resident #11, the likelihood of cross contamination would be minimized. The CNA</p>	F 282	<p>resident is no longer in isolation. Any discrepancies will be addressed immediately with the Director of Nursing and Administrator</p> <p>The Staff Facilitator/Assistant DON will do weekly hand-washing audits on 10 facility staff members' for four weeks then 10 facility staff members' monthly for 3 months and then 10 facility staff members quarterly. All audits will be forwarded to the Director of Nursing and Administrator for review and follow up. The results of these audits will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during the QA process the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion date: 11/17/2013 11-18-13 <i>per J. Carlson</i> <i>by PB 11-15-13</i></p>	



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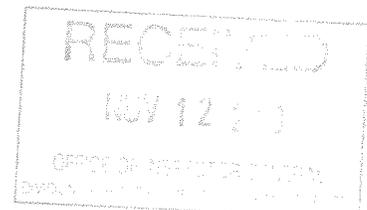
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F 282	Continued From page 4 care card reflected that Resident #11 was in contact isolation and those procedures should have been followed by all who entered Resident #11's room.	F 282			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to maintain an error rate of less than five (5) percent (%) during a medication pass. There were five (5) errors out of twenty-seven (27) opportunities, resulting in a 18.52% medication error rate for four (4) of seventeen (17) sampled and five (5) unsampled residents, Unsampled Residents A, B, C and D had errors during their medication administration. The findings include: Review of the facility's policy regarding The Administration of Eye Drops, undated, revealed the goal was to introduce liquid medication into the eye in an accurate and safe manner to cause the resident the least amount of apprehension and discomfort to the sensitive tissues of the eye, particularly to the cornea. The staff was to pull down the lower eyelid with the index or middle finger, creating a pouch and instruct the resident to look up. Steady the hand by placing it against the resident's forehead and place the prescribed	F 332	F-332 Free of medication error rate of 5% or greater 1. The physician for Unsampled resident B was notified immediately related to medication Nexium capsule being given after breakfast and refresh tear drops being installed directly to the residents' cornea. The physician for Unsampled resident C was notified immediately related to transcription error of Robitussin DM. the physician for Unsampled resident D was notified immediately related to G-tube medications being administered without water between each medication. No adverse reactions were identified and no new physician orders were received. 2. All residents had the potential to be affected by the cited deficiency. No other residents were identified.		



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F 332	<p>Continued From page 5</p> <p>number of drops of medication inside the lower eyelid close to the outer corner of the eye. Never drop medication directly on the sensitive cornea of the eye.</p> <p>Review of the facility's policy regarding the Receipt of Physician's Orders, undated, revealed the order should be subsequently entered on the resident's medication administration record (MAR) by the licensed nurse.</p> <p>Review of the facility's policy regarding the Administration of Oral Medication Through a Gastrostomy Tube, undated, revealed an irrigation of the G-tube with thirty milliliters (30 ml) of water would be administered to reduce the risk of clogging the tube.</p> <p>1. Observation in the hallway, on 10/23/13 at 8:24 AM, revealed Licensed Practical Nurse (LPN) #1, asked Unsampld Resident B, if they were back from breakfast and ready for their medications? Unsampld Resident B, nodded yes, and said, okay. LPN #1 was observed to administer Nexium capsule forty (40) milligram (mg), one (1) by mouth.</p> <p>Review of the physician's orders for Unsampld Resident B revealed a current order for Nexium capsule, forty (40) mg, one (1) by mouth daily and to take on an empty stomach. His/Her physician orders included the diagnosis of Gastroesophageal Reflux Disease.</p> <p>2. Observation, on 10/23/13 at 8:24 AM, revealed LPN #1 instilled one (1) drop on the cornea in both eyes of Unsampld Resident B as the resident squinted each eye with each drop.</p>	F 332	<p>3. All licensed staff and medication administration aides have been re-educated related to medication administration by the Staff Facilitator/Director of Nursing to include administering eye drops, following physician time orders, administering G-tube medication, the transcription of physician orders, and infection control procedures related to medication administration on 10/31/2013. All licensed staff and medication administration aides were checked off via testing for medication administration and infection control related medication administration on 10/31/2013. All licensed staff and medication administration aides also completed actual medication administration procedure post re-training with Staff Facilitator/Director of Nursing/Unit Manager initiated on 11/8/2013. Nurses identified specifically during annual survey as making medication errors have been re-educated by the Director of Nursing and checked off on medication administration and transcription of</p>	

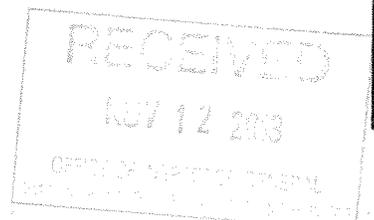


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F 332	Continued From page 6 Review of the physician orders for Unsampled Resident B revealed a current physician's order for Refresh Tear Drop, one (1) drop in each eye four times a day. 3. Observation, on 10/23/13 at 8:35 AM, revealed LPN #1 instilled Patanol Solution 0.1%, one (1) drop in each eye on the cornea in Unsampled Resident B's eyes. The resident squinted each eye with each drop instilled. Review of the physician's orders for Unsampled Resident B revealed a current order for Patanol Solution 0.1%, one (1) drop to each eye twice a day. Interview, on 10/23/13 at 8:45 AM, with LPN #1 revealed she had been trained on how to instill eye drops. She stated, the resident was difficult to put the eye drops in because he/she did not hold their eyes open. She reported, she had been in-serviced on how to administer medications. 4. Observation, on 10/23/13 at 8:51 AM, revealed LPN #2 administered Robitussin DM, five (5) milliliters (ml) by mouth to Unsampled Resident C. Review of the physician orders for Unsampled Resident C, dated 10/21/13, revealed Robitussin DM, fifteen (15) ml by mouth every four (4) hours for cough was ordered. Interview, with LPN #2, on 10/23/13 at 1:20 PM, revealed she had received training on medication pass and also had attended in-services at the facility. She reviewed the physician orders and reported she incorrectly transcribed the order as	F 332	physician medication orders. All facility in-service training will be completed by 11/17/2013. 4. Staff Facilitator/Assistant DON will complete medication administration audits weekly for 4 weeks to include all Licensed staff/medication administration aide with potential to administer medications within the month. Staff Facilitator/Assistant DON will complete medication administration audits with five Licensed staff/medication administration aide monthly for 5 months, then quarterly. All findings will be forwarded to the Director of Nursing/Administrator for review and follow up if indicated. The results of these audits will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance. 5. Completion date: 11/17/13	

11-18-13 per J. Carlson
by PB 11-15-13



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F 332	<p>Continued From page 7</p> <p>Robitussin DM five (5) ml and it should have read on the medication administration record as fifteen (15) ml. She stated she took it off and it was written incorrectly. She stated, the staff reviewed the new orders on the night shift.</p> <p>5. Observation of the medication pass for Unsampled Resident D, on 10/23/13 at 11:55 AM, revealed LPN #1 administered crushed medications via G-Tube without a flush, followed by Vitamin C liquid via G-Tube. LPN #1 continued to administer Keppra liquid, Reglan liquid without water flushes between each medication administered via the G-Tube.</p> <p>Interview, on 10/23/13 at 6:07 PM, with LPN #1 revealed she was trained on medication administration with G-Tubes. She stated, she should have flushed the G-Tube with water between each medication.</p> <p>Review of the in-service training reports with staff attendance, dated 06/13/13 at 1:00 PM, revealed subjects covered, included medication pass and documentation. LPN #2 signed the in-service attendance record. Record review of the in-services training report with staff attendance, dated 06/27/13 at 1:00 PM, revealed subjects covered, included medication pass and documentation. LPN #1 signed the in-service attendance record.</p> <p>Interview, on 10/24/13 at 2:27 PM, with the Director of Nurses (DON) revealed the night shift verifies the physician orders have been signed off. She reported they do not check for accuracy of the transcription. She revealed the staff had been in-serviced on medication administration. The DON further stated the nursing staff should</p>	F 332			

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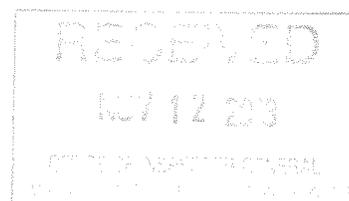
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F 332	Continued From page 8 have flushed the G-Tube between medications and eye drops should have been administered correctly.	F 332			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure food was stored under sanitary conditions. Five (5) food products stored in Side By Side Freezer #2 were not labeled with the opened date. One (1) of the five food products in Freezer #2 was not sealed properly and left open to air. The findings included: Review of the facility's policy titled, Purchasing and Storage, dated August 2013, revealed food and stock items were to be dated and rotated. The policy did not mention proper procedures for storage of frozen items concerning labeling with opened dates and sealing opened items from air. Observation of the side by side freezer #2, on	F 371	F-371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY 1. All food items identified to be not stored, labeled or dated correctly were disposed immediately upon observation on October 22, 2013. 2. All residents had the potential to be affected by cited deficiency. No other food items were identified to be stored, labeled/dated incorrectly. 3. The Dietary Manager was in-serviced by the Administrator on 10/31/13 on the facility Purchasing and Storage Policy regarding proper storage, labeling and dating food items. The Dietary Manager initiated in-service training for all dietary staff on October 31, 2013 regarding proper storage, labeling and dating food items.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2013
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
(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 371	Continued From page 9 10/22/13 at 8:30 AM, during the initial kitchen tour, revealed one (1) package of frozen Fujita chicken, one (1) package of frozen biscuits, one (1) package of frozen tater tots, and one (1) package of dinner rolls were opened and not labeled with the opened date. Another package of frozen Fujita chicken was observed opened, not labeled with the opened date or sealed to air. Interview with the Dietary Manager (DM), on 10/22/13 at 9:00 AM, revealed she was new in her position and had only worked at the facility for two months. The DM revealed there was no way to know how long these food items had been opened. The items not labeled with open dates and the item opened to air could become stale, taste badly, or become contaminated.	F 371	All Dietary Staff will be in-serviced by Dietary Manager and Staff Facilitator by November 17, 2013. 4. The Dietary Manager will audit daily the freezers, walk-in cooler and dry storage area for proper storage, labeling and dating of food items, Monday – Friday, and the AM Cook/Helper will audit on Saturday and Sunday. The Dietary Manager will review the weekend audits on		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	<i>Continued next page</i> F441 Infection control, prevent spread, Linens 1. Resident #11 room was cleaned by the housekeeping department on 10/24/2013. On 10/25/2013 resident #11 was moved into a private room. 2. All residents have a potential to be affected but no other residents, including Resident #2, were identified		



7371 - (Cont)

Monday. Any discrepancies will be addressed immediately.

The audits will be conducted daily for a minimum of 30 days, weekly and PRN for 3 months and then monthly and PRN thereafter.

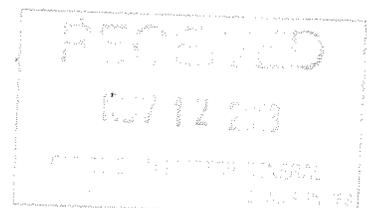
All findings will be forwarded to the Administrator for review and follow up if indicated per the daily/weekly/monthly audits beginning November 1, 2013. The results of these audits will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance.

5. Completion date: ~~11-17-2013~~

11-18-13

per J. Corbin

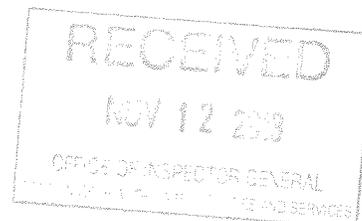
by PG 11-15-13



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F 441	<p>Continued From page 10</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy reviews, it was determined the facility failed to provide an Infection Control Program to ensure a safe, sanitary environment as evidenced by staff that failed to consistently practice contact isolation precautions for one (1) of seventeen (17) sampled residents. The facility staff failed to use proper hand hygiene when caring for Resident #11, in addition, the facility staff failed to properly cohort Resident #11 with a non-infected resident per the Centers for Disease Control (CDC) guidelines. In addition, staff members failed to practice proper hand hygiene during the medication pass.</p> <p>The findings include:</p>	F 441	<p>with a positive or suspected C-Difficile infection.</p> <p>3. A resident identified with an infection that requires isolation will be placed in a private room if available or will be cohorted with residents with the same infection.</p> <p>All facility staff members were educated on the infection control policy procedure by the Staff Facilitator/Director of Nursing to include isolation procedures, hand washing and wearing gloves on 10/31/2013 and again on 11/8/2013.</p> <p>All housekeeping staff members have been re-educated on infection control policy and procedures by the Housekeeping supervisor/Director of Nursing on 10/31/2013 and again on 11/8/2013.</p> <p>All facility in-service training will be completed by 11/17/13.</p>	



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F 441	<p>Continued From page 11</p> <p>Review of the facility's Infection Control policy regarding Contact Isolation (dated August 2005), revealed a private room was preferred for residents with diagnoses that required contact isolation. However, if a private room was unavailable, residents with the same infection may be cohorted. In addition, there were bulleted steps for maintaining contact isolation. Specifically, staff was to utilize clean gloves when entering the resident's room; and remove gloves and wash their hands before leaving the resident's area. If the caregiver anticipated soiling his/her clothing he/she should wear a gown when caring for the resident, and remove/dispose of the gown before leaving the room. The Centers for Disease Control (CDC) was listed as a reference for this policy.</p> <p>Review of the CDC guidelines for Contact Isolation, dated 11/25/10 and last reviewed 03/06/12, revealed persons with known or suspected C-Difficile were to be placed in private rooms. If private rooms were unavailable, patients could be cohorted with other patients with a C-Difficile infection. Gloves were to be used when entering the patient's room, and during patient care. Hands should be washed with soap and water after glove removal and gowns were to be used when entering the patient's room and during care. In addition, contact isolation should continue until the diarrhea has ceased.</p> <p>1. Observation, on 10/22/13 at 8:25 AM during initial tour of the facility, revealed Resident #11 and Resident #2 resided in the same room. Contact precautions were in effect for Resident</p>	F 441	<p>4. The Staff Facilitator/Assistant Director of Nursing will do ten hand-washing infection control audits weekly for four weeks then monthly for 3 months then quarterly after that. Director of Nursing/Unit Manger/Weekend Supervisor will review all residents with infection diagnosis upon admission or initial diagnosis of said infection to ensure isolation precautions are in place. Director of Nursing/Unit Manager will monitor all residents with infections weekly until the resident is no longer in isolation The results of these audits will be forwarded to the Director of Nursing and Administrator for review. The results of these audits will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion date: 11/17/13 11-18-13 per J. C. Rubin</p>

ky PB 11/15/13



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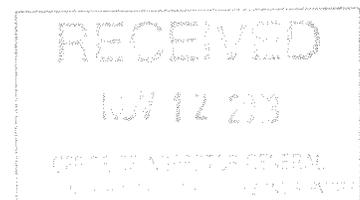
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F 441	<p>Continued From page 12</p> <p>#11, with personal protective equipment (PPE) available for use at the entry way. A sign was posted on the door which read, gloves were to be worn when entering the room, gowns were to be worn if it was anticipated one's clothing would come in contact with the resident, and hands were to be washed before leaving the room.</p> <p>Review of the clinical record for Resident #11, revealed the facility admitted the resident on 04/03/13 with diagnoses of Spinal Stenosis, Paralytic Ileus, Anemia (unspecified) Asthma, Vitamin D Deficiency (unspecified), Osteoarthritis, Depressive Disorder, and Lack of Coordination. Review of the Minimum Data Set (MDS), Section H, Bowel and Bladder Continence, completed on 09/21/13, revealed Resident #11 was always incontinent of bowel (no episodes of continent bowel movements). Further review of the clinical record revealed Resident #11 was diagnosed with C. Difficile Colitis on 10/07/13, and the physician prescribed and antibiotic. In addition, Resident #11's interdisciplinary care plan included a focus area for actual infection related to C-Difficile with contact isolation as an intervention, and the Certified Nursing Assistant (CNA) Care Guide listed contact isolation as a special precaution when caring for Resident #11.</p> <p>Review of the clinical record for Resident #2, revealed the facility admitted the resident on 06/07/11 with diagnoses of Closed Head Injury, Seizure Disorder, Neurogenic Bladder, Diabetes, Dementia, Metabolic Encephalopathy, History of Sepsis, Constipation, and Chronic Obstructive Pulmonary Disease (COPD). There was no evidence in the clinical record that Resident #2</p>	F 441		
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F 441	<p>Continued From page 13</p> <p>currently had or had a history of a C-Difficile infection. Review of the Minimum Data Set (MDS) Quarterly assessment, dated 08/17/13, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 10, and section H of the MDS revealed the resident had an indwelling urinary catheter.</p> <p>Interview, on 10/22/13 at 8:25 AM, with the Unit Manager during the initial tour revealed Resident #11 in bed A was currently under treatment for C-Difficile Colitis, and contact isolation was in effect because he/she continued to have loose stools. The UM stated Resident #11 was incontinent of bowel, and wore a brief to contain his/her stool and urine. Resident #2 in bed B did not have a diagnosis of C-Difficile; was not under contact isolation precautions; had an indwelling urinary catheter, liked to be out in the activity areas of the facility on most days; and slept in the room at night and napped there in the afternoons.</p> <p>Interview, on 10/23/13 at 8:30 AM, with LPN #3 revealed catheter care was performed each shift for Resident #2, and a new leg bag was attached daily. She stated catheter care had been performed earlier during the shift as this was the resident's routine most days upon rising.</p> <p>2. Observation, on 10/22/13 at 12:14 PM, during lunch meal tray pass, revealed Certified Nursing Assistant (CNA) #1 delivered Resident #11's meal tray, used hand sanitizer, but did not don gloves upon entering the room. Resident #11 was seated in a wheelchair in the room. CNA#1 placed the tray on a counter top, assisted Resident #11 with</p>	F 441		
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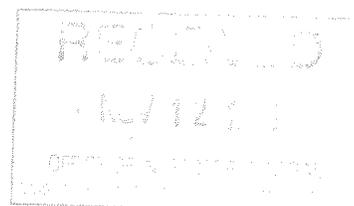
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F 441	<p>Continued From page 14</p> <p>set up of the meal tray, placed a clothing protector on Resident #11, and positioned the resident closer to the tray touching the handles of the resident's wheelchair. Resident #11 requested iced tea for lunch which was not on the tray. CNA #1 stated she would go get tea for the resident, washed her hands and left the room.</p> <p>Continued observation, on 10/22/13 at 12:26 PM, revealed CNA #1 returned to Resident #11's room with two (2) cups of iced tea, entered the room, did not don disposable gloves, placed the cups of tea on the resident's tray and removed the cup lids. CNA #1 washed her hands prior to leaving the room.</p> <p>Interview, on 10/24/13 at 2:15 PM, with CNA #1 revealed she should have worn disposable gloves when assisting Resident #11 because she touched the resident's wheel chair and placed a clothing protector across Resident #11's chest. In addition, CNA #1 stated her uniform could have been in contact with surfaces in the room while giving care to Resident #11. CNA #1 stated she was not certain, but thought she was last in-serviced on isolation precautions one week ago.</p> <p>3. Observation, on 10/24/13 at 11:15 AM, revealed Housekeeper #12 removed her disposable gown and gloves in the hallway after exiting Resident #11's room, and stuffed them in the biohazard bag she was carrying. Housekeeper #12 tied the bag and carried it down the hall, deposited the bag in the soiled utility room and went to a sink at the centrally</p>	F 441		



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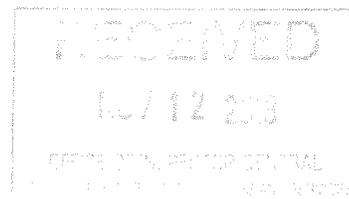
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F 441	Continued From page 15 located nurses' station to wash her hands. Interview, on 10/24/13 at 2:20 PM, with Housekeeper #12 revealed she should have washed her hands before leaving Resident #11's room, and she should not have carried the biohazard bag to the soiled utility room with her ungloved hand. Housekeeper #12 said she thought in her haste to get some help for Resident #11, who had just vomited, she forgot to utilize proper contact isolation procedures. Housekeeper #12 stated the lack of consistent hand hygiene and improper transport of biohazard waste created a risk for the spread of infection to other residents and staff members. Housekeeper #12 stated her Supervisor and/or the Director of Nursing (DON) reviewed isolation precautions with housekeeping staff twice per year. Interview, on 10/24/13 at 2:45 PM, with the Unit Manager (UM) revealed Resident #11 was placed in contact isolation and his/her care plan was revised to include contact isolation precautions as soon as the lab reported the stool was positive for C-Difficile. A private room would be ideal for residents in contact isolation if a room was available, but if the resident was bed ridden like Resident #11, then a private room was not necessary. If contact isolation precautions were consistently in effect as planned and practiced by all caregivers who performed care for Resident #11, then any cross contamination was minimized. The UM stated indwelling catheter care and other care areas for Resident #2 were performed by trained nursing staff, and it was unlikely cross contamination would occur. The	F 441		



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F 441	<p>Continued From page 16</p> <p>UM stated the direct care staff should have worn gloves during the meal service for Resident #11, and the housekeeper should have washed her hands before leaving Resident #11's room, regloved at least one hand to transport the red bag waste, removed the glove after depositing the bag in the soiled utility room, and then she should have washed her hands at the nearest sink. The CNA care card reflected that Resident #11 was in contact isolation and those procedures should have been followed by all who entered his/her room.</p> <p>Interview, on 10/24/13 at 2:35 PM, with the Staff Development/Educator/ Infection Control Nurse revealed contact isolation was implemented for Resident #11 on the day the first stool culture was obtained and tested, and staff members were in-serviced on contact isolation the day it went into effect for Resident #11. Further, the resident's physician would have to order discontinuation of contact isolation precautions. The Staff Development Nurse said the particular organism, and situations particular to each resident determined whether a private room was necessary or if it would be acceptable to cohort him/her with an uninfected resident. For example, if the infected stool was contained in a brief, as in the case of Resident #11, then a roommate who did not have the same infection could live in the room. Further, as a result of the contact isolation status for Resident #11, the staff frequently sanitized surfaces in the room, and since trained staff performed catheter care, she did not think there was a risk for cross contamination.</p> <p>Interview, on 10/24/13 at 3:05 PM with the</p>	F 441		



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F 441	<p>Continued From page 17</p> <p>Director of Nursing (DON), revealed there was not a private room available for Resident #11 at the time of his/her C-Difficile diagnosis, due to room renovations that were underway in the facility. Further, both Resident #2 and Resident #11 were incontinent and did not use the toilet in the room, and since trained nurses provided the direct cares for both residents, the risk for cross contamination was minimal.</p> <p>4. Review of the facility's Handwashing Policy, dated August 2005, revealed personnel were required to wash their hands after each direct or indirect resident contact for which handwashing was indicated by acceptable standards of practice. Personnel should wash their hands after the removal of gloves and between resident contacts. In addition, when indicated between tasks and procedures to prevent cross contamination of different body sites.</p> <p>Observation of Resident #3, on 10/23/13 at 11:33 AM, upon entering the resident room revealed Licensed Practical Nurse (LPN) #1 performed a blood glucose check. Upon completion, of the procedure, she removed her gloves and proceeded with a nebulizer treatment. She removed her items of trash from the setting and disposed of the items. She did not complete hand hygiene after disposal of trash. She proceeded to care for the resident's room mate. She resumed care of Resident #3 without completion of hand hygiene between resident care.</p> <p>Interview, with LPN #1, on 10/23/13 at 3:20 PM, revealed she was trained and in-serviced on hand</p>	F 441			



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F 441	Continued From page 18 hygiene practices. She stated it was okay to wear the gloves instead of washing her hands between the residents. She stated, it was okay because she wore gloves and washed her hands when she left the room. Review of the In-Service Training Report, dated 06/27/13, revealed the subjects covered included infection control. The agenda included handwashing and changing gloves. The sign in record revealed LPN #1 signed in attendance. Interview, with the Director of Nursing (DON), on 10/24/13 at 2:27 PM, revealed hand hygiene should be completed: between tasks; upon removal of gloves; and between resident care. She reported the failure to complete hand hygiene was a concern for cross contamination between residents. She stated, hand hygiene inservices were conducted for the staff.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure two (2) of two (2) unlocked restrooms, accessible to residents, were equipped with an emergency call system to directly communicate their needs to staff.	F 463	F-463 483.70(f) RESIDENT CALL SYSTEM – ROOMS/TOILET/BATH 1. The door closure to the staff bathroom by the nurses' station was adjusted immediately upon surveyor observation to ensure automatic closing on October 22, 2013. The door closure to the staff bathroom by the front lobby was adjusted on October 25, 2013 to ensure automatic closing.	



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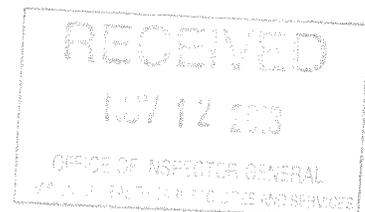
F 463	<p>Continued From page 19 The findings include:</p> <p>The facility provided no policy on emergency call lights.</p> <p>Observation during the initial tour, on 10/22/13 at 9:55 AM, of the bathroom located in the nurses station area revealed the two bathroom doors were unlocked and resident accessible. The bathrooms did not have an emergency call light.</p> <p>Continued observation of these bathrooms, on 10/23/13 at 8:00 AM, located in the hallway revealed the bathroom doors were ajar, the doors were unlocked and resident accessible.</p> <p>Additional observation of the bathrooms, on 10/23/13 at 1:00 PM, revealed the doors remained unlocked and remained resident accessible.</p> <p>Observation, on 10/24/13 at 5:10 PM, revealed the restrooms located in the hallway, were unlocked. These restrooms remained accessible to the residents and there was no emergency call system in place to meet the residents' need.</p> <p>Interview, on 10/24/13 at 2:05 PM, with the Maintenance Director revealed the two (2) restrooms identified without an emergency call light system was designated for staff and visitor use. He continued to state everyone was responsible to ensure these restroom doors remained locked for resident safety. However, without an emergency call light system in the restroom a resident had no means to communicate their needs to staff.</p> <p>Interview with the Director of Nurses (DON), on</p>	F 463	<p>2. All residents had the potential to be affected by this cited deficiency. No other bathroom doors were identified.</p> <p>3. Daily monitoring of the two cited doors to staff bathrooms was initiated November 4, 2013. Resident call lights are scheduled to be installed by November 15, 2013. All staff in-service training was initiated by the Staff Facilitator on October 31, 2013. The Maintenance Director, Maintenance Assistant, and Weekend Nursing Supervisor were in-serviced by the Administrator on November 6, 2013. In-service training will be completed for all staff by the Staff Facilitator by November 17, 2013.</p> <p>4. Daily audits will be completed by the Maintenance Director and/or Maintenance Assistant, Monday through Friday, and by the Weekend Nursing Supervisor, Saturday and Sunday. The Maintenance Director or</p>	
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
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F 463	<p>Continued From page 20</p> <p>10/24/13 at 2:15 PM, revealed the two (2) locked restrooms were identified for staff use. She continued to state staff had been inserviced on the importance of keeping the restroom doors locked due to no pull cord or call light system in place. The DON stated the importance of the emergency call light system was for residents to contact staff if needed.</p> <p>Interview with the Administrator, on 10/24/13 at 2:20 PM, revealed the purpose of the emergency call light system was for the residents to communicate to staff when assistance was needed.</p>	F 463	<p>Maintenance Assistant will review the audits from the weekend on Monday. Any discrepancies will be addressed immediately.</p> <p>The audits will be conducted daily for a minimum of 30 days, weekly and PRN for 3 months and then monthly and PRN thereafter.</p> <p>All findings will be forwarded to the Administrator for review and follow up if indicated per the daily/weekly/monthly audits beginning November 4, 2013. The results of these audits will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion date: 11-17-2013 <i>11-18-13</i> <i>per g carlin</i> <i>by PB 11/15/13</i></p>	



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K 000	<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 V (111)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II, 175 KW generator, installed new in 2009. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/22/13. Rivers Edge Nursing and Rehab Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has one-hundred (100) certified beds and the census was eighty-two (82) 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>Rivers Edge Nursing & Rehab acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Rivers Edge Nursing & Rehab's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Rivers Edge Nursing & Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p>	

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

X [Signature]

TITLE

X Administrator X

(X6) DATE

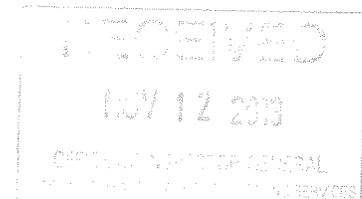
11/12/13

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

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K 000	Continued From page 1	K 000	<p>K027</p> <ol style="list-style-type: none"> The cross-corridor coordinator to the hallway door on First Street was adjusted immediately upon surveyor observation on October 22, 2013 to ensure the door closed completely. Life Safety Code Surveyor was present to ensure the cross-corridor door closed correctly after the coordinator was adjusted. All residents had the potential to be affected by this cited deficiency. No other cross-corridor doors were identified as not closing properly. Daily monitoring of all the cross-corridor doors was initiated on November 4, 2013. All staff in-service training was initiated by the Staff Facilitator on October 31, 2013. The Maintenance Director, Maintenance Assistant, and Weekend Nursing Supervisor were in-serviced by the Administrator on November 6, 2013. In-service training will be completed for all staff by November 17, 2013. Daily audits will be completed by the Maintenance Director and/or Maintenance Assistant, Monday 	
K 027 SS=D	<p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors, located in a smoke barrier, would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, approximately forty (40) residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was eighty-two (82) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/22/13 at 8:52 AM, with the Director of Maintenance revealed the cross-corridor doors located in the First Street Hall would not completely close when tested, leaving a gap of approximately three (3) inches at</p>	K 027		



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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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K 027 Continued From page 2
the head of the doors in the closed position. The pair of doors could not close completely and resist the passage of smoke in the event of an emergency.

Interview, on 10/22/13 at 8:52 AM, with the Director of Maintenance revealed he was not aware of the pair of doors not completely closing and not being capable of resisting the passage of smoke in the event of an emergency. Further interview with the Director of Maintenance revealed the door coordinating device had malfunctioned and needed adjusting.

Reference: NFPA 101 (2000 edition)

8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.

Reference: NFPA 80 (1999 Edition)

Standard for Fire Doors 2-3.1.7
The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.

K 147
SS=D NFPA 101 LIFE SAFETY CODE STANDARD

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

K 027 through Friday, and by the Weekend Nursing Supervisor, Saturday and Sunday. The Maintenance Director or Maintenance Assistant will review the audits from the weekend on Monday. Any discrepancies will be addressed immediately.

The audits will be conducted daily for a minimum of 30 days, weekly and PRN for 3 months and then monthly and PRN thereafter.

All findings will be forwarded to the Administrator for review and follow up if indicated per the daily/weekly/monthly audits beginning November 4, 2013. The results of these audits will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance.

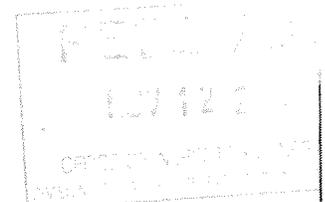
5. Completion date: 11-17-2013
11-18-13
per J. Collier
Ry 10-11-13



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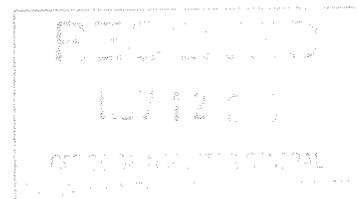
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K 147	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was eighty-two (82) on the day of the survey. The facility failed to ensure three (3) feet of clearance around one (1) electrical panel.</p> <p>The findings include:</p> <p>Observation, on 10/22/13 at 9:33 AM, with the Director of Maintenance revealed the electrical panel within the Janitor's Closet, located in the Second Street Hall, had boxes of records stored within 3 feet of the panel.</p> <p>Interview, on 10/22/13 at 9:33 AM, with the Director of Maintenance revealed he was unaware of the boxes of records being temporarily stored within three (3) feet of the electrical panel.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p>	K 147	<p>K147</p> <ol style="list-style-type: none"> The boxes of records identified to be in the Janitor's Closet on Second Street were removed immediately upon surveyor observation on October 22, 2013 to ensure no items were stored within 3 feet of the electrical panel. All residents had the potential to be affected by the cited deficiency. No other electrical panels were identified to have any items stored within 3 feet. Daily monitoring of all the electrical panels was initiated on November 4, 2013. All staff in-service training was initiated by the Staff Facilitator on October 31, 2013. The Maintenance Director, Maintenance Assistant, and Weekend Nursing Supervisor were in-serviced by the Administrator on November 6, 2013. In-service training will be completed for all staff by November 17, 2013. Daily audits will be completed by the Maintenance Director and/or Maintenance Assistant, Monday through Friday, and by the Weekend



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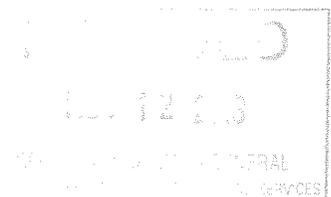
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K 147	<p>Continued From page 4</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="2">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th>Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>601-1000</td> <td>900 mm (3 ft)</td> <td>1 m (3 1/2 ft)</td> </tr> <tr> <td>1001-1500</td> <td>900 mm (3 ft)</td> <td>1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall</p>	Nominal Voltage to Ground	Minimum Clear Distance		Condition 1	Condition 2	Condition 3	0-150	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	900 mm (3 ft)	601-1000	900 mm (3 ft)	1 m (3 1/2 ft)	1001-1500	900 mm (3 ft)	1.2 m (4 ft)	K 147	<p>Nursing Supervisor, Saturday and Sunday. The Maintenance Director or Maintenance Assistant will review the audits from the weekend on Monday. Any discrepancies will be addressed immediately.</p> <p>The audits will be conducted daily for a minimum of 30 days, weekly and PRN for 3 months and then monthly and PRN thereafter.</p> <p>All findings will be forwarded to the Administrator for review and follow up if indicated per the daily/weekly/monthly audits beginning November 4, 2013. The results of these audits will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion date: 11-17-2013 <i>11-18-13</i> <i>per G. Colvin</i></p> <p><i>per PG 11-15-13</i></p>
Nominal Voltage to Ground	Minimum Clear Distance																				
Condition 1	Condition 2	Condition 3																			
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K 147	Continued From page 5 not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond	K 147			



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K 147	Continued From page 6 the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment,	K 147		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2013	
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
(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 7 switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.	K 147		

