

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS A Recertification Survey was initiated on 03/05/13 and concluded on 03/08/13 with deficiencies cited with the highest Scope and Severity of a "G".	F 000	Redbanks--Plan of Correction Standard Survey 3/8/13 Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 241 SS=D	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 and interview, it was determined the facility failed to ensure privacy and dignity for one (1) of twenty-eight (28) sampled residents (Resident #4). The privacy curtain for Resident #4 was not completely pulled around when a family member of Resident #4's roommate walked across the room where he/she had visual access to staff providing catheter care to Resident #4. The findings include: Review of the facility's policy titled "Privacy and Confidentiality", undated, revealed residents had the right to personal privacy and staff should provide care in a manner that maintained privacy of the person's body. Observation, on 03/6/13 at 2:25 PM, revealed while Registered Nurse (RN) #1 and Certified Nursing Assistant (CNA) #3 provided catheter	F 241	F 241 Dignity 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 Criteria 1: Nursing staff provide privacy for resident #4 during catheter care as determined by compliance rounds and care observations performed by the Administrative Nursing Staff. The program manager provided immediate verbal education to the employee who failed to provide privacy to resident #4 on 3/6/2013. The facility provided further education to the employee who failed to provide privacy to resident #4 on the importance of providing privacy and dignity during care on 3/21/2013. Social Services spoke to resident #4 on 4/16/13. Resident #4 with no psychosocial concerns re: denial of privacy. Resident #4 stated, "it did not bother her" and "did not consider the whole thing a problem." Social services will continue to meet with resident #4 weekly X one month and then monthly X 2 months. Criteria 2: Administrative nursing which includes program managers, MDS nurses and the night shift supervisor conducted compliance rounds beginning 3/18/13 (ongoing), as assigned by the DON. Compliance rounds were to include the monitoring: the full closure of privacy curtains,blinds and doors are closed, call light within reach etc.To identify residents potentially affected by the alleged deficient practice. Compliance rounds were documented and turned into the Adm./DON weekly for review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dyan Wells, Administrator</i>	TITLE Administrator	(X6) DATE 4-18-13
---	------------------------	----------------------

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

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page 1 care to Resident #4 a family member of Resident #4's room-mate walked across the room to a closet. Resident #4's curtain was not fully closed allowing the visitor visual access of Resident #4. Interview, on 03/06/13 at 3:40 PM, with Resident #4 revealed when the family member of his/her room-mate came near the end of his/her bed while catheter care was being provided that it bothered him/her. Interview, on 03/06/13 at 3:50 PM, with RN #1 revealed the curtain should have been pulled around a little more in order not to expose Resident #4 and to afford the resident more privacy. Interview, on 03/08/13 at 4:40 PM, with the Director of Nursing revealed the facility wanted to honor the residents' personal privacy and staff should have adjusted the curtain or asked the person to wait in the hallway.	F 241	Criteria 3: In-service education was provided for licensed and non-licensed nursing staff by the DON/Staff Development Coordinator on 3/21/13, 3/23/13, 3/24/13, 3/25/13, 3/26/13, 3/27/13, 4/2/13, 4/3/13, 4/4/13, 4/9/13, 4/10/13, 4/11/13, 4/16/13, 4/17/13, 4/18/13, 4/19/13 which included but was not limited to: Providing privacy for residents during all care by: pulling the privacy curtains fully, shutting the door, and closing the blinds/curtains. The CQI indicator for the monitoring of resident privacy/dignity issues, including but not limited to providing privacy during resident care, will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the Director of Social Services. Criteria 4: The CQI indicator for the monitoring of resident privacy/dignity issues, including but not limited to providing privacy during resident care, will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the Director of Social Services. Target Date :	04/21/2013	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	F 280 Comprehensive Care Plans A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 651 KIMSEY LANE HENDERSON, KY 42420	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 2</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to revise the Plan of Care for one (1) of twenty-eight (28) sampled residents (Resident #25). Resident #25 was supposed to have a mesh bag over her/his bed alarm to prevent the resident from turning the bed alarm off. Observation, on 03/08/13, revealed a mesh bag was not covering the bed alarm and the alarm was turned off. Review of the plan of care revealed the care plan was not revised to include the use of the mesh bag.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Development of a Care Plan", undated, revealed the care plan was to be revised as per the Resident Assessment Instrument with changes in resident's orders as received by the Minimum Data Set Coordinator.</p> <p>Observation, on 03/08/13 at 10:25 AM, revealed Resident #25 was lying in bed. Further observation revealed there was a bed alarm in</p>	F 280	<p>Criteria 1 The care plan for resident #25 has been reviewed/revised by the Care plan team for interventions addressing provision of alarm use and the mesh bag for the alarm. The alarm bag is utilized in accordance with the care plan.</p> <p>Criteria 2: Residents requiring alarm use have been reviewed by the Unit Managers/MDS Coordinators to determine that the alarms and related equipment are in use and addressed as indicated on the care plan. On 4/16/13 an audit of all care plans was conducted by the interdisciplinary team to include MDS, Activities, Social Services and Dietary, to ensure all care plans were revised as necessary, not just related to alarms.</p> <p>Criteria 3: The nursing staff have received in-service education by the DON/Staff Development Coordinator on 3/21/13, 3/23/13, 3/24/13, 3/25/13, 3/26/13, 3/27/13, 4/2/13, 4/3/13, 4/4/13, 4/9/13, 4/10/13, 4/11/13, 4/16/13, 4/17/13, 4/18/13, 4/19/13, on the provision of alarms and related equipment in accordance with the resident orders and care plan. The MDS Coordinators have received in-service education by the Nurse Consultant on 3/19/13 on the documentation of the use of the alarms and related equipment on the care plan in accordance with the resident orders. Education was provided by the Clinical nurse administrator on 4/16/13 to the entire interdisciplinary care plan team re: revision of the care plan as per Resident Assessment Instrument with changes as they occur.</p>	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 3 place that was not turned on and no mesh bag was covering the resident's alarm. Certified Nursing Assistant (CNA) #19 went into Resident #25's room and turned the bed alarm on. CNA #19 stated "I don't know why it was off, I turned it on." Interview, on 03/08/13 at 11:00 AM, with Registered Nurse (RN) #2 revealed that Resident #25 did have a "bed alarm sensor to bed at all times." Interview, on 03/08/13 at 12:30 PM, with Licensed Practical Nurse (LPN) #3 revealed that Resident #25 was supposed to have a mesh bag, but didn't have it on. LPN #3 further stated, the bag was there the weekend, and she didn't notice it Wednesday or Thursday. She further stated the mesh bag should have been on because the resident has been known to turn the alarm off. Interview, on 03/08/13 at 1:05 PM, with RN #2 revealed that they update care plans if they have physician orders, and she was responsible for doing all the updating on quarterly and significant changes Interview, on 3/08/13 at 3:20 PM, with CNA #20 revealed that they have a buddy system to check alarms when come on shift and off shift and sign the buddy alarm check form. Interview on 03/08/13 at 4:50 PM with LPN #3 revealed that she could not find a buddy alarm check form. Review of the CNA Care Plan dated 01/2013, and review of the physicians' order, dated 07/16/12,	F 280	Criteria 4: The CQI indicator for the monitoring of care plan intervention implementation including use of resident alarms and related equipment will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON. Target Date :	04/21/2013	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 861 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 4 revealed the resident was to have a sensor alarm while in bed with the unit in a mesh bag. Interview, on 03/08/13 at 5:05 PM, with RN #2 revealed that the majority of the time she updated the care plan. She further stated she reviewed and updated the care plan for fall risk 03/04/13. She further stated the care plan did not reflex that the resident needed the alarm to be in a mesh bag. She stated, "I do feel like it should have been on the care plan that's my error. I should have caught that, I should have updated the care plan."	F 280			
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and review of facility policy it was determined the facility failed to ensure care plan interventions were implemented for one (1) of twenty-eight (28) sampled residents (Residents #18). Resident #18 was assessed by the facility to have weakness in the upper extremities with decreased dexterity in his/her hands and was care planned to have his/her meals set up, which included opening beverages. On 02/25/13 during the breakfast meal service, Resident #18 was given a cup of coffee with a lid on it. When the resident	F 282	F282 Comprehensive Care Plans The services provided or arranged by the facility shall be provided by qualified staff in accordance with each resident's plan of care. Criteria 1: Resident #18 receives hot liquid spill prevention interventions as indicated on the care plan. On 2/25/13 after the burn on resident #18, a hot liquid assessment was completed. Two vinyl backed clothing protectors were implemented 2/25/13. Kennedy cups were implemented for resident #18 for all liquids on 2/25/13. Resident #18's name was added to the Dining Room Monitoring form on 2/25/13. The Dining Room Monitoring Form was completed daily by restorative aides to determine if all equipment is in place. Charge nurse notified MD and a new order was received and initiated for Silvadene cream to chest area T1D until healed and Tylenol 500 mg T1D routine X3days on 2/25/13. The Staff Educator in-serviced all staff on "You Stop and Watch" protocol to identify when there was a change in residents condition.		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 5</p> <p>attempted to remove the lid on his/her own, the coffee spilled onto Resident #18's mid chest area, which resulted in a second degree burn measuring eight (8) by four and a half (4.5) centimeters (cm).</p> <p>The findings include:</p> <p>Review of the medical record revealed the facility admitted Resident #18, on 03/11/96, with diagnoses which included Cerebral Palsy; Epilepsy NOS; Genu Valgum; Morbid Obesity; Intellect Disability; Depression; Impulse Control Disorder, Dysphagia; and Anxiety. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 02/11/13, revealed the facility assessed Resident #18 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review of the MDS revealed the facility assessed Resident #18 to require extensive assistance of two (2) staff for bed mobility, transfers and dressing and set-up assistance by one staff for eating.</p> <p>Review of the Comprehensive Plan of Care, dated 12/07/12, revealed Resident #18 required assistance to perform activities of daily living, which included eating related to physical weakness, decreased strength and due to having Cerebral Palsy.</p> <p>Review of Nurse's Notes and the facility's Event Report Investigation, dated 02/25/13, revealed during the breakfast meal service Resident #18 removed the lid from a cup of coffee and spilled hot coffee to the mid chest area directly to the resident's skin. Further review of the</p>	F 282	<p>Criteria 2: An audit was completed by the program managers to determine that residents on their units are receiving hot liquid spill interventions in accordance with their care plans. Hot Liquid Assessments were completed on all residents by Unit Managers and MDS Coordinators on 3/11/13 through 3/13/13. A hot liquid assessment will be completed for all new admissions by the charge nurse. An audit of all care plans was conducted by the interdisciplinary team on 4/16/13 to ensure all care plans revised as necessary. Education was provided by the Clinical nurse administrator on 4/16/13 to the entire interdisciplinary care plan team re: revision of the care plan as per Resident Assessment Instrument with changes as they occur.</p> <p>Criteria 3: The nursing staff have received in-service education as provided by the DON/Staff Development Coordinator on the provision of All care planned interventions including those for hot liquid spill prevention in accordance with each resident's care plan, conducted on 3/14/13, 3/21/13, 3/23/13, 3/24/13, 3/25/13, 3/26/13, 3/27/13, 4/2/13, 4/9/13, 4/10/13, 4/11/13, 4/16/13, 4/17/13, 4/18/13, 4/19/13, 4/20/13. Education was provided by the Clinical nurse administrator on 4/16/13 to the entire interdisciplinary care plan team re: revision of the care plan as per Resident Assessment Instrument with changes as they occur as per policy "Development of the Care Plan."</p> <p>Criteria 4: The CQI Indicator for the monitoring of hot liquid spill prevention interventions in accordance with the care plan will be utilized monthly X 2 months and then quarterly as per the established CQI calendar, under the supervision of the DON. The CQI indicator for the monitoring of the RA1 process and implementation of the care plan will be utilized monthly X2 months and then quarterly as per the established CQI calendar, under the supervision of the DON.</p> <p>Target Date:</p>	04/21/2013	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) OATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 651 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 6</p> <p>investigation revealed the resident had sustained an eight (8) by four and a half (4.5) centimeter (cm) reddened area with peeling skin. The report listed the possible causative factor was the resident 'took top off coffee cup'.</p> <p>During observation on 03/06/13 at 4:00 PM of Resident #18, Resident #18 revealed he/she had a burn to his/her chest related to a coffee burn.</p> <p>A record review of aide care plan dated 03/13, revealed Resident # 18 was assessed by the facility to need set-up assistance with eating and was assessed to have decreased dexterity in his/her right hand. Additionally, review of the Comprehensive Care Plan with revision dates of, 12/07/12, 02/20/12, and, 05/12/13 revealed set-up meal tray for resident for independent eating with each meal.</p> <p>Interview with State Registered Nursing Assistant/Restorative Aides (SRNA/RA) #23, on 03/08/13 at 4:15 PM, revealed Resident #18 had one hand that did not work well. She stated Resident #18 had a long history of taking the lids off of coffee cups and he/she should have been closely supervised during meals.</p> <p>An interview with SRNA/RA #22, on 03/08/13 at 4:10 PM, revealed she would set the resident up for a meal by cutting up his/her meat, opening and adding salt, pepper and butter and open milk cartons and removing the lids on cold drinks. Further interview revealed she was not allowed to remove the lid from coffee cups; only the residents were allowed to remove the lids. She stated residents were encouraged not to remove the lids from coffee because there was a little</p>	F 282			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 hole in it and they were supposed to leave them on and drink from the cup.	F 282		
F 323 SS=G	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 observation, interview, record review and facility policy review it was determined the facility failed to ensure supervision to prevent accidents for one (1) of twenty-eight (28) sampled residents (Resident #18). Resident #18 was assessed by the facility to have weakness in the upper extremities with decreased dexterity in his/her hands and was care planned to have his/her meals set-up, which included opening beverages. On 02/25/13 during the breakfast meal service, Resident #18 was given a cup of coffee with a lid on it, when the resident attempted to remove the lid on his/her own, the coffee spilled onto Resident #18's mid chest area, which resulted in a second degree burn measuring eight (8) by four and a half (4.5) centimeters (cm). The findings include: Review of the facility's policy titled "Event Report	F 323 F 323 Accidents 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. Criteria 1: Resident #18 receives hot liquid spill prevention interventions as indicated on the care plan. On 2/25/13 after the burn on resident #18, a hot liquid assessment was completed. Two vinyl backed clothing protectors were implemented 2/25/13. Kennedy cups were implemented for resident #18 for all liquids on 2/25/13. Resident #18's name was added to the Dining Room Monitoring form on 2/25/13. The Dining Room Monitoring Form was completed daily by restorative aides to determine if all equipment is in place. Charge nurse notified MD and a new order was received and initiated for Silvadene cream to chest area TID until healed and Tylenol 500 mg TID routine X3days on 2/25/13. The Staff Educator inserviced all staff on "You Stop and Watch" protocol to identify when there was a change in residents condition. Criteria 2: An audit was completed by the program managers to determine that residents on their units are receiving hot liquid spill interventions in accordance with their care plans. Hot Liquid Assessments were completed on all residents by Unit Managers and MDS Coordinators on 3/11/13 through 3/13/13. A hot liquid assessment will be completed for all new admissions by the charge nurse. An audit of all care plans was conducted by the interdisciplinary team on 4/16/13 to ensure all care plans revised as necessary. Education was provided by the Clinical nurse administrator on 4/16/13 to the entire interdisciplinary care plan team re: revision of the care plan as per Resident Assessment Instrument with changes as they occur.		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(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 323	<p>Continued From page 8</p> <p>Investigation", not dated, revealed an event report was to be completed for any occurrence which was not considered a normal occurrence, such as a burn. Further review of the policy revealed it was the purpose of the report to assure that events were investigated comprehensively in order to prevent the occurrence from happening again.</p> <p>Review of the medical record revealed the facility admitted Resident #18, on 03/11/96, with diagnoses which included Cerebral Palsy; Epilepsy NOS; Genu Valgum; Morbid Obesity; Intellect Disability; Depression; Impulse Control Disorder, Dysphagia; and Anxiety. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 02/11/13, revealed the facility assessed Resident #18 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review of the MDS revealed the facility assessed Resident #18 to require extensive assistance of two (2) staff for bed mobility, transfers and dressing and set-up assistance by one staff for eating.</p> <p>Review of the Comprehensive Plan of Care, dated 12/07/12, revealed Resident #18 required assistance to perform activities of daily living, which included eating related to physical weakness, decreased strength and due to having Cerebral Palsy.</p> <p>Review of Nurse's Notes and the facility's Event Report Investigation, dated 02/25/13, revealed during the breakfast meal service Resident #18 removed the lid from a cup of coffee and spilled hot coffee to the mid chest area directly to the</p>	F 323	<p>Criteria 3: The nursing staff have received in-service education as provided by the DON/Staff Development Coordinator on the provision of All careplanned interventions including hot liquid spill prevention in accordance with each resident's care plan, conducted on 3/14/13, 3/21/13, 3/23/13, 3/24/13, 3/25/13, 3/26/13, 3/27/13, 4/2/13, 4/9/13, 4/10/13, 4/11/13, 4/16/13, 4/17/13, 4/18/13, 4/19/13, 4/20/13. Education was provided by the Clinical Nurse Administrator on 4/16/13 to the entire interdisciplinary care plan team re: revision of the care plan as per Resident Assessment Instrument with changes as they occur as per policy "Development of the Care Plan."</p> <p>Criteria 4: The CQI Indicator for the monitoring of hot liquid spill prevention interventions in accordance with the care plan will be utilized monthly X 2 months and then quarterly as per the established CQI calendar, under the supervision of the DON. The CQI indicator for the monitoring of the RAI process and implementation of the care plan will be utilized monthly X2 months and then quarterly as per the established CQI calendar, under the supervision of the DON.</p> <p>Target Date :</p>	4/21/2013	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(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 323	<p>Continued From page 9</p> <p>resident's skin. Further review of the investigation revealed the resident had sustained an eight (8) by four and a half (4.5) centimeter (cm) reddened area with peeling skin. The report listed the possible causative factor was the resident 'took top off coffee cup'.</p> <p>Observation, on 03/07/13 at 9:15 AM, of Registered Nurse (RN) #3 conducting a dressing change to Resident #18's burn to the chest area revealed a black scabbed area measuring approximately 8.0 x 4.5 cm. Interview with RN #3, at that time, revealed she believed the burn was a second degree burn because it blistered when it occurred. Further interview with RN #3, on 03/08/13 at 4:00 PM, revealed State Registered Nursing Assistant/Restorative Aide (SRNA/RA) #23 had called her to the dining room on the morning of 02/25/13 because the resident had removed the lid from a cup of coffee and spilled coffee on himself/herself. She stated the resident's hand dexterity was compromised and Resident #18 should have been supervised and assisted with the hot coffee.</p> <p>Interview with Resident #18 during the dressing change, on 03/07/13, revealed he/she had spilled a cup of coffee on himself/herself a few weeks ago and it had really hurt on her chest. RN #3 stated "tell her how you spilled it" and Resident #18 replied "I took the lid off" as held his/her head down as he she spoke.</p> <p>Interview with SRNA/RA #23, on 03/08/13 at 4:15 PM, revealed Resident #18 had one hand that did not work well. She stated she was in the dining room when Resident #18 was burned. She stated Resident #18 had a long history of</p>	F 323			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(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 323	<p>Continued From page 10</p> <p>taking the lids off of coffee cups and he/she should have been closely supervised during meals.</p> <p>An interview with SRNA/RA #22, on 03/08/13 at 4:10 PM, revealed she would set the resident up for a meal by cutting up his/her meat, opening and adding salt, pepper and butter and open milk cartons and removing the lids on cold drinks. Further interview revealed she was not allowed to remove the lid from coffee cups; only the residents were allowed to remove the lids. She stated residents were encouraged not to remove the lids from coffee because there was a little hole in it and they were supposed to leave them on and drink from the cup.</p> <p>An interview, on 03/08/13 at 5:35 PM, with the Administrator and Consultant Nurse revealed on 02/04/13 they had identified, at a behavior meeting that the facility needed to do a hot beverage assessment on all residents; however, this was not initiated prior to Resident #18's burn. The Consultant Nurse stated they also decided to order new liquid absorbing clothing protectors for all residents, but at this point had only ordered one for Resident #18 after his/her burn. The Consultant Nurse stated the facility staff had not completed a hot beverage assessment on the residents because they were waiting until they had the equipment available so when the assessments were completed the equipment such as clothing protectors and spill proof cups would be available for use. Further interview revealed that once Resident #18 was burned they did assess her and implemented the liquid absorbing clothing protector and spill proof cup, but had not assessed other residents for the need</p>	F 323			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(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 323	Continued From page 11 of assistive devices or the ability to handle hot liquids independently to prevent possible burns for other residents.	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure nutritional parameters were maintained for one (1) of twenty-eight (28) sampled residents (Resident #2). Resident #2 sustained an eleven percent (11%) weight loss in one hundred and eighty (180) days. The Registered Dietician's recommendations were not implemented to increase Boost; provide finger foods; and to provide nutritional shakes with lunch and supper to prevent further weight loss. The findings include: Review of the facility's policy, "Significant Weight Loss or Gain", Nutrition Risk Assessment C.3.6, no date, revealed if a significant change (loss or	F 325	F 325 Nutrition Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. Criteria 1: Resident #2 receives dietary recommendation interventions as per indicated on the care plan. 12/7/12 significant weight loss notification via telephone conversation with responsible party. 1/3/13 significant weight loss notification via telephone conversation with responsible party. Care Plan conferences attended by responsible party with discussion of weight loss included 8/17/12, 8/22/12, 10/24/12, and 1/18/13. Criteria 2: On 3/7/13 the Dietician, Clinical Nurse Administrator and MDS Coordinators immediately compared dietary recommendations for the past three months with those sent to the physicians to determine if other residents were affected by the alleged deficient practice. Physicians were notified of any outstanding orders and new orders were received. All recommendations are discussed in the morning meetings attended by Unit Managers.		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(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)	IX51 COMPLETION DATE	
F 325	<p>Continued From page 12</p> <p>gain) occurred, nursing would notify the dietary manager or registered dietitian in writing of the significant change. The resident would be referred to the registered dietitian for a nutritional assessment. Nursing would notify the physician and family of the significant change.</p> <p>Review of the facility's policy, "Nutrition Risk Assessment", C:3.1 not dated revealed, The Dietitian would communicate a summary of findings and recommendations to the dietary manager and appropriate nurse.</p> <p>Record review revealed the facility admitted Resident #2 on 06/14/12 with diagnoses of Dementia with psychotic agitated features, Hypokalemia, Vascular dementia, Hyperlipidemia, and abnormal gait-muscle weakness. Further review revealed Resident #2's weight on 06/14/12 was one-hundred eighty six and four tenths pounds (186.4 pounds).</p> <p>Review of the Minimum Data Set (MDS) Assessment dated 08/09/12 and 01/07/13, revealed the facility assessed the resident to have severely impaired cognitive skills for daily decision making. The facility also assessed the resident under the Nutritional Status; Section K, to have weight loss of five percent (5%) or more in the last month or loss of ten percent (10%) or more in last six (6) months.</p> <p>Review of Care Area Assessment Summary (CAA) dated 08/09/12, revealed Nutrition Status triggered. Review of the indicators for nutritional status revealed the resident left significant proportion of meals, snacks and supplements daily. Further review of the Care Summary</p>	F 325	<p>Criteria 3: The nursing staff have received in-service education as provided by the DON/Staff Development Coordinator on the provision of dietary interventions in accordance with each resident's care plan, conducted on 3/21/13, 3/23/13, 3/24/13, 3/25/13, 3/26/13, 3/27/13, 4/2/13, 4/3/13, 4/4/13, 4/9/13, 4/10/13, 4/11/13, 4/16/13, 4/17/13, 4/18/13, 4/19/13.</p> <p>Criteria 4: The CQI indicator for the monitoring of provisions of dietary interventions in accordance with the care plan will utilized monthly X 2 months and then quarterly as per the established CQI calendar, under the supervision of the DON.</p> <p>Target Date:</p>	04/21/2013	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(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 325	<p>Continued From page 13</p> <p>statement revealed significant weight loss of six and seven tenths percent (6.7%) in thirty days (30), eight and three tenths percent (8.3%) in ninety (90) days, and twelve and two tenths percent (12.2%) in one hundred and eighty (180) days. The plan was to monitor on Nutritional at Risk (NAR).</p> <p>Review of the Care Plan, dated 08/15/11 and updated 01/08/13, revealed Resident #2 was at risk for altered nutrition; weight loss; and dehydration. Review of the goal with a begin date of 10/24/12 and a target date of 04/08/13, revealed Resident #2 would remain adequately nourished with no weight loss of five percent (5%) or more in one (1) month. Interventions dated 08/15/11, included to monitor per facility's nutritional at risk (NAR) policy, and provide Boost one hundred and twenty(120) cubic centimeter (cc) followed by one hundred and twenty (120) cubic centimeter of water three times a day (TID) in between meals for planned weight gain.</p> <p>Review of the Significant Weight Change Notification, dated 01/03/13, revealed Resident #2 had lost thirty (30) pounds, sixteen and nine tenths percent (16.9%) in one hundred and eighty (180) days, with current weight at one hundred and forty-seven pounds (147) and fair appetite. Further review revealed the Physician had signed and dated the notification on 01/09/13.</p> <p>Review of Nutritional Recommendation dated 01/08/13 by the Registered Dietician to the Physician, revealed Boost two hundred and forty (240) cubic centimeters (cc) three times a day (TID), nutritional shakes twice a day (BID) with lunch and supper, and finger foods for planned</p>	F 325		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE B51 KIMSEY LANE HENDERSON, KY 42420		
(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 325	<p>Continued From page 14</p> <p>weight gain. Further review revealed to proceed with the recommendations acknowledge by checking the box and return to Registered Dietician within seventy two (72) hours. Review revealed the Physician signed and dated to proceed with recommendation on 01/09/13.</p> <p>Review of the monthly nutrition at risk review (NAR), dated 02/06/13 and 02/21/13, revealed weight loss continued, nutritional recommendation for more supplements related to continued weight loss, and decreased fluid intake (PO). However, further review revealed supplements and snacks ordered during this time included Boost one hundred twenty (120) cubic centimeters (cc) and one hundred twenty (120) cubic centimeters (cc) of water. There was no evidence the Registered Dietician's recommendations from 01/08/13 and signed by the Physician on 01/09/13 were implemented.</p> <p>Review of Resident #2's Physician orders, dated 03/2013, revealed Boost one hundred twenty (120) cubic centimeters (cc) followed by one hundred twenty (120) cubic centimeters (cc) of water between meals three times a day (TID) for planned weight gain.</p> <p>Record review of weights for Resident #2, dated 09/01/12 through 02/28/13, revealed an eleven percent (11%) weight loss; from one hundred fifty nine pounds (159#) to one hundred and forty pounds (140#).</p> <p>Review of Nutritional Recommendation dated 02/28/13, revealed to increase Boost Plus to two hundred forty (240) cubic centimeters (cc), change ice cream to magic cup and provide at</p>	F 325			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(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 325	<p>Continued From page 15</p> <p>lunch and supper, and provide nutritional shake at breakfast for significant weight loss. Further review revealed the Physician's signature was not noted on recommendation.</p> <p>Record review of fax log, on 03/06/13, revealed there was no pending faxes to the Physician for Resident #2 and none returned.</p> <p>Interview with Registered Dietitian on 03/08/13 at 2:45 PM revealed, she placed the nutritional recommendation in the program manager's mailbox and waited until she obtained a green copy of the Physician order attached to the recommendation. She only followed-up with her recommendations when she received a green copy of the Physician order. She further stated she never received the green copy. However, she stated she assumed the order was done, and the time frame from the original recommendation of 01/08/13-03/06/13 was a long time for a recommendation to be implemented.</p> <p>Interview, with the Program Manager #1 revealed the nutritional recommendations were placed in her mailbox and either she or the nurse would fax the recommendations to the Physician. The recommendations were placed in the fax book to follow-up if there was no response. When the Physician returned the fax to the facility, the Physician's order would be written, and the copy given to the Dietician along with the original recommendation. Per interview, she never received Resident #2's nutritional recommendation and thought this was a system failure, with too many hands involved. Further interview revealed pending recommendations were discussed during the Nutritional At Risk</p>	F 325		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(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 325	Continued From page 16 (NAR) meeting every week, and she was not aware of this being pending. Interview on 03/08/13 at 3:40 PM with Medical Records Supervisor #16, revealed they picked up orders and dietary recommendations on each unit that needed to be signed or the Physician wanted to be faxed. The signed originals went back to the units' mailbox and the dietary recommendations went directly to the Dietician, as stated on the Nutritional Recommendation form. Per interview, she could not remember if she saw Resident #2's recommendations or not. Interview with the Director of Nursing (DON) on 03/07/13 and 03/08/13, revealed the Dietician, Program Managers, and the DON attended the weekly Nutritional At Risk (NAR) meeting. Weight loss, hydration, and interventions were discussed. These issues and pending recommendations were also discussed at the clinical meetings. Per interview, depending on Physician preference, orders and recommendations were either faxed or hand carried to the Physician. She stated Resident #2's Physician liked his orders faxed. She further stated the issue with Resident #2's recommendations was somewhat a system failure.	F 325		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 Food Procure, Store/Prepare/Service-Sanitary The facility must store, prepare, distribute and serve food under sanitary conditions.	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observations on 03/05/13 revealed there was food in the reach in the refrigerator that had expired; two (2) dented cans stored in the dry goods store room; a can opener with grease and food build-up; dried grease and food build-up between the stove and the deep fat fryer; ladles, a can opener and tongs stored in a utensil drawer, dried food and grease build-up on drawer handles and refrigerator handles and cans not rotated in the dunnage rack in the dry good store room. In addition, observation during the supper meal, on 03/06/13, revealed staff left the tray-line service, touched refrigerator doors, microwaves and themselves and returned to the tray-line without washing hands and changing gloves. The findings include: Review of the facility's policy titled "Handwashing", undated, revealed handwashing and hand antisepsis should be regarded by the facility as the single most important means of preventing the spread of infections. The policy further stated all personnel should follow the established handwashing and hand antisepsis procedures to prevent the spread of infection and disease to other personnel, residents, and	F 371	Criteria 1: The expired food and dented cans were discarded by the dietary manager immediately. The can opener was replaced on 3/11/13. Areas with grease/food build up were cleaned on 3/11/13 under the supervision of the dietary manager. Cans were rotated in the dry storage room in accordance with facility policy by the dietary manager on 3/11/13. Dietary staff will follow infection control standards for glove use and hand washing when serving food on the tray line. All dietary employees received in-service education by the Dietician, Dietary Manager and Dietary Director on 3/19/13 to include Sanitation, Handwashing procedures and Trash Disposal/Waste Control. Criteria 2: An audit was completed of the kitchen to identify any dietary sanitation issues. All identified issues addressed as indicated. The dietary department audit was conducted on 3/14/13 by the dietary director to identify any potential areas affected by the alleged deficient practice. Issues identified were and corrected by 3/29/13. A dietary deep clean was conducted on 3/19/13 through 3/29/13. All dietary employees completed a hand washing competency with a return demonstration on 4/3/13 conducted by the Dietary manager. Criteria 3: The dietary staff have received inservice education on dietary sanitation issues including but not limited to cleaning schedules, dating and rotating of food items, and handwashing/glove use while serving food on the tray line as provided on 3/19/13 by the RD/Dietary Manager.	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 18 visitors. Review of the facility's policy titled "Dry Storage", undated, revealed stock would be rotated on a first in first out (FIFO) basis. Further review of the policy revealed damaged canned food containers would be stored in a separate and distinct area away from other food items and the area should be labeled and the containers returned to the vendor. Review of the facility's policy titled "Refrigerated Storage", undated, revealed all foods would be properly wrapped and/or stored in sealed containers, dated, labeled and discarded within appropriate shelf life. Observation, on 03/05/13 at 10:35 AM, revealed the blade of a large can opener had thick black sticky substance build-up. Observation of a utensil storage drawer revealed a can opener replacement, ladles and tongs stored in opposite directions. Further observation revealed the handle of the drawer was sticky and greasy. Continued observation and interview with the Dietary Manager, on 03/05/13 at 10:40 AM, revealed several items in the refrigerator which were past the use by date. These items included four (4) bowls of salad with a use by date of 02/26 (seven days prior), a plastic container of chocolate pudding with a use by date of 02/28 (five days prior), a plastic container of cut-up tomatoes with a use by date of 02/25 (eight days prior), a plastic container of thick white substance with chunks of potatoes that did not have a label or date, ground ham with a use by date of 02/28 (five days prior), pinto beans with a use by date of	F 371	Criteria 4: The CQI indicator for the monitoring of dietary sanitation will be utilized as monthly per the established CQI calendar under the supervision of the Dietary Manager. Target Date :	04/21/2013

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 19</p> <p>02/24 (nine days prior), lima beans with a use by date of 03/02 and a bowl of egg salad with a use by date of 03/03. Interview with the Dietary Manager, at that time, revealed the items had expired and should have been thrown out. Further interview revealed she had recently hired several new staff and probably needed to re-train them. Further observation of a pot and pan storage rack revealed four (4) half sized and nine one third sized steam table pans were stacked and stored wet.</p> <p>Observation during the supper tray-line service, on 03/06/13 at 4:40 PM, revealed that Dietary Aide #2 left the tray line went to the microwave touched the door handle with gloved hands and went back to the tray line service and touched the inside of lids and the rims of plates of food without removing gloves, washing hands and putting on a new pair of gloves. Further observations revealed Dietary Aide #2 kept putting gloved hands on hips while waiting between trays several times without removing gloves, washing hands and putting on a new pair of gloves.</p> <p>Interview, on 03/06/13 at 6:00 PM with Dietary Aide #2 revealed when leaving the tray line staff was supposed to dispose of gloves, wash hands and obtain fresh gloves. Further interview revealed she usually washed her hands after leaving the tray-line and prior to returning to the tray-line but she must have forgotten.</p> <p>Observation, on 03/06/13 at 4:45 PM, revealed Dietary Aide #1 dropped a package of crackers on the floor, picked them up with gloved hand and went back to the tray line touching trays, plates,</p>	F 371		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 651 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IO PREFIX TAG	(X5) COMPLETION DATE
F 371	<p>Continued From page 20</p> <p>crackers, meal ticket, bagged silverware, and cold plates without removing gloves, washing hands and putting on a new pair of gloves. Further observation revealed Dietary Aide #1 left the tray-line service, went to the walk-in refrigerator and touched the handle which had dried red particles with gloved hand and going back to tray line without removing gloves, washing hands and putting on a new pair of gloves.</p> <p>Interview with Dietary Aide #1, on 03/06/13 at 5:45 PM, revealed he had been employed at the facility for four (4) days and had received training that he was supposed to remove his gloves, wash his hands and put a new pair of gloves on anytime he went from one task to another such as leaving the tray-line. He indicated he realized after he completed the tray-line that he had only washed his hands and put new gloves on once during tray-line service and had not completed that task every time he left the tray-line or when he picked up the package of crackers.</p> <p>Observation, on 03/06/13 at 5:05 PM, revealed the Dietary Manager took salad tongs that she was dipping salad from a large bowl into single serving bowls with tongs. Further observation revealed she then used the tongs to remove the lid from a can of parmesan cheese. The top of the can dropped into the big salad bowl and the Dietary Manager took the tongs and removed the lid from the big bowl of salad. She then took the same tongs and continued to serve salad from the big salad bowl to the single serving salad bowls.</p> <p>Interview with the Dietary Manager, on 03/06/13</p>	F 371			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(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)	IX51 COMPLETION DATE	
F 371	Continued From page 21 at 5:55 PM, revealed she should have thrown the salad out and made new salad because the tongs touching the lid and then the lid dropping into the salad could cause cross contamination. Further interview with the Dietary Manager revealed to prevent cross contamination, staff was supposed to remove gloves, wash hands and put a new pair of gloves on after leaving the tray-line. Additional interview revealed the facility had recently hired several new staff and she needed to re-train staff related to proper cleaning and infection control practices.	F 371			
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure garbage and refuse were properly disposed. Observations, on 03/05/13 and 03/06/13, revealed that not all of the dumpster lids were closed. Further observations revealed gloves, food items, trash and debris around the dumpster area. The findings include: Review of the facility's policy "Waste Control", Safety and Sanitation A:6.10, not dated, revealed, trash should be kept in approved cans with plastic liners. Lids were to be kept on cans at all times,	F 372	F 372 Dispose of Garbage and Refuse Properly. The facility must dispose of garbage and refuse properly. Criteria 1: The trash around the dumpsters was removed and the lids to the dumpsters were closed immediately on 3/7/13 by one dietary aide and the Dietary Manager. Criteria 2: The dumpster area is monitored by the Environmental Director to determine that trash is placed in the dumpsters and the lids are kept closed. Criteria 3: All staff have received inservice education by the Environmental Director/ Staff Development Coordinators 3/15/13, 3/18/13, 3/20/13, 3/21/13, 3/23/13, 3/24/13, 3/25/13, 3/26/13, 3/27/13, 3/29/13, 4/2/13, 4/3/13, 4/4/13, 4/9/13, 4/10/13, 4/11/13, 4/12/13, 4/16/13, 4/17/13, 4/18/13, 4/19/13 on the need to place trash in the dumpsters and to keep the lids closed at all times.		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 372	Continued From page 22 and trash should be discarded in the dumpsters frequently and at least at the end of each shift. The dumpster must be kept closed at all times when not in use. Observations, during the initial tour, on 03/05/13 and 03/06/13 at 10:30 AM, revealed three (3) dumpsters; and, two (2) recycle bins outside the food delivery exit, with the lid completely open on two (2) of the three (3) dumpsters. Further observation revealed boxes and debris on the ground in the surrounding area, including a container of applesauce, four (4) pairs of gloves and trash. Interview, on 03/08/13 at 6:00 PM, with the Environmental Services Director revealed, the garbage should be properly contained in the dumpsters with the lids and doors closed and not on the ground in order to prevent harborage and feeding of pests and animals.	F 372	Criteria 4: The GQI indicator for the monitoring of the dumpster areas will be utilized monthly X 2 months and then every six months as per the established calendar under the supervision of the Environmental Director. Target Date :	04/21/2013	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431	F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS Drugs and biological 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.		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 861 KIMSEY LANE HENDERSON, KY 42420		
(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 23</p> <p>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> <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 review of the facility's policy, it was determined the facility failed to ensure all controlled drugs were stored separately from other medications in a double locked compartment, when two (2) bottles of liquid Ativan were found in two (2) different unlocked refrigerators.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Medication Storage in the Facility, not dated, revealed all</p>	F 431	<p>Criteria 1: The locks for the med room refrigerator in the Central Bay and Marina Med rooms were inspected by the program managers to verify function. The lock for Central bay was replaced by Staff Development Coordinator.</p> <p>Criteria 2: All med room refrigerator locks were inspected by Program Managers on 3/18 to verify function. The lock for Central Bay med room refrigerator was replaced with combination lock on 4/18/2013 by the DON.</p> <p>Criteria 3: Medication Administration staff have received inservice education by the DON/Staff Development Coordinator on the need to keep all narcotic medications under double lock, and to immediately notify maintenance if any of the locks are not functioning properly as provided on 3/21/13, 3/23/13, 3/24/13, 3/25/13, 3/26/13, 3/27/13, 4/2/13, 4/3/13, 4/4/13, 4/9/13, 4/10/13, 4/11/13, 4/16/13, 4/17/13, 4/18/13, 4/19/13.</p> <p>Criteria 4: The CQI for the monitoring of the storage of narcotic medications will be utilized monthly X 2 months and then quarterly as per the established calendar under the supervision of the DON.</p> <p>Target Date:</p>	04/21/2013	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO 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 24</p> <p>schedule two (2), three (3), four (4) and five (5) controlled medications were to be stored separately from other medications in a double locked drawer or compartment designated for that purpose.</p> <p>Observation, on 03/07/13 at 10:00 AM, revealed the refrigerator in the medication room on the Central Bay Unit was unlocked. Further observation revealed a bottle of liquid Ativan (a controlled medication used to treat anxiety).</p> <p>Interview with Registered Nurse (RN) #1, on 03/07/13 at 10:00 AM, revealed if a refrigerator contained a controlled medication, then the refrigerator should be locked. He further stated the refrigerator containing the Ativan should have been locked.</p> <p>Observation, on 03/07/13 at 11:00 AM, revealed the refrigerator in the medication room on the Marina Unit was unlocked and contained a bottle of liquid Ativan.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 03/07/13 at 11:05 AM, revealed the refrigerator should have been locked since it contained a controlled medication.</p> <p>Interview with the Unit Manager, on 03/07/13 at 4:00 PM, revealed if a refrigerator in the medication rooms contained a controlled medication, the refrigerator should be locked.</p>	F 431			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(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	Continued From page 25 She further stated since the refrigerator in the medication rooms on Central Bay, and on the Marina units contained liquid Ativan, they should have been locked.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	F 441 Infection Control The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Criteria 1: Administrative nursing observations indicate nursing staff perform handwashing and changing of gloves in accordance with infection control standards of practice when providing care for residents. The bleach, food items, hygiene items, and staff personal items were removed from the medication room. Criteria 2: Administrative nursing observations indicate that nursing staff perform handwashing and changing of gloves in accordance with infection control standards of practice, and that staff personal food or hygiene items, cleaning supplies and other non-medication supply items are not stored with medication in the medication room. The Unit Managers immediately inspected the medication carts and inspected medication rooms for cleanliness, free of clutter, and that disinfectants were stored separately from medications.		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 26</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy it was determined the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection during a dressing change improper technique was used, and wound contamination occurred on Resident #25. In addition, the facility failed to ensure medications were properly stored when observation revealed a container of bleach stored on the same shelf as resident's drinks in the medication room and an open package and unopened package of girl scout cookies, Jello, an open can of soda, a resident's used electric razor, a staff's toiletry bag which contained a staff's personal items, and cans of soup were stored with medications and medical supplies.</p> <p>The findings include:</p> <p>Review of the facility's Policy on "Handwashing" revealed "Handwashing and hand antisepsis shall be regarded by this facility as the single most important means of preventing the spread of infections. Policy further states under, "Protocol</p>	F 441	<p>Criteria 3: Nursing staff have received inservice education on infection control standards of practice, including but not limited to: provision of resident care, including wound care, to include handwashing/changing of gloves in accordance with infection control standards of practice; and the requirement for prevention of storage of non-medication supply items with medications, as provided by the Staff Development Coordinator on 3/13/13, 3/14/13, 3/21/13, 3/23/13, 3/24/13, 3/25/13, 3/26/13, 3/27/13, 4/2/13, 4/3/13, 4/4/13, 4/9/13, 4/10/13, 4/11/13, 4/16/13, 4/17/13, 4/18/13, 4/19/13.</p> <p>Criteria 4: The CQI indicator for the monitoring of infection control standards/handwashing/glove changing during care and proper storage of items in the medication rooms will be utilized monthly X 2 months and then every six months in accordance with the established CQI calendar under the direction of the DON. The Clinical Nurse Administrator will observe and monitor correct infection control techniques for meal service/ feeding resident, medication administration, trach care, wound care, passing ice and/or water, oral hygiene, and any other infection control techniques that become available in the facility monthly x 2 months and then every six months in accordance with the established CQI calendar under the supervision of the DON:</p> <p>Target Date:</p>	04/21/2013

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(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 441	<p>Continued From page 27</p> <p>1.) All personnel shall follow the established handwashing and hand antiseptis procedures to prevent the spread of infection and disease to other personnel, residents, and visitors.</p> <p>1. Review of the facility's policy, titled Medication Storage in the Facility, not dated, revealed potentially harmful substances, such as disinfectants, were to be stored separately from medications. Further review revealed medication storage areas were to be kept clean, and free of clutter.</p> <p>Observation on 03/05/13 at 2:00 PM, revealed a bottle of germicidal bleach on the same shelf as residents' drinks in the medication room located on the Pier unit.</p> <p>Interview with Registered Nurse (RN) #1 on 03/05/13 at 2:30 PM, revealed the bottle of bleach should not be on the same shelf as medication or food items. She further stated she was not aware the bleach was there.</p> <p>Observation on 03/06/13 at 11:00 AM, revealed three (3) containers of Jello and two (2) cans of soup were stored on the same shelf as Ostomy supplies in the medication room on the South Port unit.</p> <p>Interview, with Licensed Practical Nurse (LPN) #3 on 03/06/13 at 12:00 PM, revealed the containers</p>	F 441			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(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 441	<p>Continued From page 28</p> <p>of Jello and the cans of soup should not have been stored on the same shelf as medical supplies.</p> <p>Observation in the medication room on the Marina unit, on 03/07/13 at 11:00 AM, revealed a box of open Girl Scout cookies and an unopened box of Girl Scout cookies on the shelf with a container of Vic's Vapor rub and a tube of Voltaren Gel. Further observation revealed an open can of Diet A&W Rootbeer on a shelf with different medical supplies. Observation of the medication cart revealed a resident's electric razor in the same drawer as the medications, as well as a staff member's toiletry bag which contained a bottle of body spray, a bottle of nasal spray, and two (2) tubes of lip gloss in the bottom drawer of the medication cart.</p> <p>Interview with RN #5, on 03/07/13 at 11:10 AM, revealed the electric razor and the toiletry bag should not be stored in the medication cart with the medications. She further stated, the Girl Scout cookies and the opened can of Diet A&W Rootbeer were staff food items and should not have been stored in the medication room.</p> <p>Interview with the Infection Control Nurse, on 03/08/13 at 5:20 PM, revealed potentially harmful substances, such as disinfectants, should not have been stored in the medication room, on the same shelf as the resident's drinks. She further stated food items as listed above should not be stored on the same shelf as medications and medical supplies. Further interview revealed the</p>	F 441			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO 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 441	Continued From page 29 electric razor and the toiletry bag should not have been stored in the medication cart with medications. 2. Observation, on 03/06/13 at 2:25 PM, revealed that Registered Nurse (RN) #1 just washed half way up the top of his/her hands and did not wash the hands to his/her wrist. RN #1 removed four (4) undated and not initialed dressings to four (4) wounds. Observation revealed RN #1 went from wound to wound without changing gloves, washing hands or degloving. Interview, on 03/06/13 at 3:50 PM, with RN #1 revealed there were no dates or initials on the dressings. RN #1 further stated that you should change your gloves when going from one wound to another to prevent cross contamination. The RN further stated that she did not do that. RN #1 stated that when washing your hands you were supposed to cover the wrist, top and bottom of the hands.	F 441			

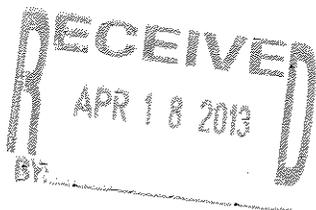
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. B1/BLONG 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1975. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (200). SMOKE COMPARTMENTS: Eighteen (18) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1967 and upgraded in 2013 with one hundred and forty-seven (147) smoke detectors and three (3) heat detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1975 and upgraded in 2013. GENERATOR: Type II generator installed in 2011. Fuel source is Diesel. A standard Life Safety Code survey was conducted on 03/06/13 and 03/07/13. Redbanks was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Two-Hundred Twenty-Two (222) beds with a census of One-Hundred Eighty-Three (183) on the day of the survey.	K 000		
-------	--	-------	--	--



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Bryce Wells, Administrator TITLE Administrator (X6) DATE April 1, 2013

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.

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	

[X4] IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X5] COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000 Continued From page 1
The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).

K 017 SS=D
Deficiencies were cited with the highest deficiency identified at "F" level.
NFPA 101 LIFE SAFETY CODE STANDARD

Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)
19.3.6.1, 19.3.6.2.1, 19.3.6.5

This STANDARD is not met as evidenced by:
Based on observation and interview it was determined the facility failed to ensure that rooms open to the corridor would not interfere with egress requirements in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eighteen (18) smoke

K 000 Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.

K 017
K017 Ensure that rooms that open to the corridor would not interfere with egress requirements in accordance with NFPA standards.
Criteria 1 - The employee dining room tables have been arranged to allow a minimum egress path of 36" per the Deputy State Fire Marshal. The exit for the employee dining area has had a concrete sidewalk poured to assure a durable surface to the public way.
Criteria 2 - All exits have been inspected by the Environmental Director to assure none are obstructed. All exits have been inspected by the Environmental Director to assure there is a durable surface to the public way.
Criteria 3 - The Environmental Director and the Maintenance staff received in-service education on maintaining unobstructed egress paths by the Administrator on 3/29/13. All Staff shall be in-serviced on maintaining an unobstructed egress path at all exits by the in-service Director.
Criteria 4 - The CQI tool ES-3 shall be utilized for the monitoring of egress paths and exit paths to the public way by the Environmental Director monthly x 2, then quarterly thereafter under the supervision of the Administrator.
Target Date:

4/30/13

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		[X3] DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
[X4] IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X5] COMPLETION DATE	
K 017	Continued From page 2 compartments, residents, staff and visitors. The facility is certified for two hundred and twenty-two (222) beds with a census of one-hundred eighty-three (183) on the day of the survey. The facility failed to ensure the egress path at the employee dining area was not obstructed. The findings include: Observation, on 03/07/13 at 11:19 AM, with the Administrator and the Environmental Director, revealed an employee dining room that was part of the exit corridor in the dining area. Further observation revealed the tables obstructed the egress path of the corridor. In addition, the exit in this corridor area did not have a durable surface to the public way. Interview, on 03/07/13 at 11:19 AM, with the Administrator and the Environmental Director, revealed once the exit located in the corridor was brought to code that would be the exit for this area. NFPA 101 (2000) 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. (See also 19.2.5.9.) Exception No. 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas.	K 017			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 e. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
[X4] IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X5] COMPLETION DATE
K 017	Continued From page 3 (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.	K 017		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K018- Ensure doors to the resident rooms were in accordance with NFPA Standards. Criteria 1 - The corridor doors identified in the survey, 100, 415, 413, 406, 405, 400, 501 and 614 have been repaired to eliminate the gap around the jamb. Criteria 2 - All corridor doors have been inspected by the facility Environmental Director to determine that there is not a gap larger than 1/2" around the jamb. Criteria 3 - The Environmental Director and the maintenance staff have received in-service education on the inspection of corridor doors for gaps larger than 1/2" and the need to correct to resist the passage of smoke by the Administrator on 3/29/13. Criteria 4 - The CQI indicator, ES-3 which includes the monitoring of corridor doors for gaps larger than 1/2" shall be completed by the Environmental Director monthly x 2, then Quarterly thereafter under the supervision of the Administrator. Target Date:	4/30/13

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
[X4] ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X5] COMPLETION DATE
K 018	Continued From page 5 Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	

[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
--------------------	--	---------------	---	----------------------

<p>K 025 SS=F</p>	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect eighteen (18) of eighteen (18) smoke compartments, all residents, staff and visitors. The facility is certified for two hundred and twenty-two (222) beds with a census of one hundred eighty-three (183) on the day of the survey. The facility failed to ensure twenty (20) smoke barriers were accessible and sealed to resist the passage of smoke.</p> <p>The findings include:</p> <p>Observations, on 03/06/13 between 3:45 PM and 4:30 PM with the Administrator, the Maintenance Supervisor, the Environmental Director, and the Regional Training Manager, revealed the smoke partitions, extending above the ceiling located</p>	<p>K 025</p>	<p>K025- Facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards.</p> <p>Criteria 1 - The unsealed penetrations to the smoke partitions identified during the survey that extend above the ceiling have been repaired and sealed. Attic access panels have been installed to assure access to smoke barriers to check the condition of the smoke walls.</p> <p>Criteria 2 - All smoke walls have been inspected and repaired and sealed with no further issues identified.</p> <p>Criteria 3 - The Environmental Director and the maintenance staff have received in-service education on 3/29/13 by the Administrator on the need to inspect the smoke walls on a quarterly basis and/or when any service vendor has had access to the attic space to assure any unsealed penetrations are corrected.</p> <p>Criteria 4- The CQI indicator, ES-3 which includes the monitoring of smoke walls in the attic to assure there are no unsealed penetrations shall be completed by the Environmental Director monthly x 2, then Quarterly thereafter under the supervision of the Administrator.</p> <p>Target Date:</p>	<p>4/30/13</p>
-----------------------	--	--------------	---	----------------

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		[X3] DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
[X4] IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X5] COMPLETION DATE	
K 025	Continued From page 7 throughout the facility were penetrated by pipes, homemade door openings and wires. Further observation revealed some of the smoke barriers were inaccessible to check the condition of the barriers. Interview, on 03/06/13 between 3:45 PM and 4:30 PM, with the Administrator, Maintenance Supervisor, Environmental Director, and the Regional Training Manager revealed they were unaware of the penetrations in the smoke barriers as they were under the assumption that the walls were sealed. The Environmental Director stated she always checks with the vendors when they come from the attic to ensure the walls are completely sealed. Further interview revealed they were unaware the smoke barriers at all locations were not accessible to check the condition of the walls. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall	K 025			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
--	---

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X5] COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 025	Continued From page 8 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
--	---

[X4] IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X5] COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 027	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect fifteen (15) of eighteen (18) smoke compartments, one hundred and eighteen (118) residents, staff and visitors. The facility is certified for two hundred twenty-two (222) beds with a census of one hundred and eighty-three (183) on the day of the survey. The facility failed to ensure thirteen (13) doors in the smoke barriers had a gap less than one eighth (1/8) inch where the doors meet. The findings include: Observation, on 03/07/13 at 3:15 PM, with the Administrator and Environmental Director, revealed the cross-corridor doors, located on the main hall next to therapy, which included resident rooms # 100, 114, 301, 400, 514, 501, 512 and 601; the oxygen trans-filling room, therapy office, business office, and the office on the 600 hall would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Interview, on 03/07/13 at 3:15 PM, with the Administrator and Environmental Director, revealed they were unaware the doors would not close all the way leaving a gap between the doors in the closed position.	K 027	K027- The facility failed to ensure cross corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA Standards. Criteria 1- The cross corridor doors identified during the survey that did not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors have been repaired. Criteria 2- All cross corridor doors in the facility have been inspected by the Environmental Director and those identified have been repaired to assure when closed there is no greater than 1/8" gap where the doors meet. Criteria 3- The Environmental Director and the maintenance staff have received in-service education on 3/29/13 by the Administrator on the need to inspect the cross corridor doors on a monthly basis and repair any door that has greater than a 1/8" gap where the doors meet. Criteria 4- The CQI indicator, ES-3 which includes the monitoring of cross corridor doors to assure there is no more than a 1/8" gap where the doors meet shall be completed by the Environmental Director monthly x 2, then quarterly thereafter under the supervision of the Administrator. Target Date:	4/30/13
-------	--	-------	---	---------

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		{X1} PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	{X2} MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	{X3} DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
{X4} IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	{X5} COMPLETION DATE
K 027	Continued From page 10 Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18 mm) for wood doors.	K 027		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with Section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of eighteen (18) smoke compartments, eighty-five (85) residents, staff and visitors. The facility is certified for two hundred twenty-two (222) beds with a census of one hundred eighty-three (183) on the day of the survey. The facility failed to ensure two (2) exits	K 038	K038- The facility failed to ensure the exits were maintained in accordance with NFPA standards. Criteria 1- The two exits for the employee dining area and hallway have had a 4' concrete sidewalk poured to assure a durable surface to the public way. The delayed egress signs on the Memory Care Unit, (Marina and Harbor) have been removed and these two units are now considered Special Locking Arrangement areas per approval of the Deputy State Fire Marshal. The Delayed Egress signs have been removed on these two units. Criteria 2- All exit doors other than those in the Marina and Harbor Unit have been inspected by the Environmental Director and are properly identified with delayed egress signs. Criteria 3- The Environmental Director and the maintenance staff have received in-service education on 3/29/13 by the Administrator to assure that all public exits have a durable surface and that all doors equipped with a delayed egress are properly identified and doors that are approved as Special Locking Arrangement do not have delayed egress signage. Criteria 4- The CQI indicator, ES-3 which includes assuring that exits to the public way have a 4' sidewalk and that delayed egress doors are properly identified shall be completed by the Environmental Director monthly x 2, then Quarterly thereafter under the supervision of the Administrator. Target Date: 4/30/13	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 038	<p>Continued From page 11</p> <p>had a durable surface to the public way and delayed egress signs were on all doors that were on a delay.</p> <p>The findings include:</p> <p>Observation, on 03/07/13 at 11:19 AM, with the Administrator and Environmental Director, revealed the employee dining room hallway and the employee dining area did not have a four foot (4') wide durable surface to a public way.</p> <p>Interview, on 03/07/13 at 11:19 AM with the Administrator and Environmental Director, revealed they were unaware all exits require a durable path to the public way.</p> <p>Observation, on 03/07/13 at 11:53 AM with the Administrator and Environmental Director, revealed three (3) sets of doors in the Marina area of the facility that were equipped on a delay without the proper signage stating how to operate these doors.</p> <p>Interview, on 03/07/13 at 11:53 AM with the Administrator and Environmental Director, revealed they understood if the wing is a dedicated Alzheimer's unit the signs did not have to be in place on every door.</p> <p>Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access</p>	K 038	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038	Continued From page 12 shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. CMS S&C letter 5-38 Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted,	K 038			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 038	Continued From page 13 provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors	K 038	
K 040 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 This STANDARD is not met as evidenced by:	K 040	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION]	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY]	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 040	<p>Continued From page 14</p> <p>Based on observation and interview it was determined the facility failed to ensure exit discharge doors opened in the direction of egress in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eighteen (18) smoke compartments, twenty-eight (28) residents, staff and visitors. The facility is certified for two hundred twenty-two (222) beds with a census of one-hundred and eighty-three (183) on the day of the survey. The facility failed to ensure one (1) gate was swinging in the correct way and all gates could be easily unlocked from the egress path.</p> <p>The findings include:</p> <p>Observation, on 03/07/13 at 3:30 PM, with the Administrator and Environmental Director, revealed the exit gate at the Marina exit to the courtyard did not swing outward. The gate would have to be pulled against the egress travel in the event of an evacuation. Further observation revealed there was a padlock located on the outside of the gate at the exit located next to room #527.</p> <p>Interview, on 03/07/13 at 3:30 PM, with the Administrator and Environmental Director, revealed they were not aware the exit discharge gate needed to open in the direction of egress and the padlock was placed on the egress gate.</p> <p>NFPA 101 (2000 edition) 7.2.1.4.3 A door shall swing in the direction of egress travel where used in an exit enclosure or where serving a high hazard contents area, unless it is a door from an individual living unit that opens directly</p>	K 040	<p>K040- The facility failed to ensure exit discharge doors opened in the direction of egress in accordance with NFPA standards.</p> <p>Criteria 1- The exit door has been repaired to allow exit in the direction of egress. The padlock on the gate leading to the public way has been removed.</p> <p>Criteria 2- All exit gates have been inspected by the Environmental Director to assure all gates open in the direction of the egress and no gates have padlocks.</p> <p>Criteria 3- The Environmental Director and the maintenance staff have received in-service education on 3/29/13 by the Administrator to assure that all public exits that have gates open in the direction of the egress and no gates have padlocks.</p> <p>Criteria 4- The CQI indicator, ES-3 which includes assuring that exit doors open in the direction of the egress and that gates do not have padlocks shall be completed by the Environmental Director monthly x 2, then Quarterly thereafter under the supervision of the Administrator.</p> <p>Target Date:</p>	4/30/13
-------	---	-------	---	---------

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO 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 040	Continued From page 15 into an extl enclosure.	K 040		
K 045 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect three (3) of eighteen (18) smoke compartments, forty-eight (48) residents, staff and visitors. The facility is certified for two hundred and twenty-two (222) beds with a census of one hundred and eighty-three (183) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at four (4) exits.</p> <p>The findings include:</p> <p>Observation, on 03/07/13 between 8:00 and 4:30 PM with the Administrator and Environmental Director, revealed the exterior exits at the main ambulance exit, the employee dining hall, exit #2 at the trash area, and the laundry exit only had a single light for illumination of the outside of the exit.</p> <p>Interview, on 03/07/13 between 8:00 and 4:30 PM with the Administrator and Environmental</p>	K 045	<p>K045- Facility failed to ensure exits were equipped with lighting in accordance with NFPA standards.</p> <p>Criteria 1- The exterior exits identified during the survey that had single lights have been corrected to assure that there are either two single light fixtures or one double light fixture at each exit identified.</p> <p>Criteria 2 -- All exterior exits have been inspected by the Environmental Director and any exits identified to have only a single light fixture for illumination have been changed to have either two single light fixtures or one fixture with two bulbs.</p> <p>Criteria 3- The Environmental Director and the maintenance staff have received in-service education on 3/29/13 by the Administrator to assure that all exterior exits have either two single light fixtures or one fixture with two bulbs.</p> <p>Criteria 4- The CQI indicator, ES-3 which includes assuring that the exterior exit lights have two single bulb fixtures or one double bulb fixture shall be completed by the Environmental Director monthly x 2, then Quarterly thereafter under the supervision of the Administrator.</p> <p>Target Date:</p>	4/30/13

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSLEY LANE HENDERSON, KY 42420	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION]	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY]	(X5) COMPLETION DATE
K 045	Continued From page 16 Director, revealed they were unaware the lighting fixtures serving the exterior exits must include more than one (1) bulb for illumination of the egress path.	K 045		
K 056 SS=D	Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency	K 056	K056- The facility failed to ensure the building had a complete sprinkler system in four areas of the facility in accordance with NFPA standards. Criteria 1- The areas identified during the survey, the Administrator's closet, the walk in freezer #5, the office closet in the Marina dining area and the post office area have been corrected by the facility sprinkler vendor. The 8" canopy attached to the back of the building outside the employee break area has been removed. Criteria 2- All areas of the facility have been inspected by the Environmental Director and the facility contracted sprinkler vendor to assure there are no other areas not properly covered by our sprinkler system. Criteria 3- The Environmental Director and the maintenance staff have received in-service education on 3/29/13 by the Administrator to assure that the facility is inspected to assure there are no areas in the building that are not properly covered by our sprinkler system. Criteria 4- The CQI indicator, ES-3 which includes assuring that there is proper sprinkler coverage in all areas of the building shall be completed by the Environmental Director monthly x 2, then Quarterly thereafter under the supervision of the Administrator. -Target Date: _____	4/30/13

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
[X4] IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION]	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY]
K 056	<p>Continued From page 17</p> <p>had the potential to affect three (3) of eighteen (18) smoke compartments, twenty-eight (28) residents, staff and visitors. The facility is certified for two hundred and twenty-two (222) beds with a census of one hundred and eighty-three (183) on the day of the survey. The facility failed to ensure four (4) areas of the building had proper sprinkler coverage.</p> <p>The findings include:</p> <p>Observation, on 03/07/13 between 8:00 and 4:30 PM with the Administrator and Environmental Director, revealed the Administrator's closet, walk-in freezer #5, the office closet in the Marina dining area, and the post office were not sprinkler protected. Further observation revealed an eight foot (8') canopy attached to the back of the building at the employee outside break area did not have sprinkler protection.</p> <p>Interview, on 03/07/13 between 8:00 and 4:30 PM with the Administrator and Environmental Director, revealed they were not aware that the areas listed did not have proper sprinkler protection.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13.8.1</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in</p>	K 056	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
--	---

[X4] IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION]	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY]	[X5] COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 056	Continued From page 18 accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.	K 056		
K 069 SS=D	Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. Reference: NFPA 13 (1999 edition) 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the cooking appliances were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eighteen (18) smoke compartments, residents, staff and visitors. The facility is certified for two-hundred and twenty-two	K 069	K069- The grease fryer was located directly next to the stove. The stove did not have an eight (8) inch splash guard in place. Criteria 1 - The stove has had an eight inch (8) splash guard attached to it. Criteria 2 - There are no other areas affected by this deficiency. Criteria 3 - The Environmental Director, the maintenance staff, Dietary Manager and Dietary Director have received in-service education on 3/29/13 by the Administrator to assure that there are no other areas in the dietary department that do not have the appropriate splash guard protection. Criteria 4- The CQI indicator, ES-3 which includes assuring that there is an eight inch (8) splash guard on the stove if the grease fryer is located closer than 16' to the stove shall be completed by the Environmental Director monthly x 2, then Quarterly thereafter under the supervision of the Administrator. Target Date:	4/30/13

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
[X4] IO 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 069	<p>Continued From page 19</p> <p>(222) beds with a census of one hundred and eighty-three (183) on the day of the survey. The facility failed to ensure separation from the grease fryer and the cooking appliance.</p> <p>The findings include:</p> <p>Observation, on 03/07/13 at 4:15 PM, with the Environmental Director, revealed the grease fryer was located directly next to the stove. The stove did not have an eight (8) inch splash guard in place.</p> <p>Interview, on 03/07/13 at 4:15 PM with the Environmental Director, revealed she was unaware the grease fryer had to have a sixteen inches (16") between the fryer and the stove unless a splash guard was installed.</p> <p>NFPA 96 (1998 Edition) 9-1.2.3 All deep fat fryers shall be installed with at least 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed at a minimum 8 in. (203 mm) in height between the fryer and surface flames of the adjacent appliance.</p>	K 069	
K 143 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p>	K 143	

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
--	---

[X4] IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X5] COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 143	Continued From page 20 (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring, and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation, interview and plan of correction review, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect three (3) of eighteen (18) smoke compartments, forty (40) residents, staff and visitors. The facility is certified for two hundred and twenty-two (222) beds with a census of one hundred and eighty-three (183) on the day of the survey. The facility failed to ensure the oxygen transferring room had no combustible storage in the room, a concrete or ceramic floor, and a fire rated door assembly. The findings include: Observation, on 03/06/13 at 3:15 PM with the Administrator, Maintenance Supervisor, Environmental Director, and the Regional	K 143	K143- The facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. Criteria 1-The use of Liquid O2 has been discontinued. Criteria 2 - There are no other areas of the facility affected by this practice. Criteria 3- The facility will begin using E-tanks instead of Liquid O2 and will maintain no more than twelve (12) E-tank cylinders in any individual smoke compartment. The Environmental Director, maintenance staff, Licensed Nursing Staff and the O2 vendor have received in-service education on this practice by the Administrator on 3/29/13 and the In-service Director. Criteria 4- The CQI indicator, ES-3 which includes assuring that there are no combustibles stored within five (5) feet of the O2 cylinders and recommends no more than twelve (12) cylinders be stored in any individual smoke compartment shall be completed by the Environmental Director monthly x 2, then Quarterly thereafter under the supervision of the Administrator. Target Date:	4/30/13
-------	---	-------	--	---------

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 E. WING _____	[X3] DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
[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-143	Continued From page 21 Training Manager, revealed the oxygen trans-filling room was also being used as a storage room. The room did not have a concrete or ceramic floor and the door had a fire rating label but it was painted over. Interview, on 03/06/13 at 3:15 PM with the Administrator, Maintenance Supervisor, Environmental Director, and the Regional Training Manager, revealed they were unaware of the requirements to make a room suitable for oxygen trans-filling. Reference: NFPA 99 (1999 Edition). 8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.	K-143		

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS		STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(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)	(X6) COMPLETION DATE
K 143	Continued From page 22 The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect six (6) of eighteen (18) smoke compartments, forty five (45) residents, staff and visitors. The facility is certified for two hundred and twenty-two (222) beds with a census of one hundred eighty three (183) on the day of the survey. The facility failed to ensure six (6) electrical panels maintained three (3) feet of clearance around them. The findings include: Observations, on 03/07/13 between 8:00 AM and 4:30 PM, with the Administrator and Environmental Director, revealed the electrical panels in the Dinette, outside electrical room, soiled linen room in the Marina area, suites dining mechanical room, storage room for dietary, and in the kitchen had storage within three (3) feet of	K 147	K147- Facility failed to ensure electrical panels were maintained in accordance with NFPA standards. Criteria 1- The electrical panels identified during the survey that had items stored within three (3) feet have been corrected. Criteria 2- All areas of the facility have been inspected by the Environmental Director to assure there are no other electrical panels that have storage within three (3) feet of the panel. Criteria 3- The Environmental Director and the maintenance staff have received in-service education on 3/29/13 by the Administrator to assure that the facility electrical panels do not have anything stored within three (3) feet of the panel. Criteria 4- The CQI indicator, ES-3 which includes assuring that there are no items stored within three (3) feet of the electrical panels shall be completed by the Environmental Director monthly x 2, then Quarterly thereafter under the supervision of the Administrator. Target date:	4/30/13

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K-147	Continued From page 23 the electrical panels. Interview, on 03/07/13 between 8:00 AM and 4:30 PM with the Administrator and Environmental Director, revealed they were unaware there could not be storage within three (3) feet of electrical panels. Reference: NFPA 99 (1999 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. Table 110.26(A)(1) Working Spaces Nominal Voltage to Ground Minimum Clear	K-147			

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
--	---

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY]	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 147	Continued From page 24 Distance Condition 1 Condition 2 Condition 3 0-150 900 mm (3 ft) 900 mm (3 ft) 900 mm (3 ft) 151-600 900 mm (3 ft) 1 m (3½ ft) 1.2 m (4 ft) Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between. (a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on non-electrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all un-insulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition	K 147		
-------	---	-------	--	--

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124		[X2] MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		[X3] DATE SURVEY COMPLETED 03/07/2013	
NAME OF PROVIDER OR SUPPLIER REDBANKS				STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420			
[X4] ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		[X5] COMPLETION DATE
K 147	Continued From page 25 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 1.10.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment.			K 147			