

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

PRINTED: 03/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2011
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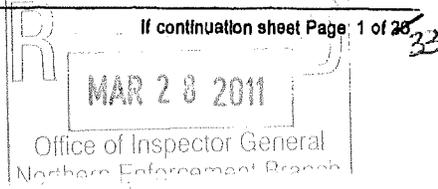
NAME OF PROVIDER OR SUPPLIER ROSEDALE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4260 GLENN AVENUE COVINGTON, KY 41015
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F 000	INITIAL COMMENTS A standard health survey was conducted 02/28/11 through 03/03/11 and a Life Safety Code survey was 03/02/11 through 03/03/11. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated survey investigating KY00015281 and KY00015022 was initiated 02/28/11 and concluded 03/03/11. KY00015281 was unsubstantiated. KY00015022 was substantiated and deficiencies cited were 483.15 Quality of Life F246 at a S/S if an "E".	F 000	PLAN OF CORRECTION: The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care. This plan of correction also serves as our allegation of compliance as of April 15, 2011.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain dignity for three (3) of thirty-four (34) sampled residents and two (2) unsampled residents during the meal service. Observation of the noon meal service on 03/02/11 revealed Resident #3, #10, #17 and unsampled residents waiting for 20-30 minutes for food while the other residents at the table were eating and staff standing to assist residents with eating. The findings include:	F 241	F241 DIGNITY AND RESPECT OF INDIVIDUALITY Rosedale Manor's team of care providers remains committed to promoting care for our residents in a manner and environment that maintains or enhances each of our resident's dignity and respect in full recognition of his or her individuality. With regards to all meal services, the charge nurse(s) are ultimately responsible to assist with meal service, regardless of the nurse aide staffing level. During the survey, the practice for meal delivery included that all residents on the floor (both 2N and 2S) participated in the meal service at the same time and each nurse aide was responsible for ensuring timely meal service for the residents on their	4/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sherida Knollman* TITLE Administrator (X6) DATE 3/05/11

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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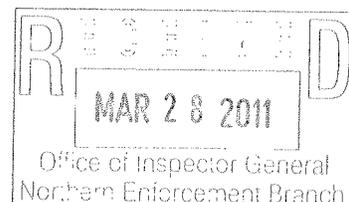
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F 241	<p>Continued From page 1</p> <p>Review of the facility policy regarding serving meals on 03/03/11 revealed ...13. Be alert to the dangers of choking while residents are eating; and 14. Be sure that everyone is served.</p> <p>Review of the facility policy for feeding the resident states the staff should provide complete attention to the resident and refrain from causing the resident to feel hurried, and provide a pleasant experience during mealtime.</p> <p>Observation of the noon meal on 03/01/11 at 12:00pm revealed Resident #3 sitting in the dining room at the table with two other unsampled residents. Each unsampled resident was served a lunch tray at 12:15pm and 12:30pm. Resident #3 continued to sit at the table watching the other two residents eating and was not served a tray. Staff was observed to remove Resident #3 from the table and take to the resident's room for toileting, then returned the resident to a different table; however, observation at 12:40pm revealed Resident #3 was taken to a different table where 5 residents were eating their lunch. Continued observation revealed the resident was not served a tray until 12:52pm.</p> <p>Observation of the noon meal on 03/02/11 at 11:50pm revealed Resident #10 pouring out small amounts of milk into a napkin, then picked up the napkin and drank the excess milk from the napkin, at which time the resident was observed to repeat this action. Observation revealed that after the napkin was saturated, the resident took a large bite of the napkin and appeared to chew and swallow the large piece of napkin. Observation revealed eight (8) staff members in the dining room with no action taken. After surveyor intervention, the licensed nurse removed</p>	F 241	<p>particular assignment only. Each nursing assistant was also responsible to pass trays to their assigned residents who consume meals in their rooms. Due to the number of residents in the dining room, the number of residents who eat in their room and the specific assignments for each aide, this practice resulted in a potential delay in meal service to residents. To improve the delivery time for meals, changes will be made to the current procedure.</p> <p>With regards to resident #3, monitoring has been completed by the nurse manager, charge nurse, and dietary manager to ensure that the resident receives her tray in a timely manner consistent with others seated and eating at her table. Resident #3 has received her meals in a timely manner.</p> <p>With regards to resident #10, monitoring has been completed by the nurse manager, charge nurse, and dietary manager to ensure that the resident receives her tray in a timely manner as to minimize the chance that she will place non-food items in her mouth. Resident #10's care plan was updated on 3/2/11 by the RAI nurse to reflect that she has a tendency to put non-food items in her mouth, that she requires supervision during meals, and a request was made to dietary to remove edible, non-food items from the tray.</p> <p>Observation of resident #10 has not</p>	
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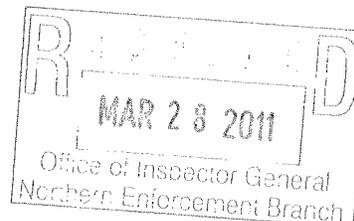
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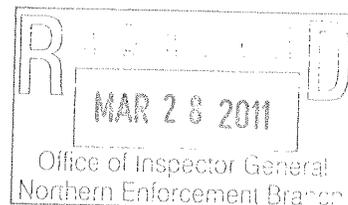
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F 241	<p>Continued From page 2</p> <p>a 2 inch compressed ball of the napkin with a gloved hand, which had pocketed in Resident #10's mouth.</p> <p>Interview with CNA #1 on 03/03/11 at 11:35am revealed they always start with table #1 and if we see four to six residents sitting at the table, we should always serve everyone together. CNA #1 stated they don't always know how long the residents sit with no tray, because sometimes it gets confusing. CNA #1 stated there is a seating arrangement to help with this.</p> <p>Interview with Licensed Practice Nurse (LPN) #1 on 03/03/11 at 11:35am revealed the Certified Nurse Assistants (CNA) runs the dining service during meal times and primarily the licensed staff only provides assistance when there is a CNA shortage for the shift. LPN #1 stated they don't always know how long the residents sit with no tray, because sometimes it gets confusing. LPN #1 stated there is a seating arrangement to help with this. LPN #1 reported it is definitely a dignity issue when residents are not served and there is a long wait between service when residents are sitting at the same table and eating their meal.</p> <p>Observation on 03/01/11 at 12:45pm during lunch service in the second floor dining area revealed that CNA #6 stood while assisting two (2) unsampled residents with lunch. CNA #8 stood and assisted another unsampled resident with lunch.</p> <p>Observation on 03/02/11 at 12:15pm during lunch service in the second floor dining area revealed the first tray was served at the table near the television where eight (8) female unsampled</p>	F 241	<p>shown her to put any non-food items in her mouth.</p> <p>With regards to resident #17 and other unsampled residents, staff has been monitored by the nurse manager, charge nurse, and dietary manager during meals and has been observed to be sitting while assisting residents with meals.</p> <p>All nursing and dietary staff will be inserviced as of April 8, 2011, by the staff development coordinator, charge nurse, supervisor, nurse manager, ADON, Dietary Manager or designee on the changes to the procedure for meal service on the 2nd floor, to include the following: (1) the meal service will be divided into two sittings, with a goal to decrease the number of residents waiting to be served at any one time (ideally approximately 50 residents per seating, as opposed to the current procedure of approximately 100 residents on the floor coming to the dining room at the same time). (2) Each nursing assistant will have a specific assignment, to include either serving meals to residents in the dining room, serving meals to residents in their rooms or answering call lights. (3) Residents will be served their meal tray in the order they come into the dining room, priority will be given to any person that enters the dining room for a meal who sits at a table with any person already eating their meal. Should</p>	



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more than one resident enter the dining room and seat themselves with others who are already eating, priority will be given to the person who entered first, followed by each person who is found to be sitting at a table where others are eating. (4) to assist with this process, a designated person, (to include, but not limit to, charge nurse, nurse manager, RAI nurse, unit clerk, CMA, nurse aide, ancillary department member or other staff member), will be assigned to monitor (hostess) the dining room at all times while meals are being served. The purpose of this hostess will be to monitor and ensure that all residents are offered something to drink while waiting for their meal, that all residents are served in a timely manner, that all residents at a table are served together according to the set criteria, to track the order in which residents enter the dining, and to monitor the room for any issues related to any potential dangers or choking and to intervene immediately when warranted (5) should any delay in meal service be identified, notification should be made to the Nurse Manager, Nursing or Dietary Supervisor, Dietary Manager and / or DON so that additional assistance can be provided. (6) Staff shall start serving at the table where the first resident is seated. Although meal service may not begin immediately upon a resident arriving to the dining room, service shall start with the resident

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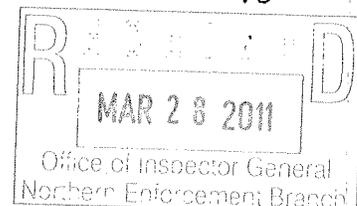
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F 241	Continued From page 3 residents were seated. The final tray was served to the table at 12:40pm where some residents waited thirty (30) minutes to be served as other residents ate lunch. Observation on 03/02/11 at 12:25pm during lunch service in the second floor dining area revealed the first tray was served at the table furthest away from the television where five (5) unsampled residents were seated. The final tray was served to the table at 12:45pm where some residents waited twenty (20) minutes to be served as other residents ate lunch. Observation on 03/02/11 at 12:40pm during lunch service on the second floor dining area revealed Unit Coordinator #1 stood while assisting an unsampled resident and Resident #17 with lunch. Interview on 03/01/11 at 1:00pm with CNA #6 revealed that it is acceptable to stand while assisting a resident with a meal, and that CNA #6 was trained to assist residents in this way. Interview on 03/02/11 at 3:30pm with Unit Coordinator #1 revealed that staff were trained to sit while assisting a resident with a meal, but that staff were standing while assisting the residents in the dining room to prevent any further delays in meal service and said the staff don't usually stand when assisting residents with meals. Interview on 03/03/11 at 10:25am with the Second Floor Manager revealed that staff are trained to sit when assisting residents with meals, and said staff should never stand while assisting with meals.	F 241	who enters first and shall then proceed to others as they enter. (7) At any time there is more than one resident at a table, all residents at that table shall be served before moving to serve residents at another table. (8) Staff is to remain seated while assisting residents with their meals unless a specific task requires otherwise. QA monitoring of a meal service will be conducted daily x2 weeks (beginning on 3/7/11), then weekly x2 weeks, then monthly x2 months, then as needed as determined by random annual audits. QA monitoring will be completed by the dietary manager, dietary supervisor, nurse manager, charge nurse or a designee. Compliance with this requirement will be reviewed at least quarterly for one year by our facility QA committee. F246 REASONABLE ACCOMODATION OF NEEDS/PREFERENCES Rosedale Manor's team of care providers continues to support each of our resident's right to reside and receive services in a facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		4/11

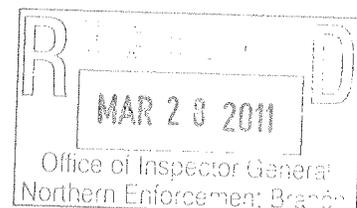


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F 246	<p>Continued From page 4</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure call lights were placed in reach of six (6) Residents (#3, 11, 18, 32, 33 and 34) of the thirty-four (34) sampled residents.</p> <p>The findings include:</p> <p>Record review of the facility's Resident Safety Policy revealed that staff are trained to create a safe environment for the resident by placing the call light within reach of the resident.</p> <p>Record review of Resident #11's Minimum Data Set (MDS), dated 01/20/11, revealed the resident was cognitively intact, as he/she scored fifteen (15) of fifteen (15) on Summary Score of Cognition.</p> <p>Observation on 03/02/11 at 10:55am with Resident #11 revealed the resident could not locate or reach the call light. Resident #11 stated when he/she can't find the call light it is usually looped around the over the bed lamp, which is out of reach. The call light was found looped over the headboard of the bed which was beyond the reach of the resident. Resident #11 stated the</p>	F 246	<p>With regards to resident #11, staff was immediately educated by the staff development coordinator, charge nurse, supervisor, nurse manager and ADON regarding proper placement of the call light. QA audits performed by the nurse manager or nursing staff have shown the call light to be in reach of the resident when in the room and have not been noted to be hanging over the headboard.</p> <p>With regards to resident #32, staff was immediately educated by the staff development coordinator, charge nurse, supervisor, nurse manager and ADON regarding proper placement of the call light. QA audits performed by the nurse manager or nursing staff have shown the call light to be in reach of the resident when in the room. The call light has not since been found on the floor, under the sheet or under the lift pad.</p> <p>With regards to resident #33, staff was immediately educated by the staff development coordinator, charge nurse, supervisor, nurse manager and ADON regarding proper placement of the call light. QA audits performed by the nurse manager or nursing staff have shown the call light to be in reach of the resident when in the room. Resident #33 is able to propel herself in her wheelchair and may move herself</p>	

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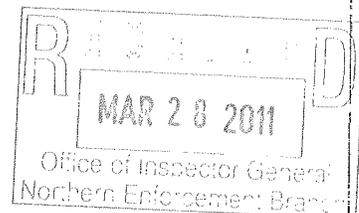
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F 246	<p>Continued From page 5</p> <p>staff were slow to answer the call lights and that recently he/she lost control of his/her bowels before the staff responded to a call light to request assistance with the bedpan.</p> <p>Observation on 03/02/11 at 11:10am of Resident #32 revealed the resident could not locate the call light. Resident #32 stated, when he/she could not find the call light it is usually on the floor. The call light was found under the bottom sheet and lift pad, which was inaccessible to the resident. Resident #32 said when the call light is on the floor, he/she calls out 'like crazy' until help arrives. Record review of Resident #32 MDS, dated 09/15/10, revealed the resident was considered modified independent with difficulty only with new situations only.</p> <p>Observation on 03/02/11 at 11:15am of Resident #33 revealed the resident sitting in a wheelchair about eight (8) feet from the bed where the call light was fastened to the top covers on the bed. Resident #33 was asked if he/she could reach the call light, and the resident stated, "Of course I cannot reach it! They do things like that because they want you to lay up here and die! I am angry!" Record review of Resident #33 MDS, dated 02/04/11, revealed the resident was cognitively intact, as he/she scored fourteen (14) of fifteen (15) on Summary Score of Cognition.</p> <p>Observation on 03/02/11 at 11:20am of Resident #34 revealed the resident was sitting in a wheelchair facing the door, with the call light attached to the top covers of the bed directly behind the wheelchair. When Resident #34 was asked if he/she could reach the call light, the</p>	F 246	<p>away from her call light at times. Resident #33's care plan has been updated by the RAI nurse as of 3/24/11 to reflect that she may wheel herself away from her call light at times and that staff has been instructed to make sure the call light is within reach anytime they are in her room. Since admission, resident #33 has been noted on her care plan to have issues with anxiety and anger that result in negative outbursts.</p> <p>With regards to resident #34, staff was immediately educated by the staff development coordinator, charge nurse, supervisor, nurse manager and ADON regarding proper placement of the call light. QA audits performed by the nurse manager or nursing staff have shown the call light to be in reach of the resident when in the room. Resident #34 is able to propel herself in her wheelchair and may move herself away from her call light at times. Staff has been instructed to make sure the call light is within reach anytime they are in her room. Resident #34's care plan has been updated by the RAI nurse as of 3/24/11 to reflect that she may wheel herself away from her call light at times and that staff has been instructed to make sure the call light is within reach anytime they are in her room.</p> <p>With regards to resident #18, staff has been educated by the staff</p>	
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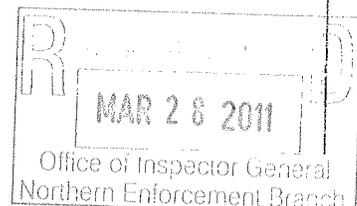


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F 246	<p>Continued From page 6</p> <p>resident responded that they did not know where the call light was located. Record review of Resident #34 MDS, dated 01/28/11, revealed the resident was moderately impaired in cognitive ability, as he/she scored eleven (11) of fifteen (15) on Summary Score of Cognition.</p> <p>Interview on 03/03/11 at 10:25am with the Second Floor Manager revealed that staff have been trained to always leave the call light in reach of each resident to provide a safe environment. The Second Floor Manager said that he/she performs periodic call light audits to ensure compliance with the call light policy, but does not maintain a log or document the audit frequency or findings.</p> <p>Observations of Resident #18 on 03/01/11 at 11:20am and at 12:15pm revealed the resident sitting in his/her wheelchair parked near the bed without a call light near the resident's hand. The resident's call light was lying in the middle of the resident's bed. Observation of Resident #18 at 12:15pm reaching for the call light revealed they were unable to reach the call light lying on the bed.</p> <p>Record review of Resident #18 revealed an admission date of 11/24/08 with diagnoses of Hypothyroidism, Hypertension, Seizure Disorder, Dementia, Cerebral Vascular Disease with Right Sided Hemiplegia and Aphasia and Cardiovascular Disease. Record review of the Fall Risk Care Plan for Resident #18 dated 09/01/10 which revealed he/she was care planned to make sure the resident's call light is always kept within reach of the resident. The Resident's Care Plan was Care Conferenced on</p>	F 246	<p>development coordinator, charge nurse, supervisor, nurse manager and ADON regarding proper placement of the call light. QA audits performed by the nurse manager or nursing staff have shown the call light to be in reach of the resident when in the room. The call light has not since been noted to be in the middle of her bed out of her reach.</p> <p>With regards to resident #3, staff has been educated by the staff development coordinator, charge nurse, supervisor, nurse manager and ADON regarding proper placement of the call light. QA audits performed by the nurse manager or nursing staff have shown the call light to be in reach of the resident when in the room. The call light has not since been noted to be across the room from the resident.</p> <p>An audit was initiated and will be completed by the nurse managers to ensure that all call light cords are sufficiently long to reach any location in the room where the resident may be placed in a stationary chair or in bed. This audit will be completed on March 28, 2011. Any call light that is not of sufficient length will be replaced as of April 15, 2011. Should any resident's call cord be deemed not long enough to reach a particular stationary location, the resident will not be placed in that location until the appropriate call cord is in place.</p>	

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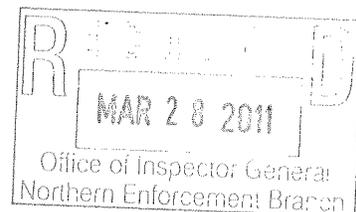


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F 246	<p>Continued From page 7 11/11/10 and 01/27/11 with updates.</p> <p>Interview with Resident #18 on 03/01/11 at 12:20pm revealed she/he pointed toward the call light located in the middle of the bed when asked how to get help from the staff. Resident #18 was asked if they could reach the call light located in the middle of the bed while sitting in his/her wheelchair and then demonstrated they were not able to reach the call light.</p> <p>Record review of Resident #3 revealed he/she was originally admitted on 07/29/09 with diagnoses of Esophagitis, Atrial Fibrillation, Diabetes, Glaucoma, Heart Disease, Depression, Hypothyroidism, Colon Cancer and Blindness. A readmission date of 02/07/11 revealed added diagnosis of a fractured right wrist.</p> <p>Observation of Resident #3 on 02/28/11 at 2:40pm revealed the resident sitting in a recliner in the resident's room with the right arm in a cast up to the elbow. The call light was on the bed across the room.</p> <p>Interview with Resident #3 on 02/28/11 at 2:40pm revealed the resident wanted to move from the recliner to the wheelchair. The resident stated that he/she had been hoping someone would come by to help him/her go to the bathroom. The resident indicated they could not do that alone and couldn't reach the call light. He/She also stated they should not get up without help.</p> <p>Interview with RN #1 on 03/03/11 at 12:15pm revealed the expectation was to ensure call lights are in the reach of the residents when they are in their rooms. She stated the expectation was that</p>	F 246	<p>Inservicing will be completed as of April 15, 2011 for all nursing staff regarding the proper placement of call lights. All other departments will be inserviced by the department head of their department as of April 8, 2011 regarding the placement of call lights and the expectation that any staff member that enters a room is to ensure call light placement within reach of the resident, if the resident is in the room, before they leave.</p> <p>QA monitoring on call light placement will be completed daily x2 weeks (this monitoring began on 3/14/11) then weekly 2 weeks, then monthly x2 months, then as needed as determined by random annual audits. QA monitoring will be completed by the nurse manager, charge nurse or a designee.</p> <p>Compliance with this requirement will be reviewed at least quarterly for one year by our facility QA committee.</p>	

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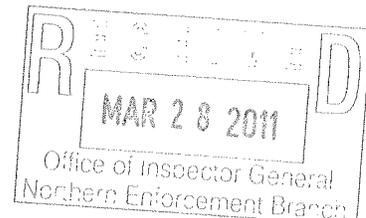


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2011
NAME OF PROVIDER OR SUPPLIER ROSEDALE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4260 GLENN AVENUE COVINGTON, KY 41015	
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F 246	Continued From page 8 when staff assists a resident to bed or chair that the call light will be placed within reach of the resident.	F 246	F272 COMPREHENSIVE ASSESSMENTS Rosedale Manor's team of care providers remains committed to conducting initial and periodic comprehensive, accurate, standardized reproducible assessments of each of our resident's functional capacity. We continue to make a comprehensive assessment of our resident's needs using the RAI specified by our state. With regards to resident #12, upon being reported that this resident had fallen and was returned to her unit per a visitor, the incident was investigated to determine the specific circumstances. The identity of the visitor is unknown as they returned resident #12 to the unit, indicated that she had fallen outside and that she was ok, and the visitor left before staff could ascertain more information. Due to the fact that this resident most often does not self propel and has a history of being escorted outside by visitors, it was reasonable to believe that the visitor that returned her was the person who had escorted her outside. The resident had not been considered at risk for leaving the facility unattended. This resident has not been known to exhibit behaviors whereby she is seeking to exit the facility. This resident has been known to be taken outside by visitors previously, but the visitors have always returned the resident to the	4/15/11
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by:	F 272		

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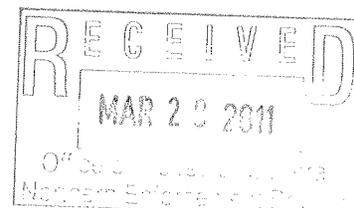


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F 272	<p>Continued From page 9</p> <p>Based on interview and record review, it was determined that the facility failed to reassess one (1) resident (#12) of the thirty-four (34) sampled residents after the resident was found outside.</p> <p>The findings include:</p> <p>Review of the facility's policy on Elopement, which is dated 06/01/08, revealed that a full assessment and appropriate care planning will be completed when elopement is determined as a resident problem.</p> <p>Review of the clinical record for Resident #12 revealed the resident was admitted with the following diagnoses: Dementia, aphasia, and weakness. The facility assessed the resident on 12/31/10 as having severe impairment in the ability to make daily care decisions, and required assistance with transfers, dressing, bathing, and eating. An Elopement Risk Assessment completed on 12/31/10 did not score the resident as a risk for elopement, however, on 01/09/11 the Nurses Notes revealed an entry describing the resident as being found by a visitor outside of the building.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 03/02/11 at 10:50am revealed that the resident was not reassessed for elopement after the incident, and no other elopement risk assessments have been completed since December. The LPN also revealed that the Minimum Data Set (MDS) coordinator is responsible for completing the risk assessment. The LPN also stated that the facility did not believe another assessment needed to be completed.</p>	F 272	<p>unit in the past. The resident was in front of the facility on the sidewalk, an area that is considered a safe area for this resident, as well as for all other residents. Many residents take themselves to and from this area several times per day. During the daytime, this area is frequently passed by visitors and staff. The door to this location is secured in the evening when it is less traveled and staff must escort a resident out of the facility, thereby ensuring that staff knows the residents are outside. Residents do not always report that they are going out front to sit, but it is common practice for staff to check this area for residents routinely.</p> <p>On 1/09/11, the resident's physical and mental status had not changed from the assessment 9 days prior and a subsequent elopement risk assessment was not indicated. A Roam Alert was placed on the resident, not to prevent her from sitting outside, but to alert staff that she was going out.</p> <p>On March 3, 2011, an elopement risk assessment was completed by the RAI nurse and confirmed that this resident remains not at risk for elopement. The elopement risk assessment factors in cognition, mobility, behaviors (including anger regarding placement, combativeness, history of elopement attempts, history of setting off exit alarms, history of history of attempting to</p>	

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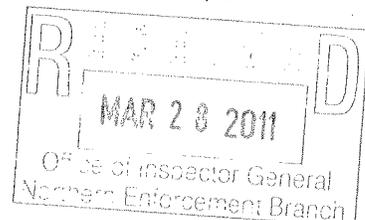


F272

open exit doors, verbalizations of wanting to leave the facility, and being resistant to redirection of staff, verbally abusive, failure to return from outings or appointments, aimless wandering, packing belongings, etc) as well as other areas. This resident, although cognitively impaired, did not fit the criteria for being an elopement risk and specifically lacks all of the significant behaviors that would flag her as being at risk. Cognitive impairment in and of itself does not automatically qualify a resident as high risk.

Inservicing was initiated on 3/4/11 for all nursing staff and will be completed as of April 15, 2011. The inservice includes that any resident with cognitive impairment, who was previously determined to not be at risk for elopement, who experiences an incident outside on the grounds of the facility and who was outside without staff knowledge, will be immediately reassessed by the charge nurse, nurse manager, or RAI nurse to determine if their status has changed and they should be considered at risk for elopement. If the circumstances fit the definition of elopement (being in an unsafe place without staff knowledge), reporting of the incident to OIG will occur within the required time frames. Inservicing will be completed by the staff development coordinator, nurse managers, and supervisors.

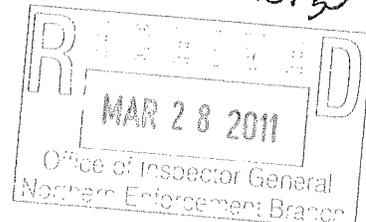
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F 272	Continued From page 10 Interview with the Director of Nursing (DON) on 03/03/11 at 12:00pm revealed that she did not consider the incident an elopement despite the resident being found outside without supervision or staff knowledge. The DON also revealed she did not consider the resident an elopement risk. The DON confirms that she is ultimately responsible for ensuring that the staff follows the facility's policy and procedure.	F 272	Ongoing QA monitoring of all incident reports will be completed by the nurse manager, ADON, DON, Administrator or Fall Committee chair person to observe for incidents that may warrant an elopement risk assessment being completed. Elopement risk assessments will be completed by the charge nurse, RAI nurse or nurse manager when indicated.	
F 323 SS=E	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 record review, observation, and interview, the facility failed to complete thorough investigations for three (3) residents (#11, #12 and #19) of the 34 sampled residents. Resident #11 did not have an investigation completed after sustaining a fracture. Resident #12 did not have an investigation completed after an elopement, and was not reassessed for elopement risk. Resident #19 did not have a falls investigation and was not followed by the falls committee. The findings include: 1. Record review of the Fall Prevention Policy revealed that any time a resident sustains a fall, a fall investigation should be completed by the	F 323	Compliance with this requirement will be reviewed at least quarterly for one year by our facility QA committee. F323 FREE OF ACCIDENT HAZARDS / SUPERVISION / DEVICES Rosedale Manor's team of care providers remains committed to ensuring that our resident's environment remains as free of accident hazards as is possible; and each of our resident's receives adequate supervision and assistance devices to prevent accidents. Regarding resident #11 and the incident dated 4/16/10. During care, two nursing assistants were turning the resident to provide peri-care when they heard a loud pop. They immediately informed the nurse who assessed the situation and revealed the resident complained of pain, but that there was no bruising or swelling	4/16/11



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F 323	<p>Continued From page 11 Charge Nurse.</p> <p>Record review of the Incident/Accident Report dated 4/16/10 which was completed by the Charge Nurse revealed Resident #11 was being transferred onto the bedpan by two (2) CNA's when the Injury was reported. The resident was admitted on 01/04/10, with diagnosis of CVA.</p> <p>Record review of the Minimum Data Set (MDS) for Resident #11, dated 01/15/10 and completed upon admission to the facility, revealed the cognitive skills for daily decision-making as independent. Record review of the most recent annual MDS for Resident #11, dated 01/20/11, revealed the resident's cognitive skills for decision-making was rated as fifteen (15) on a scale from 0 to 15, which showed the resident was independent.</p> <p>Observation on 03/02/11 at 10:20 am of Resident #11 during an assisted transfer from the wheelchair to the bed with use of a mechanical lift revealed the resident was of non-weight bearing status.</p> <p>Interview on 03/02/11 at 10:55 am with Resident #11 revealed he/she had not been ambulatory since having been diagnosed with a CVA prior to admision to the facility. Resident #11 also revealed a different account of the circumstances of the accident which occurred on 04/16/10 during the interview.</p> <p>Interview on 03/01/11 at 3:00 pm with the Charge Nurse revealed that she was working on 04/16/10. The Charge Nurse said she initiated the Incident/Accident Report based on the information which was provided by the CNA's</p>	F 323	<p>noted. The nurse directed the CMA to administer pain medication. Upon interview of the resident, the resident indicated that she was turning over in bed and it just started hurting. The physician was immediately notified and an x-ray was ordered. The x-ray revealed a fracture and extensive degenerative changes involving the knee joint and osteopenia. The resident remained in bed awaiting the results of the x-ray. Upon receipt of the results, the physician ordered transport to the hospital. When informing the resident about the results and pending transfer to the hospital, the resident told the nurse that she was "I feel so bad for that girl. After breakfast they were going to weight me and I fell on top of her. I hope she's not hurt". Upon arrival of the ambulance for transport, the resident told the ambulance crew that her leg was hurt by dangling off of the bed. She then told the ambulance crew that she fell after breakfast.</p> <p>Our policy includes that "All residents that sustain a fall shall be reassessed as needed via the Resident Assessment Protocol for falls (which is our post fall assessment, not the initial incident report). The nurse manager shall review the nurses' assessment and complete the Comprehensive Resident Assessment Progress Note. The plan of care shall be reviewed and revised to include new interventions, if appropriate, and to address prevention of falls." The</p>	

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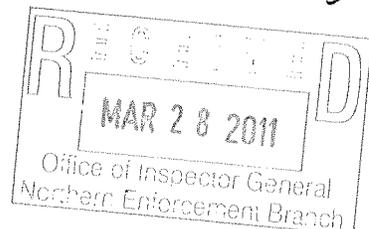
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F 323	<p>Continued From page 12</p> <p>present. The Charge Nurse revealed she did a physical assessment, and notified the Second Floor Manager and the Director of Nursing. The Charge Nurse also stated that Resident #11 reported an accident in the bathroom, and was told no further action was necessary. The Charge Nurse said she did not think the accident alleged by Resident #11 could have occurred. The Charge Nurse said Resident #11 provided different explanations of how the injury occurred. The Charge Nurse said she probably should have documented the accident reported by Resident #11 and initiated the Incident/Accident Report, which included the account of the injury as reported by Resident #11.</p> <p>Interview on 03/03/11 at 10:25 am with the Second Floor Manager revealed that she asked the Administrator, the Director of Nursing, and the Associate Director of Nursing if any further investigation were necessary based on the accident reported by Resident #11. The Second Floor Manager was told by Administration no further action would be necessary.</p> <p>Interview on 03/03/11 at 11:20 am with the Director of Nursing (DON) revealed that she was told Resident #11 changed her version of the details of the accident. The DON said when a decision is made regarding the need to initiate an investigation, it is always a team decision including collaboration of the Administrator, DON, Associate Director of Nursing, and any other team members involved. The DON stated that an Accident/Incident report was not initiated to address the accident as reported by Resident #11 and an investigation. The DON did not provide evidence to support an investigation into Resident #11's explanation of the incident. The DON</p>	F 323	<p>injury for resident #12 did not occur as a result of a fall, therefore, this policy is not applicable.</p> <p>Our policy regarding accidents and incidents includes: (1) Reporting of Accidents / Incidents: (a) Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the department supervisor, and a report must be completed on the shift that the accident or incident occurred. (This criteria was met) (b) An employee witnessing an accident or incident involving a resident, employee, or visitor, must report such occurrence to his or her immediate supervisor as soon as practical (this criteria was met). Do not leave an accident victim unattended unless it is absolutely necessary to summon assistance (this criteria was met); and (c) the charge nurse must be informed of all accidents or incidents so that medical attention can be provided as needed (this criteria was met). (4) Investigative Action: (a) The charge nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident (this criteria was met as the charge nurse interviewed the resident and staff and obtained statements). (b) The following data, as it may apply, must be included on the report: 1. The date and time the accident or incident took place; 2. The nature of the injury or</p>	

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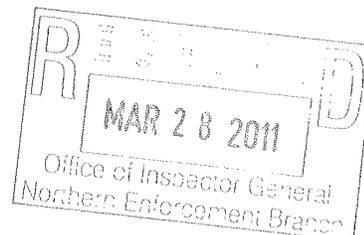


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F 323	<p>Continued From page 13</p> <p>stated she did not document any interviews or findings from the investigation, and that she should have.</p> <p>2. Review of the facility's Fall Prevention Policy, dated 07/2004, revealed that at the time any resident sustains a fall, the charge nurse shall conduct a clinical evaluation of the resident's status and take immediate action to assure the resident's safety and implement care needs per nursing standards of practice. Documentation of incidents shall be made in the nurses' notes and the Fall Investigation form. The Fall Committee is to review the interventions that are in place to prevent future falls and follow-up for no less than six weeks.</p> <p>Review of the facility's Missing Resident Policy, dated 10/01/07, revealed that no resident will leave the facility without staff knowledge and employee's assigned to care for the residents will be expected to know where their assigned residents are at any given time.</p> <p>Observation on 02/28/11 at 1:00pm revealed Resident #12 sitting in a wheelchair in the dining room. The resident was being fed lunch by a Certified Nursing Assistant. A tab alarm was attached to the resident.</p> <p>Observation on 03/01/11 at 9:00 am revealed Resident #12 in the dining area sitting in a wheelchair with a tab alarm attached. No attempts noted of the resident self-propelling the wheelchair.</p> <p>Observation on 03/01/11 at 10:15am revealed Resident #12 sitting in a wheelchair located in the hallway. A tab alarm was attached to the resident.</p>	F 323	<p>illness (e.g., needlestick, bruise, fall, nausea, etc.); 3. The circumstances surrounding the accident or incident; 4. Where the accident or incident took place; 5. The name(s) of any witnesses and their accounts of the accident or incident; 6. The injured person's account of the accident or incident; 7. The time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions; 8. The date and time the injured person's next-of-kin was notified and by whom; 9. The condition of the injured person, to include his or her vital signs; 10. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.); 11. Any corrective action taken; 12. Follow-up information; 13. Other pertinent data as necessary or required; and 14. The signature and title of the person completing the report (all criteria were met).</p> <p>When resident #11 was being turned by staff, the popping sound was heard; staff secured the resident; summoned the nurse; and the nurse assessed the situation; filled out an incident report; made all appropriate notifications; completed all physician's orders timely; and transferred the resident to the hospital as directed. The nurse documented each explanation of the cause of the injury that the resident provided, including the resident's</p>	

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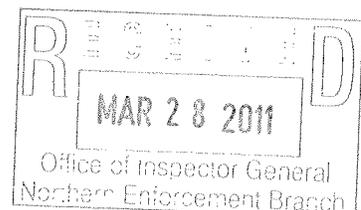
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F 323	<p>Continued From page 14</p> <p>No attempts were made by the resident to self-propel the wheelchair.</p> <p>Review of the clinical record for Resident #12 revealed the resident was admitted with the following diagnoses: Dementia, Aphasia, and Weakness. The Facility assessed Resident #12 on the Minimum Data Set (MDS) dated 12/31/10 as having severe impairment in the ability to make daily care decisions, and required assistance with transfers, dressing, bathing, and eating. Review of the Elopement Risk Assessment, completed on 12/31/10, did not score the resident as a risk for elopement. Review of the Comprehensive Resident Assessment Progress notes revealed there were no exit seeking behaviors prior to leaving the building. The Nurses Notes, dated 01/09/11 at 4:00pm, revealed an entry describing the resident as being found outside in front of the building, and brought back by a visitor. A roam alert bracelet was applied by the facility as an intervention at that time. Review of the Incident/Accident Report dated 01/09/11 revealed that the visitor information was marked as not applicable, equipment or property involved was not marked, the witness area was left blank, the investigation of events leading up to fall was left blank, and the internal risk factors were not assessed.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 03/02/11 at 10:50am revealed that the nurse assigned to the resident completes the investigation report. The unit managers and the Director of Nursing (DON) are to review each investigation report once they are completed. The LPN stated the occurrence was not an elopement. When asked to define elopement, the LPN stated elopement is intent to leave. The</p>	F 323	<p>initial report that matched that of the staff.</p> <p>Upon review of the documentation in the resident's medical chart and the statements obtained from staff by the Director of Nursing, further investigation continued. Discussions with the DON and Nurse Manager on resident #12's unit revealed the following: (1) had the resident fallen on the staff, due to the size of the resident, it would have been next to impossible for staff to get her back up without summoning assistance and without staff suffering injuries, (2) regardless of the facts in #1, the resident was assessed by the nurse manager for signs that a fall may have occurred. There were no outward signs of trauma, other than a bruise noted at the knee, and (3) when asked, the resident who is alert and oriented, indicated that no one had done anything to her to hurt her. Review of the staff statements, considering the fact that the initial report by the resident supported the staff's statements, information obtained through interview with the nurse manager, and the fact that the x-ray showed extensive demineralization and osteopenia, the investigation was closed.</p> <p>The charge nurse was instructed that another incident report was not required for the additional recollections made by the resident, as this was one incident, but that she</p>	

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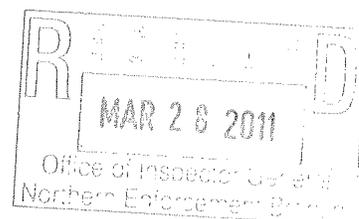


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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2011
NAME OF PROVIDER OR SUPPLIER ROSEDALE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015	
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F 323	<p>Continued From page 15</p> <p>LPN could not explain why investigation information was not completed on the Incident/Accident Report form.</p> <p>Interview with Registered Nurse (RN) #4 on 03/03/11 at 10:45am revealed that elopement in-services are provided to the employees. The RN reported the last in-service was held in July of 2010. The RN stated that elopement is defined during the training and all employees should be aware of how to investigate these occurrences.</p> <p>Interview with LPN #5 on 03/03/11 at 11:20am revealed that both the Unit Manager and the Director of Nursing (DON) were notified of the incident, but she was never informed that further information would be required for the investigation.</p> <p>Interview with the DON on 03/03/11 at 12:30pm revealed that staff are educated on elopement procedures annually and defined elopement as a resident being in an unsafe area without supervision or without staff knowledge of the resident's location. The DON confirmed the resident was outside of building, but did not consider the incident as an elopement, due to the resident not being assessed initially as an elopement risk. The DON confirmed ultimate responsibility for ensuring that investigations are both complete and thorough.</p> <p>3. Observation on 03/02/11 at 10:40am revealed Resident #19 lying in the bed with the fall mats in place on the floor. The bed was in low position, ¼ bed rails were in the up position, the call light was attached to the left bed rail, and the bed alarm was in place.</p>	F 323	<p>should document all of the residents statements in the medical record.</p> <p>All incidents are investigated, and each scenario provided by resident #11 regarding this incident was considered. The policy does not indicate the need for an additional incident report for each version of events, but rather a report of the incident itself.</p> <p>Review of our policy indicates that according to the circumstances of this incident, that our policy was followed appropriately.</p> <p>The situation was discussed by the DON, ADON, and Administrator and the facts of the incident did not warrant further investigation.</p> <p>The incident report, statements from staff, copies of daily staffing sheets, the x-ray report and copies of the nurse's notes were provided to the surveyor when requested. A summary of the investigation could not be located when requested, but the DON recalled the investigation and the summary of the investigation was verbally shared with the surveyor by the DON. A written summary of the investigation was recreated by the DON on March 4, 2011.</p> <p>Resident incidents involving investigations completed by administration were reviewed for the</p>	

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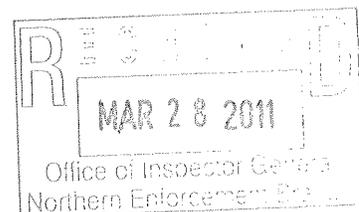


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F 323	<p>Continued From page 16</p> <p>Observation on 03/02/11 at 3:10pm revealed Resident #19 sitting in a wheelchair in the dining area. The resident was bending forward and self-propelling the wheelchair with his/her feet. A pressure alarm was in place.</p> <p>Review of the clinical record for Resident #19 revealed the resident was admitted to the facility with the following diagnoses: Urinary Tract Infection, Dementia, Anxiety, Depression, The resident was status post Open Reduction Internal Fixation of the Right hip in 2010. The facility assessed Resident #19 on the Minimum Data Set (MDS) dated 12/23/10 as having severe impairment to the ability to make daily care decisions, and was also assessed as requiring assistance with transfers, dressing, bathing, and eating. The Comprehensive Resident Assessment Progress Notes revealed that on 12/12/10 the resident was found on the floor beside the bed. There were no entry's noted on the Nurses Notes, and the facility was unable to produce an Incident/Accident Report form. Review of the Fall's Committee flow sheet revealed that the residents fall had not been noted, the interventions were not reviewed, and there was not follow-up in accordance with the facility's policy.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 02/02/11 at 3:10pm revealed that the Nurse assigned to each resident is responsible for completing the Incident/Accident Report form and the Unit Manager's are responsible to review the forms. No explanation was given as to why the fall had not been documented in the progress notes and why an Incident/Accident Report form was not completed. LPN #2 did state that falls are reported to the Director of Nursing during morning</p>	F 323	<p>last year and all investigations were noted to have the appropriate investigation summary. This review was completed on March 25, 2011 the DON and Administrator.</p> <p>Future incidents that are investigated by administration will be documented in written form and will be maintained by the DON or Administrator.</p> <p>The ADON / QA director will be responsible for QA monitoring of each investigated incident to ensure that the appropriate summary statements are present and that the appropriate actions were taken. This audit will be given to the DON or Administrator for review.</p> <p>With regards to resident #12, upon being reported that this resident had fallen and was returned to her unit per a visitor, the incident was investigated to determine the specific circumstances. The identity of the visitor is unknown as they returned resident #12 to the unit, indicated that she had fallen outside and that she was ok, and the visitor left before staff could ascertain more information. Due to the fact that this resident most often does not self propel and has a history of being escorted outside by visitors, it was reasonable to believe that the visitor that returned her was the person who had escorted her outside. The resident had not been considered at</p>		

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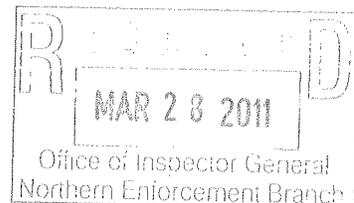
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risk for leaving the facility unattended. This resident has not been known to exhibit behaviors whereby she is seeking to exit the facility. This resident has been known to be taken outside by visitors previously, but the visitors have always returned the resident to the unit in the past. The resident was in front of the facility on the sidewalk, an area that is considered a safe area for this resident, as well as for all other residents. Many residents take themselves to and from this area several times per day. During the daytime, this area is frequently passed by visitors and staff. The door to this location is secured in the evening when it is less traveled and staff must escort a resident out of the facility, thereby ensuring that staff knows the residents are outside. Residents do not always report that they are going out front to sit, but it is common practice for staff to check this area for residents routinely.

On 1/09/11, the resident's physical and mental status had not changed from the assessment 9 days prior and a subsequent elopement risk assessment was not indicated. A Roam Alert was placed on the resident, not to prevent her from sitting outside, but to alert staff that she was going out.

On March 3, 2011, an elopement risk assessment was completed by the RAI nurse and confirmed that this

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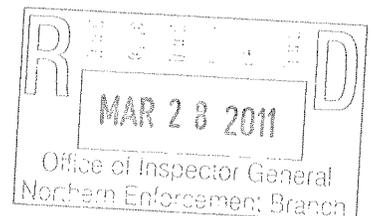


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resident remains not at risk for elopement. The elopement risk assessment factors in cognition, mobility, behaviors (including anger regarding placement, combativeness, history of elopement attempts, history of setting off exit alarms, history of history of attempting to open exit doors, verbalizations of wanting to leave the facility, and being resistant to redirection of staff, verbally abusive, failure to return from outings or appointments, aimless wandering, packing belongings, etc) as well as other areas. This resident, although cognitively impaired, did not fit the criteria for being an elopement risk and specifically lacks all of the significant behaviors that would flag her as being at risk. Cognitive impairment in and of itself does not automatically qualify a resident as high risk.

Inservicing was initiated on 3/4/11 for all nursing staff and will be completed as of April 15, 2011. The inservice includes that any resident with cognitive impairment, who was previously determined to not be at risk for elopement, who experiences an incident outside on the grounds of the facility and who was outside without staff knowledge, will be immediately reassessed by the charge nurse, nurse manager, or RAI nurse to determine if their status has changed and they should be considered at risk for elopement. If

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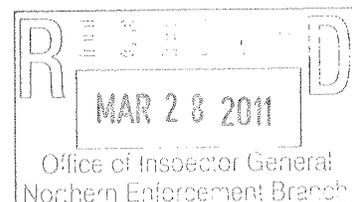
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the circumstances fit the definition of elopement (being in an unsafe place without staff knowledge), reporting of the incident to OIG will occur within the required time frames. Inservicing will be completed by the staff development coordinator, nurse managers, and supervisors.

Ongoing QA monitoring of all incident reports will be completed by the nurse manager, ADON, DON, Administrator or Fall Committee chair person to observe for incidents that may warrant an elopement risk assessment being completed. Elopement risk assessments will be completed by the charge nurse, RAI nurse or nurse manager when indicated.

With regards to resident #19, who has fall interventions in place to (1) be in a low bed (6 inches off of the floor), (2) ¼ length siderails, (3) fall mats on the floor at bedside, (4) a bed alarm in place, and (5) her call light within reach, and the entry noted in the nurse's note dated 12/12/10. Interview with the nurse manager who made the entry dated 12/12/10 revealed that 12/12 was the date of the fall committee meeting. Rarely, if ever, is a fall discussed in the fall committee on the date that it occurs. Typically, a fall that occurs on the day of the falls meeting is discussed at the next meeting to allow for proper and efficient completion of the investigation and

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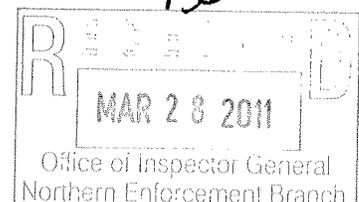
documentation. Further review of the comprehensive resident assessment protocol (CRAP) note dated 12/12/10, revealed that every other entry for resident #19, regarding falls, and made by the nurse manager, indicated the date of the fall to which the note was referring. The noted dated 12/12/10 was referring to the fall the occurred on 12/10/10, which was documented in the nurse's notes, had an incident report filled out, and was noted in the fall committee notes. Further discussion with the nurse manager revealed that the surveyor did not question her regarding this specific question, but rather asked her to go through each fall and show her the corresponding entry on the plan of care.

The DON was not aware of the fall on 12/12/10 as it had not occurred.

Beginning 3/4/11, the DON and ADON will review all 24 hours nursing reports observing for incidents (in addition to the nurse manager reporting them) that may require an incident report. Follow up with the nurse managers will be done as indicated to ensure that incident reports are completed and turned in when warranted.

The DON/ADON's review and tracking will be done as QA monitoring which will be completed daily. Issues with incident reports

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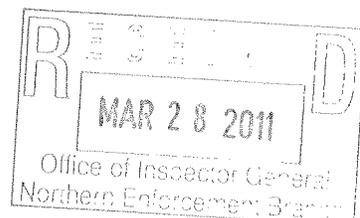


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F 323	Continued From page 17 meetings.	F 323	not being turned in will be discussed with the nurse managers for follow up.	
F 431 SS=E	<p>Interview with the Director of Nursing (DON) on 03/03/11 at 12:00pm revealed that she was aware of resident #19 having multiple falls, but was not aware that a fall had occurred on 12/23/10. The DON stated she solely relied on the nurse managers to inform her of any falls. She stated there is currently no tracking system in place to monitor reported falls in the morning meetings. She confirmed that she has not been ensuring that Incident/Accident Report forms are being completed after each occurrence. She also confirmed that she is ultimately responsible for completion of the investigations.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>	F 431	<p>Compliance with these requirements will be reviewed at least quarterly for one year by our facility QA committee.</p> <p>F431 DRUG RECORDS, LABEL / STORE DRUGS & BIOLOGICALS</p> <p>Rosedale Manor's team of care providers remains committed to employing or obtaining the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and to determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Rosedale Manor's team of care providers also remains committed to ensuring that drugs and biological used in our facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>Rosedale Manor's team of care providers strives to act in accordance with State and Federal laws by storing all drugs and biological in</p>	4/15/11

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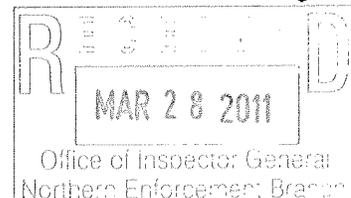


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F 431	<p>Continued From page 18</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the security of controlled drugs and monitor the drugs and biologicals used in the facility for expiration dates in three (3) of four (4) medication rooms, two (2) treatment carts, one (1) medication cart, the clean utility room, and the central supply storage area.</p> <p>The findings include:</p> <p>Record review of the facility's policy for Storage of Medications, which is not dated, revealed that only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are allowed access to the medications. The policy further revealed that outdated medications shall be immediately removed from stock and disposed.</p> <p>Record review of the facility's policy on Supplies and Equipment dated 07/01/08 revealed that all supplies which have expired shall be destroyed or returned for credit.</p>	F 431	<p>locked compartments under proper temperature controls, and to permit only authorized personnel to have access to the keys.</p> <p>Rosedale Manor's team of care providers is committed to providing separately locked, permanently affixed compartments for storage of controlled drugs listed in schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses signal unit package distribution systems in which the quantity stored is minimal and missing a dose can be readily detected.</p> <p>With regards to Unit Coordinator #3 unlocking the medication room, on 2/28/11, her key, as well as all keys to the medication rooms were retrieved by the DON from the unit coordinators with instructions that any access to the medication rooms requires supervision by a licensed nurse or certified medication aide (CMA).</p> <p>All nursing staff present on 3/1/11 were inserviced by the nurse managers and all other staff will be inserviced as of April 8, 2011, by the staff development coordinator, nurse managers, supervisors, and ADON regarding the policy that the medication room must be secured at all times (the door closed and locked). Any non-licensed person</p>	

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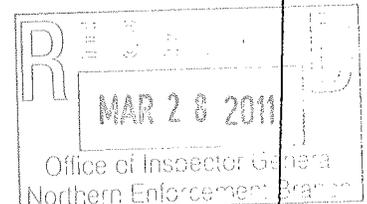


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F 431	<p>Continued From page 19</p> <p>Observation on 02/28/11 at 2:00pm revealed Unit Coordinator #3 unlocking the North Hall medication room door for the unit manager.</p> <p>Observation of the 1 North Unit Treatment Cart #3 on 03/01/11 at 9:22am revealed Saf-Gel dressings which had expired 10/2010</p> <p>Observation of the 1 North Unit Treatment Cart #2 on 03/01/11 at 9:30am revealed clotrimazole/betamethasone 0.005% ointment which had expired 08/12/10.</p> <p>Observation of the 1 North Unit medication room on 03/01/11 at 10:00am revealed two (2) mineral oil enemas which had expired on 01/2011, one (1) sodium phosphate enema which had expired in 2010, and twenty-nine (29) bottle adapters which had expired 08/30/08. The refrigerated locked emergency box, which contains Ativan, is chained to a removable shelf in the refrigerator.</p> <p>Observation of the 1 North Unit Clean Utility Room on 03/01/11 at 10:15am revealed five (5) bottles of Jevity 1.2 tube feeding which had expired 06/2010, and one (1) bottle of Jevity 1.2 tube feeding which had expired 02/2010.</p> <p>Record review of the resident 's on tube feeding revealed that resident's in rooms 134, 142-1, 142-2, 145-2, 146-2, 147-1, 153-2, 161-2, and 164-2 are all on Jevity 1.2.</p> <p>Observation of the Central Supply Storage area on 03/01/11 at 10:25am revealed two (2) bottles of mineral oil which had expired 10/2010, one (1) package of exu-dry dressings which had expired 08/2010, one (1) case of Texas/Condom catheters which had expired 2009, Twenty (20)</p>	F 431	<p>must have a nurse or CMA in the room anytime the door is open or the room is accessed by other personnel No Exceptions. As of 3/1/11, any person not authorized to be in the medication room unsupervised is being supervised by the a licensed nurse or CMA when accessing items in the medication room.</p> <p>With regards to treatment cart #3, the expired Saf-Gel was immediately removed from the cart and disposed of on 3/1/11 by the charge nurse. A review of all treatment orders for the residents on 1N was completed by the nurse manager and no resident was noted with orders for Saf-Gel on or after 10/1/10. A review of all treatment orders for the all residents in the facility was completed by the nurse managers and no resident was noted with orders for Saf-Gel on or after 10/1/10. Therefore, no resident in the facility was treated with the Saf-Gel found on the cart after the expiration date.</p> <p>With regards to treatment cart #2, the clotrimazole / betamethasone 0.005% ointment was immediately removed from the cart by the charge nurse and replaced by pharmacy on 3/1/11. The nurse managers on 1N audited all medication and treatment carts on 3/1/11 and any expired products were immediately disposed of.</p> <p>With regards to the 1N medication room, the 2 mineral oil enemas, 1</p>	

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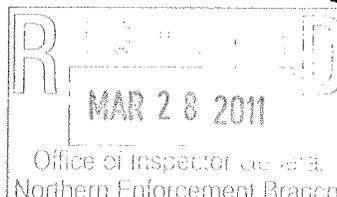
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F 431	<p>Continued From page 20</p> <p>dual-port feeding tube plugs which expired 12/2005.</p> <p>Observation of 1 South Unit medication room on 03/02/11 at 10:10am revealed nine (9) bottles of Boost supplement which expired 10/25/10.</p> <p>Interview with Unit Coordinator #3 on 02/28/11 at 2:30pm revealed that the coordinator has been employed with the facility for six months. The Unit Coordinator stated that she usually carries keys to the medication room. She also confirmed that she is not a nurse or a medication technician.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 02/28/11 at 2:45pm revealed that narcotics are double locked on all med carts. The LPN also stated that Ativan is locked in a box in the medication refrigerator, with the second lock being the door to the medication room. The LPN also revealed that the unit coordinator does carry a key to the medication room during their shift.</p> <p>Interview with Unit Coordinator #2 on 03/01/11 at 8:45am revealed that the coordinators do carry a keys to medication room to allow them access to the resident's records, which are stored in the medication room. The Unit Coordinator confirmed that she does not have a nursing license or certified to pass medications.</p> <p>Interview with LPN #3 on 03/01/11 at 9:22am revealed that expired wound treatment products/dressings could cause potential problems with healing or adverse effects. The LPN stated that pharmacy performs audits on the treatment carts and monitors for expired products. She also revealed that expired items should be returned to pharmacy.</p>	F 431	<p>sodium phosphate enema, and 29 bottle adapters were removed by the charge nurse and disposed of on 3/1/11. The nurse manager audited the entire 1N medication room on 3/1/11 and any expired products were immediately disposed of.</p> <p>With regards to the 1N clean utility room, the 5 bottles of Jevity 1.2 tube feeding that had expired was immediately discarded by the charge nurse on 3/1/11. All residents in the facility that receive tube feed products were immediately audited by the nurse manager on each unit on 3/1/11 and no resident was noted to have expired tube feeding hanging. All nurses present on 3/1/11 were interviewed by their nurse manager and every nurse indicated that they always check the expiration date on the tube feed products before administering to a resident.</p> <p>With regards to the expired products in central supply, the 2 bottles of mineral oil, 1 package of exu-dry dressings, 1 case of texas catheters, and 20 feeding tube plugs were immediately removed by the central supply clerk on 3/1/11 and were immediately disposed of. An audit was completed on 3/2/11 by the central supply clerk of all supplies in central supply and any expired products were immediately removed and disposed of. The central supply clerk will continue to rotate stock as</p>	
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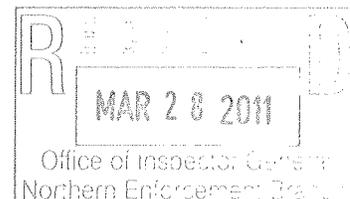


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F 431	Continued From page 21 Interview with LPN #4 on 03/01/11 at 9:30am revealed expired clotrimazole/betamethasone ointment is an active order for a resident, and is being used for treatment. The LPN stated that expired medication could potentially cause a side affect and not be effective for treatment. The LPN stated that both nursing and pharmacy are responsible for monitoring the treatment carts for expired items. Interview with LPN #5 on 03/01/11 at 10:00am revealed that bottle adapters are used to dispense the liquid Dilantin on the resident in room 161. The LPN also stated that expired adapters could potentially break off into medication causing contamination or material could breakdown causing adverse reaction. The LPN stated that expired enemas would not be as effective. The LPN confirmed that the emergency box in the refrigerator could be removed due to it being chained to a removable shelf. She also stated that all nurses and unit coordinators have keys and access to the medication room. The LPN stated that expired tube feeding could place the residents at risk for potential food poisoning and upset stomachs. She also revealed that the tube feeding is stocked by Central Supply. Interview with Central Supply Clerk on 03/01/11 at 10:35am revealed expired items found had not been used or needed recently. The Central Supply Clerk could was not able to give a date when items were last used. The clerk stated that expiration dates are checked and rotated when new shipments are received, and again checked when the supply is brought to the floor. The floor stock is monitored for expiration dates during the delivery of new stock. The clerk was not able	F 431	new deliveries arrive on a weekly basis. With regards to the 1S medication room, the 9 bottles of Boost were immediately removed by the nurse manager and destroyed on 3/2/11. The nurse managers on the other units audited their medication and treatment carts and their medication rooms on 3/2/11 and any expired products were immediately disposed of. Pharmacy will begin auditing all treatment carts on a monthly basis as of April, 2011. As of 3/24/11, the medication refrigerator in the 1N medication room has a lock on it that will be locked at all times when not actively in use by a licensed nurse or CMA. The medication refrigerator on 2N has a lock that was in place at the time of the survey. The medication refrigerators on 1S and 2S will have additional locks as of 3/28/11 per maintenance. The box inside of the refrigerators will continue to have locks in place, in addition to the lock on the refrigerator and the door. The nurse manager, supervisor, ADON or staff development coordinator will audit the medication refrigerators on each unit monthly x 12 months to ensure that the refrigerator is locked when not in use. With regards to the medication cart on 2S, the undated bottle of sodium	

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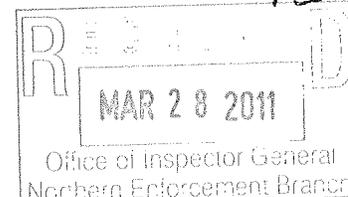


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/03/2011
NAME OF PROVIDER OR SUPPLIER ROSEDALE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015		
(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 431	<p>Continued From page 22</p> <p>explain why expired items were found in both the floor and central supply stock area.</p> <p>Interview with Registered Nurse (RN) #3 on 03/02/11 at 10:10am revealed that expired Boost was overlooked during monthly refrigerator checks. The RN did confirm that there are current residents on the supplement, but did not know to whom the supplement belonged. The RN revealed that expired Boost supplement could potentially cause illness to the residents.</p> <p>Interview with LPN #2 on 03/02/11 at 11:00am revealed that all nurses are responsible for checking the dates of tube feeding before hanging the product. She stated that every shift should be checking the treatment carts for expired medications. She also revealed that pharmacy audits carts monthly for expired products. She did confirm that Unit Managers are responsible for ensuring that dates are checked by staff members. The LPN also confirmed that the refrigerated emergency narcotics are not secured due to being chained to a removable shelf. She stated she was aware that the Unit Coordinators had keys to the medication room, and stated it is a risk to the securing of narcotics.</p> <p>Interview with Pharmacists on 03/02/11 at 12:40pm revealed that monthly audit is completed. The entire med cart is checked for expired medications, but the treatment carts are randomly checked for expiration dates. The Pharmacists stated that both nursing and the pharmacy are responsible for ensuring medications are not expired, and also confirmed that current monitoring system is not working.</p> <p>Interview with the Director of Nursing (DON) on</p>	F 431	<p>chloride and the undated bottle of Safecleens were both immediately removed from the cart on 3/2/11 by the charge nurse and disposed of.</p> <p>The 2nd floor supervisor was inserviced by the ADON on 3/2/11 that sodium chloride must be discarded within 24 hours of opening.</p> <p>As of 3/25/11, Inservicing has been completed for nurses and medication aides by the nurse managers, supervisors, staff development coordinator, and the ADON regarding all nurses and medication aides are responsible to review the contents of their cart at daily during medication / treatments passes and that any expired products are to be immediately removed and disposed of accordingly. Licensed personnel were also instructed that they are responsible to remove discontinued items from the cart(s) when obtaining an order to discontinue a product. Failure to do so will result in disciplinary action.</p> <p>The ADON will complete a monthly audit of tube feed products and 15 other random items in central supply x12 months and then as needed as determined through the QA process.</p> <p>The nurse managers on each unit will complete an audit of tube feed products and 15 random items in their medication room, storage room,</p>		

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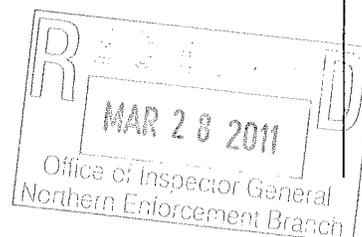


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NAME OF PROVIDER OR SUPPLIER ROSEDALE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4260 GLENN AVENUE COVINGTON, KY 41015	
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F 431	<p>Continued From page 23</p> <p>03/03/11 at 12:00pm revealed that she was not aware that the Unit Coordinators had keys to the medication room. She stated the medications were not properly secured by allowing unauthorized personnel access to medication rooms. The DON also revealed that she was not aware the pharmacy did not do a complete audit of the treatment carts. She stated that the nursing staff should be checking medications and supplies for expiration dates in both the medication rooms and in the treatment carts. The DON confirmed she is ultimately responsible for ensuring the security of controlled drugs and monitoring expiration dates of medications and biologicals.</p> <p>Observation of the medication carts on the 2 South halls on 03/02/11 at 3:00pm revealed one bottle of sodium chloride and one bottle of Safecleans Surgical cleaner with had not been dated when opened.</p> <p>Interview with the 2nd floor supervisor on 03/02/11 at 3:00pm revealed the sodium chloride should be discarded after 90 days, however review of the pharmacy guidelines policy provided by the facility revealed the sodium chloride should be discarded after 24 hours. The supervisor revealed the Safecleans surgical cleaner should be discarded.</p> <p>Interview with the Director of Nursing on 02/03/11 at 12:00 noon revealed it was the responsibility of the nurses and nurse managers to ensure that medications are checked for labeling and the responsibility of the Assistant Director of Nursing to ensure that the nurse managers are doing their job.</p>	F 431	<p>medication cart and / or treatment cart monthly x12 months and then as needed as determined through the QA process.</p> <p>Compliance with this requirement will be reviewed at least quarterly for one year by our facility QA committee.</p>	

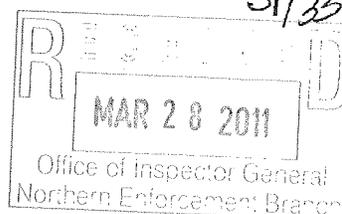
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F 465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe, functional and comfortable environment for the residents. Hallways had the hand rails blocked by a table and two (2) chairs, a bird cage, as well as a sofa. Room #151 had a hole in the wall. Room #141 had cardboard boxes stored against the heater and Room #134 had a three (3) plug apparatus plugged into the wall receptacle.</p> <p>The findings include:</p> <p>Observation on 02/28/11 at 10:28am the hallway in front of the second floor elevators had a table and two (2) chairs blocking the resident's access to the hand rails, the bird cage in excess of four foot wide on the second floor blocked the resident's access to the hand rails, as well as a sofa sitting in front of the Beauty Shop.</p> <p>Observation on 03/02/11 at 10:45am revealed room #134N had a three (3) plug apparatus plugged into the wall receptacle containing the resident's hospital bed, a nebulizer and the radio, in addition the feeding pump was plugged into the same receptacle.</p> <p>Observation on 03/02/11 10:50am revealed room #141N had two (2) brown cardboard boxes stored</p>	F 465	<p>F465 SAFE/FUNCTIONAL /SANITARY/COMFORTABLE ENVIRONMENT</p> <p>Per resident council and family member request the facility had placed furniture in the hallways at various locations such as outside the beauty shop and across from the elevators so that residents would have a place to rest while waiting for the elevators to arrive at their floor.</p> <p>On 3/11/2011 the furniture indicated in the citation was removed from the hallways. The Administrator will meet with the resident council on March 30, 2011 to explain the removal of the furniture.</p> <p>On 3/3/2011 room #134 had the three (3) prong apparatus removed and the equipment plugged into the available electrical outlets located in the room. While family members are educated during the admission process on electrical appliances and cords, the resident and family members were reeducated on 3/25/2011 by the Administrator. The medical equipment was plugged in directly to the electrical outlet in the room.</p> <p>The boxes stored on the heater in room #141 were immediately relocated. The resident and family members of the residents in room #141 were educated regarding the concern/policy of storing items</p>	4/15/11

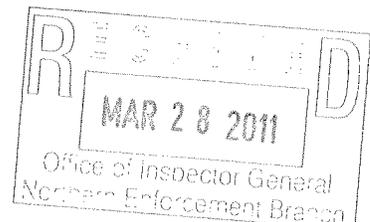


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F 465	<p>Continued From page 26 against the heater.</p> <p>Observation on 03/03/11 at 10:55am revealed room #151N had a 3"x 2" hole in the wall with black stain and loose wall finish between the sink and the baseboard in the bathroom.</p> <p>Observation on 03/03/11 at 11:00am revealed the birdcage in excess of four foot wide blocked the resident's access to the hand rails near the first floor North Nurses Station.</p> <p>Interview on 03/03/11 at 11:25am with the Director of Maintenance (DOM) revealed he had a discussion with the Director of Housekeeping to keep the boxes and personal from storage near the heaters and to keep an eye out for the plugs in the resident rooms that have multiple items plugged in. The DOM reported the electric plug receptacles are not to have the multiple plugs with medical equipment plugged into them. The DOM reported he was not aware the bird cages that blocked the resident's access to the handrails was a concern for the residents. The DOM reported it is everyone's responsibility to provide a work order when they see something that needs to be repaired. He reported the hole in the wall in room #151N had been there just a few days since they had snaked out the sewer, but did not repair the hole in the wall.</p>	F 465	<p>against the heater. The housekeeping director was inserviced by the Administrator on 3/25/2011 regarding completing room checks daily during room cleanings. The housekeeping staff will be inserviced by 4/15/2011 by the Housekeeping Supervisor regarding properly storing items in the resident rooms.</p> <p>The hole in the wall in room #151 was repaired by the maintenance staff on 3/3/2011. The maintenance staff will be educated by 4/1/2011 by the Maintenance Director regarding completely finishing all repairs when working in an area. The maintenance director will be responsible for ensuring on-going compliance.</p> <p>The bird aviary located on the first floor resident lounge was relocated to the ground floor on 3/24/2011. This will also be communicated to the resident council on the March 30th meeting.</p>		

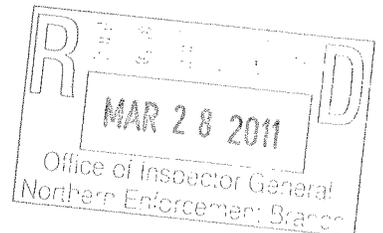
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R465

The safety committee will complete an audit on a monthly basis for the first three (3) months and then on a quarterly basis for the next three (3) quarters to ensure that there are not any obstructions to the resident handrails, that items are not stored against the heaters in the resident rooms, plug adapters and extension cords are not in use and work orders have been completed on any necessary repair. The safety committee will report to the facility quality assurance committee on a quarterly basis to ensure on-going compliance.

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NAME OF PROVIDER OR SUPPLIER ROSEDALE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41016	
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated on 03/01/11 and concluded on 03/02/11. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was at an "F" level.	K 000	PLAN OF CORRECTION: The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care.	
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 observation and interview, it was determined the facility failed to ensure the fire alarm was maintained according to NFPA standards. The deficient practice has the potential to affect all smoke compartments, and all residents, staff and visitors. The facility is licensed for two hundred ten (210) nursing beds. The census for nursing beds the day of the survey was two hundred eight (208). The findings include:	K 052	K052 NFPA 101 Life Safety Code Standard As part of the plan of correction for a life safety code inspection conducted on 3/10/2009 an alarm was placed at the front entrance next to the fire panel that was both distinctive and audible. While this location is not continuously occupied, the regulation 1-5.4.6 state that the trouble signal(s) shall be located in an area where it is likely to be heard. Staff were in-serviced on this alarm and have responded appropriately when it has sounded. However, following the inspection conducted on 3/2/2011 the enunciator was relocated from the main entrance to a location at the 1 st floor (1 North) nursing station. This was completed on 3/4/2011 by Res/Comm Security Systems, Inc.	4/15/11

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

TITLE

(X5) DATE

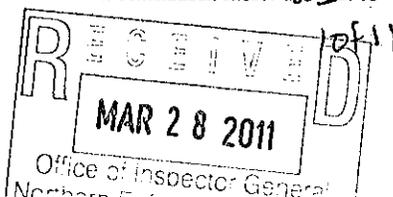
Ronda Knollman

Administrator

4/15/11

error 3/28/11 RL

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.

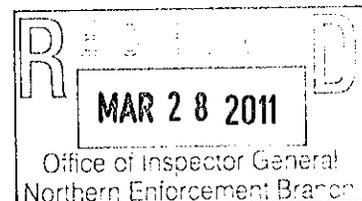


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K 052	Continued From page 1 Observation on 03/01/11 at 2:00 pm, revealed the dialers of the fire alarm system when tested, did not reveal an audible or visual alarm in an area that was constantly occupied. The observation was confirmed with the Maintenance Director. An audible and visual annunciator is located at the front door near the administrative offices, but the offices are not attended between the hours of 8:30 pm and 8:00 am. Interview on 03/01/11 at 2:15 pm, with the Administrator revealed that the offices by the front door are unattended between the hours of 8:30 pm and 8:00 am. Interview on 03/01/11 at 2:30 pm, with the Maintenance Director revealed that the annunciation by the front door is the only location that a trouble signal is annunciated. Reference: NFPA 72 1999 edition Distinctive Signals 1-5.4.4 Fire alarms, supervisory signals, and trouble signals shall be distinctively annunciated. Trouble Signals 1-5.4.6 Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. The trouble signal(s) shall be located in an area where it is likely to be heard.	K 052	The maintenance staff was inserviced by the Maintenance Director on 3/7/2011 regarding the alarm and what steps should be taken should the alarm activate. The department directors, nursing administrative staff, and charge nurses will be inserviced by the Maintenance department by April 15, 2011. The safety committee will review quality assurance audits completed quarterly by the maintenance department to ensure that an audible alarm does in fact alarm when the automatic dialer becomes non-functioning and the staff respond accordingly. The safety committee will review and analyze these audits, reporting any trends, concerns, or subsequent plans of correction that are implemented to the facility Quality Assurance Committee on a quarterly basis for the next year.	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

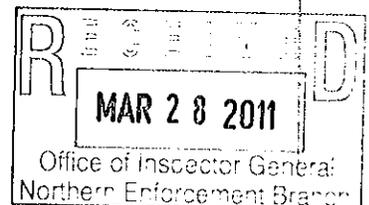
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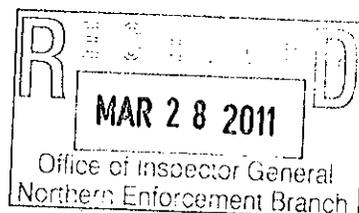
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K 062 SS=F	<p>Continued From page 2</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.8.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the sprinkler system was maintained according to NFPA standards. The deficiency has the potential to affect all smoke compartments, residents, staff and visitors.</p> <p>The findings include:</p> <p>Record review of the sprinkler system maintenance logs on 03/01/2011 at 2:25 pm, with the Maintenance Director, revealed no documented evidence the facility checked the valves or the gauges located in the sprinkler system.</p> <p>Interview on 03/01/2011 at 2:25 pm, with the Maintenance Director, revealed he did not document monthly checks of valves or gauges located in the sprinkler system.</p> <p>(1) Reference: NFPA 25 (1998 edition) 9-3.3.1 All valves shall be inspected weekly. Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Exception No. 2: After any alterations or repairs,</p>	K 062	<p>K-062 NFPA 101 Life Safety Code Standard</p> <p>On 3/2/2011 the Administrator and Maintenance Director updated the policy and procedures regarding the sprinkler system to include the weekly and monthly inspection of the valves and gauges.</p> <p>On 3/2/2011 the Maintenance Director inserviced all the maintenance staff on the new procedures regarding inspections of the valves and gauges located in the sprinkler system. A log was developed by the Maintenance Director to record these weekly & monthly inspections. This log was implemented by the maintenance staff on 3/2/2011.</p> <p>The safety committee will conduct monthly quality assurance audits to ensure that this inspection log has been completed as required by the maintenance department.</p> <p>The safety committee will review and analyze these audits, reporting any trends, concerns, or subsequent plans of correction that are implemented to the facility Quality Assurance Committee on a quarterly basis for the next year.</p>	3/25/11



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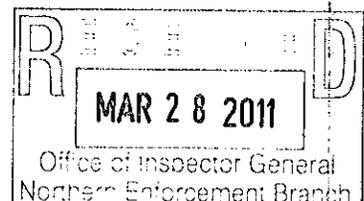
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K 062	Continued From page 3 an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised. 9-3.3.2* The valve inspection shall verify that the valves are in the following condition: (a) In the normal open or closed position (b) *Properly sealed, locked, or supervised (c) Accessible (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification (2) Reference: NFPA 25 (1998 edition) 9-2.8 Gauges. 9-2.8.1 Gauges shall be inspected monthly to verify that they are in good condition and that normal pressure is being maintained. Exception: When other sections of this standard have different frequency requirements for specific gauges.	K 062		
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degree C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and Interview It was	K 070	K 070 NFPA 101 Life Safety Code Standard The portable space heater located in the dietary office was removed immediately on 3/1/11 when the heating element was determined to have reached 324 degrees F. The Maintenance Director completed an audit on 3/1/11 to ensure that no other space heaters were in use and/or removed from the offices. The safety committee members completed an audit on 3/24/2011 of all resident rooms and offices to ensure no space heaters were in use.	4/5/11



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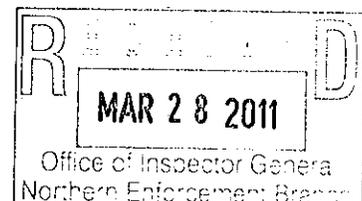
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185225	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2011
NAME OF PROVIDER OR SUPPLIER ROSEDALE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015	
(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 070	Continued From page 4 determined the facility failed to ensure, portable space heaters used in the facility were according to NFPA standards. Portable space heaters used in health care facilities must be of an approved type to limit the risk of fire. The deficiency affected two (2) smoke compartments. The findings include: Observation on 03/01/11 at 1:00 pm, revealed a portable space heater in the Dietary Office and the Dietician Office. The observation was confirmed with the Maintenance Director. Further observation, revealed that when the heater was checked with an infrared thermometer, the heating element reached 324°F. Interview on 03/01/11 at 1:00 pm, with the Maintenance Director, revealed he was aware that portable heaters could not be used in resident sleeping rooms, but was unaware that portable heaters, used in non-sleeping areas, had to meet the requirements of NFPA. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD	K 070	The Department Directors were inserviced by the Maintenance Director on 3/23/2011 regarding the NFPA standards regarding portable space-heating devices. The Maintenance Director will inservice all the maintenance staff by 4/1/2011. All office staff will be inserviced by April 15, 2011 by the maintenance staff and/or department directors regarding the NFPA standards on portable space-heating devices. The safety committee will conduct quarterly audits to ensure space heaters are not in use or if they are that they meet the Life Safety Code Standards. The safety committee will review and analyze these audits, reporting any trends, concerns, or subsequent plans of correction that are implemented to the facility Quality Assurance Committee on a quarterly basis for the next year. K 072 NFPA 101 Life Safety Code Standard	
K 072 SS=F	Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No	K 072	All items identified during the tour with the survey team were immediately relocated or removed by 3/2/11.	4/15/11



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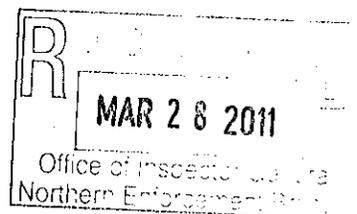
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185225	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2011
NAME OF PROVIDER OR SUPPLIER ROSEDALE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015	
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K 072	<p>Continued From page 5</p> <p>furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions according to NFPA standards. The facility has the capacity for two hundred ten (210) nursing beds; the census for nursing beds on the day of the survey was two hundred eight (208).</p> <p>The findings include:</p> <p>Observation during the Life Safety Code Survey on 03/01/11 between 10:50 am and 4:00 pm, with the Maintenance Director, revealed various items located within all the resident area corridors. These items include: birdcages, storage tables, med carts, and soiled linen carts. The observations were confirmed with the Maintenance Director.</p> <p>Interview with the staff on 03/01/11 at 11:30 am revealed these items were routinely left in the corridors. Further interview with the Administrator, and the Maintenance Director, during the exiting conference on 03/02/11 at 10:00 am confirmed the items located in the corridors.</p> <p>Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously</p>	K 072	<p>The Administrator and Maintenance Director conducted an audit of the entire facility on 3/24/2011 to determine if any other items were obstructing means of egress.</p> <p>The Department Directors were inserviced by the Maintenance Director on 3/23/2011 regarding this life safety code standard. All staff will be inserviced by their department director/supervisor by April 15, 2011.</p> <p>The safety committee will conduct monthly audits for the next year to ensure that this life safety code standard is met.</p> <p>The safety committee will review and analyze these audits, reporting any trends, concerns, or subsequent plans of correction that are implemented to the facility Quality Assurance Committee on a quarterly basis for the next year</p>	



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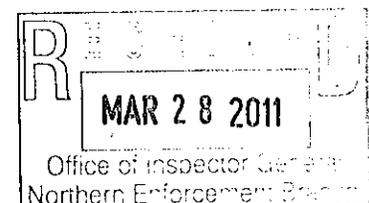
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K 072	Continued From page 6 maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		
K 078 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored according to NFPA standards. This deficiency has the potential to affect one (1) smoke compartments and approximately twenty five (25) residents, staff and visitors. The facility has the capacity for two hundred ten (210) nursing beds; the census on the day of the survey was two hundred eight (208). The findings include: Observation on 03/01/11 at 11:07 am, with the Maintenance Director, revealed oxygen cylinder tanks stored in an alcove next to nurses station.	K 076	K076 LIFE SAFETY CODE STANDARD – Medical gas storage and administration areas Rosedale Manor remains committed to storing oxygen cylinders according to NFPA standards. The main oxygen storage area located on the ground floor is in compliance with the NFPA regulations regarding oxygen storage. The intent of Rosedale Manor is to maintain an operational supply of oxygen on each nursing unit, not to exceed 300 cubic feet per compartment (which equals 12 E size tanks). To achieve this goal, Rosedale Manor intends to follow the 2005 edition of NFPA 99 Health Care Facilities guideline 9.4.3 which states that up to 300 cubic feet of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse's station or in a corridor of a healthcare facility. This amount of nonflammable medical gas per smoke compartment is not considered a hazard if the containers are properly secured, such as in a rack to prevent them from tipping	4/15/11



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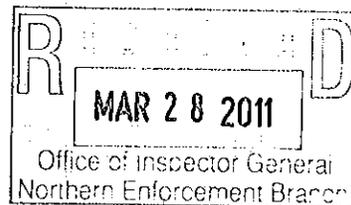
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K 076	<p>Continued From page 7</p> <p>The oxygen tanks were stored with the crash cart and within five (5) feet of combustible supplies. There were sixteen (16) tanks at this location. Full and empty tanks were stored in the same rack, some with identifying label, and some without. This observation was confirmed with the Maintenance Director.</p> <p>Interview with the Maintenance Director on 02/09/11 at 11:07 am revealed the need for proper oxygen storage.</p> <p>Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for</p>	K 076	<p>over or being damaged. In this case, the medical gas is considered an "operational supply" and not storage. If the cylinders are placed in a corridor, they should be placed so as not to obstruct the use of the corridor. This amount of medical gas is in</p> <p>addition to those cylinders contained in crash carts and in use on wheelchairs or gurneys.</p> <p>To address this issue, as of 3/2/11, a cart that holds 12 E tanks is in place outside of each medication room. Tags that are to be placed on the empty tanks are marked "EMPTY" and are in place on a shelf near the oxygen rack. Staff Inservicing began on 3/2/11 and will be completed as of 4/15/11, for all nursing staff that only 12 tanks plus the crash cart tank are to be kept in the location outside of the medication room. All oxygen tanks MUST be in the rack. NO oxygen tanks, whether full or empty, can be place on the floor unsecured. ANY oxygen tank that is empty MUST be marked with an "EMPTY" tag as soon as it is placed in the rack. There are NO exceptions. A tank carrier can be kept in this area, but it CANNOT have a 13th E tank in it. Inservicing is to be completed by the nurse managers, supervisors, ADON, or central supply clerk.</p>		



Charge nurses or medication aides will be responsible to check the oxygen supply at each shift change and document on a QA form to be kept with the narcotic count records, the number of oxygen tanks present, whether they were properly marked if empty, and if they were all secured.

The Nurse Manager, ADON, or supply clerk will complete monthly QA audits x12 months and then as needed as determined by review by the facility QA committee.

Compliance with this requirement will be reviewed at least quarterly for one year by our facility QA committee.



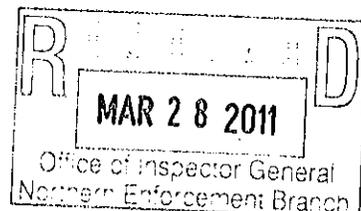
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K 076	Continued From page 8 cylinder storage.	K 076		
K 147 SS=D	<p>8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. This deficient practice affected two (2) smoke compartments, staff, visitors and approximately fifty (50) residents and staff. The facility has the capacity for two hundred ten (210) nursing beds; a census of two hundred eight (208) the day of the survey.</p> <p>The findings include:</p> <p>Observations on 03/01/11 at 11:45 am, with the Director of Maintenance revealed:</p> <p>1) Dietician Office had an unapproved extension cord in use, providing power to a personal coffee pot. Interview with the Director of Maintenance, revealed he was unaware of the extension cord</p>	K 147	<p>K 147 NFPA 101 Life Safety Code Standard</p> <p>On 3/1/2011 the Maintenance Director removed the extension cord utilized in the dietitian's office. The Maintenance Director also removed the small book case that was stored under the electrical panel located in the dietary office on 3/2/2011.</p> <p>The Department Directors were inserviced on 3/23/2011 by the Maintenance Director on the life safety code standards regarding receptacles/extension cords and work space provided around electrical equipment.</p> <p>All staff will be inserviced by their department directors by April 15, 2011 regarding the storage of items surrounding electrical panels and unapproved use of extension cords.</p>	4/15/11

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K 147	Continued From page 9 being used, and removed it. 2) Electrical panels located in the Dietary Office had storage in front of electrical panels. Interview with the Director of Maintenance, confirmed the practice of storage in front of the electrical panels. (1) Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. (2) Reference: NFPA 70 (1999 edition) 110-26. 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.	K 147	The maintenance department will conduct an audit of all electrical panels to ensure items are not stored in appropriately. This will be conducted by 4/15/2011 and will continue on a monthly basis. The safety committee will conduct quarterly audits to ensure extension cords are not utilized inappropriately and that the maintenance department has conducted their monthly audit of the electrical panels. The safety committee will review and analyze these audits, reporting any trends, concerns, or subsequent plans of correction that are implemented to the facility Quality Assurance Committee on a quarterly basis for the next year.	

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