

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

PRINTED: 07/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/22/2011
NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	F282	
F 282 SS=D	<p>Abbreviated surveys (KY #16213 and KY #16458) were conducted 06/21/11 through 06/22/11. KY #16213 was substantiated with deficiencies cited, and KY #16458 was substantiated with no deficiencies cited, with the highest scope and severity at a "D".</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure services were provided in accordance with the resident's written plan of care for three residents (#1, #2, and #3), in the selected sample of three, to prevent falls. Findings include: A review of the policy "Comprehensive Care Plan", undated, revealed the Certified Nurse Assistant (CNA) care plan would be provided to ensure nursing staff were aware of supports that are to be provided for each resident.</p> <p>1. A record review revealed Resident #1 was admitted to the facility, on 08/12/10, with diagnoses to include Dementia, Gait Difficulty/Decline and History of Falls. A review of the quarterly Minimum Data Set (MDS) assessment, dated 04/21/11, revealed the facility</p>	F 282	<p>Criteria #1: Resident's (Resident #1) bathroom door alarm will be replaced and in good working order. The sensor alarm to resident's bed will be replaced, and the smart pad will be properly placed by the bed. Staff will be inserviced by Administrative Nursing on Resident #1's alarm usage.</p> <p>Resident #3's Comprehensive Care Plan, CNA care plan, and interventions in place for fall management will be reviewed by Administrative Nursing. Appropriate alarms will be provided to Resident #3 as indicated on the CNA care plan and Comprehensive Care Plan. Staff will be inserviced on Resident #3's alarm usage.</p>	

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

TITLE

(X8) DATE

Dawn Jelden, Administrator 784

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

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F 282	<p>Continued From page 1</p> <p>Identified the resident as severely cognitively impaired and required extensive assistance of two staff for transferring and ambulation.</p> <p>A review of the Certified Nurse Aide (CNA) Care Plan Record, dated 06/11, revealed fall interventions included a sensor alarm to the resident's bed and chair, a "smart pad" alarm beside the bed and in front of the chair, and a magnetic door alarm on the bathroom door.</p> <p>An observation of Resident #1, on 06/21/11 at 1:30 PM and on 06/22/11 at 7:20 AM, revealed there was no alarm to the resident's bathroom door. Further observation, on 06/22/11 at 7:20 AM, revealed Resident #1 was lying in bed. The sensor alarm to the resident's bed was disabled and the connector was broken. The "smart pad" alarm was pushed completely under the resident's bed.</p> <p>2. A record review revealed Resident #3 was admitted to the facility, on 03/28/11, with diagnoses to include a history of falls. A review of the initial MDS assessment, dated 04/03/11, revealed the resident was cognitively intact and required limited assistance of one staff for transfers. A review of the Fall Assessment Screening Tool (FAST), dated 03/28/11 and 06/10/11, revealed the facility assessed the resident at a high risk for falls.</p> <p>A review of the CNA care plan record, dated June 2011, revealed interventions included a magnetic personal alarm to the resident's wheelchair and bed, not a sensor alarm to the bed. A review of the "Falls/Injury" comprehensive care plan revealed a sensor alarm was added to the</p>	F 282	<p>Resident #2 Staff will be inserviced by Administrative Nursing to ensure that gait belt is properly applied when utilizing the gait belts in transfers. Staff will be inserviced to ensure that they are aware Resident #2 is a two-person assist with transfers. Staff will be inserviced by Administrative Nursing on following CNA care plans.</p> <p>Criteria #2: For all resident's who have had a fall in the last six months, Administrative Nursing will review interventions put into place as supports for that resident. New interventions, if appropriate, will be added at this time. CNA care plans and Comprehensive Care plans will also be reviewed to ensure that interventions for fall management are documented correctly on both documents.</p>	

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F 282	<p>Continued From page 2 resident's wheelchair on 05/20/11.</p> <p>An observation, on 06/22/11 at 7:45 AM, revealed Resident #3 was sitting on the side of the bed. There was a sensor alarm in place on the resident's bed. The resident was transferred out of the bed by staff assistance and the sensor alarm was turned off and did not sound. There was no magnetic personal alarm noted. The resident's wheelchair had a sensor alarm in place.</p> <p>An interview with CNA #1, on 06/22/11 at 10:05 AM, revealed she did not follow the care plan for Resident #1 on 06/21/11. She was unaware the resident's bathroom door alarm was not in place and she did not know what type of personal alarms were specified for Resident #3, per the care plan.</p> <p>An interview with CNA #4, on 06/22/11 at 10:35 AM, revealed she was aware the bathroom door alarm had not been in place for a "few days", but did not report the information because she assumed the alarm had been discontinued. She revealed the resident care plan should be reviewed every day.</p> <p>3. A record review revealed Resident #2 was admitted to the facility, on 08/09/09 and readmitted 02/25/11, with diagnoses to include Hypertension, Chronic Back Pain, Osteoporosis, Osteoarthritis, Cerebral Vascular Accident, and Anxiety.</p> <p>A review of the quarterly MDS, dated 05/17/11, revealed the facility assessed the resident as severely cognitively impaired and required</p>	F 282	<p>Criteria #3: A staff/in-service will be conducted by Administration on following care plans, how to follow the CNA care plan, location of care plans, that the CNA care plans must be reviewed each shift, and they will be instructed on how to read the CNA care plan. Staff will also be provided education on ensuring that alarms are turned on and functioning. Examples of the alarms the facility utilizes for fall management will also be reviewed with staff. The practice of fall management and purpose of it will be reviewed with staff. Staff will be inserviced that alarms are to be checked every two hours to ensure that they are functioning and in good repair. Previously staff were completing one time a shift. Incident Review Committee will be held at least 3x's weekly. The committee will review incidences of falls, previous interventions, and determine an appropriate intervention to strive to prevent further occurrences of falls.</p>		

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F 282	Continued From page 3 extensive assist of two staff for transfers. A review of the CNA care plan record, dated March 2011, revealed interventions included the assistance of two staff and use of a gait belt for transfers. A review of the Nurse Log Report, dated 03/25/11 at 1:04 PM, revealed the resident sustained a fall while being transferred from the bed to the chair. An interview with CNA #7, on 06/22/11 at 11:00 AM, revealed she attempted to transfer Resident #2 from the bed to the chair, on 03/25/11. She was aware the resident required two staff to assist for transfers, but was unable to find another staff member to assist and she stated, "I was trying to get done." She used the gait belt for the transfer, but did not ensure the gait belt was properly applied. She revealed the resident began to slide down when lifted from the bed, and she lowered the resident to the floor. An interview with the Director of Nursing, on 06/22/11 at 4:10 PM, revealed she expected staff to provide each resident's care, per the care plan.	F 282	Interventions will be documented on both the CNA care plan and Comprehensive Care Plan by Administrative Nursing. The Incident Report Committee is interdisciplinary. Currently the Committee is meeting 1x a week, this will be increased to 3x a week. The facility policy will be revised by the Administrator to reflect this. Criteria #4: One time a week Administrative nursing will do an audit of alarm usage to ensure that residents that utilize these devices are being provided with the alarm designated on the comprehensive and CNA care plan. Staff will be trained by Administrative Nursing to check alarms on residents who use them every two hours for functioning and placement. One time a month CNA and Comprehensive Care Plans will be reviewed to ensure that appropriate supports for fall management are documented on both documents. This will be completed by Administrative Nursing.	
F 323 SS-D	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	F 323		

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F 323	Continued From page 4 by: Based on observations, interviews and record review, it was determined the facility failed to ensure adequate supervision and assistance devices to prevent accidents for three residents (#1, #2, and #3), in the selected sample of three. Record review and staff interviews revealed Resident #1 sustained a fall on 04/24/11 and on 05/31/11. Resident #3 sustained a fall, on 05/13/11 and on 06/02/11. It was determined the residents' safety alarms did not sound at the time of the falls. Additionally, Resident #2 sustained a fall, on 03/26/11, related to an improper transfer. Observations conducted during the survey on 06/21-22/11 revealed personal alarms were not in place and functioning per the care plans for Resident #1 and #3. Findings Include: A review of the "Personal Safety Alarms" policy, undated, revealed the facility would utilize personal safety alarms as a non-restrictive device to promote a safe environment for residents whose assessments indicated they would benefit from the device. Direct care staff would check the personal safety alarm (PSA) at least one time a shift for proper functioning. Ongoing surveillance of proper device use would be done during routine care and compliance rounds. A review of the "Resident Safe Environment" policy, undated, revealed the Incident Review Committee would review past interventions for those residents that have had a fall, and new interventions would be implemented to strive to prevent further occurrences of the same type of	F 323	A list of residents who utilize alarms and the type of alarm being utilized will be placed in the Clinical Monitoring book by Administrative Nursing. This will allow a quick reference tool to assist Charge Nurses in being aware of what alarm is being utilized for what resident. When alarm usage changes Administrative Nursing will make changes to this list to strive to ensure accuracy.	

Criteria #5:

August 5, 2011

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F 323	Continued From page 5 incident. New interventions would be documented on the comprehensive care plan to ensure they were a part of the overall care being provided. 1. A record review revealed Resident #1 was admitted to the facility, on 08/12/10, with diagnoses to include Dementia, Gait Difficulty/Decline and History of Falls. A review of the quarterly Minimum Data Set (MDS) assessment, dated 04/21/11, revealed the facility identified Resident #1 as severely cognitively impaired and required extensive assistance of two staff for transferring and ambulation. A review of the "Fall/injury" care plan, dated 08/23/10, revealed an intervention was initiated on 04/26/11, to check the resident's alarms often. A review of the Nurse Log Report, dated 04/24/11 at 1:36 PM, revealed the resident was observed lying on the floor, with a decreased level of consciousness, decreased oxygen saturation (82%) and complained of right leg pain. The resident was sent to the emergency room for evaluation and treatment. A review of the fall investigation, dated 04/24/11, revealed the resident had been ambulating without assistance and had turned off the personal safety alarm. An interview with CNA #11, on 06/22/11 at 2:20 PM, revealed she worked on 04/24/11 and found the resident in the hallway of his/her room and no alarms were sounding. An interview with Licensed Practical Nurse (LPN) #2, on 06/21/11 at 1:50 PM, revealed she was the	F 323	F323 Criteria #1: Resident's (Resident #1) bathroom door alarm will be replaced and in good working order. The sensor alarm to resident's bed will be in good working order, and the smart pad will be properly placed by the bed. This will be completed by Administrative Nursing. Administrative nursing will review Resident #1's interventions for fall management to ensure that they are appropriate. Resident #1's comprehensive care plan and CNA care plan will also be reviewed by Administrative Nursing to strive to ensure that appropriate supports for fall management are documented on both the comprehensive and CNA care plans. Resident #1's alarms will be checked for proper functioning every 2 hours by Nursing staff to ensure that they are appropriately placed and in good working order. Staff will also be provided training by Administrative		

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F 323	<p>Continued From page 6</p> <p>nurse assigned for Resident #1, on 04/24/11. She revealed a visitor reported to staff that Resident #1 was lying on the floor. On entering the room, the resident was observed lying on his/her right hip and arm near the door. She stated she heard no alarms sound at the time of the fall.</p> <p>A review of the Nurse Log Report, dated 05/31/11 at 1:49 AM, revealed Resident #1 was found sitting on the floor mat in front of the recliner. The facility assessed the resident as having an abrasion to the upper right side of the back. A review of the 05/31/11 fall investigation revealed the resident was told not to turn off the personal safety alarms and to use the call light. A review of the "Fall/Injury" care plan, dated 08/23/10, revealed a new intervention was initiated 06/08/11, to check the resident's alarms every two hours. A review of the Certified Nurse Aide (CNA) Care Plan Record, dated June 2011, revealed fall interventions included the use of a sensor alarm to the resident's bed and chair, a "smart pad" alarm beside the bed and in front of the chair, and a magnetic door alarm on the bathroom door.</p> <p>An observation of Resident #1, on 06/21/11 at 1:30 PM and on 06/22/11 at 7:20 AM, revealed there was no alarm in place at the resident's bathroom door. Further observation, on 06/22/11 at 7:20 AM, revealed Resident #1 was lying in bed and the sensor alarm attached to the bed was disabled and the connector was broken. The "smart pad" alarm was pushed completely under the resident's bed.</p> <p>An interview with CNA #1, on 06/22/11 at 10:05 AM, revealed she was responsible for Resident</p>	F 323	<p>Nursing on alarms that Resident #1 is to be provided with for fall management.</p> <p>Resident #3: Staff will be provided with Inservice training by Administrative Nursing on the types of alarms that Resident #3 is provided with for fall management. A review of Resident #3 CNA care plan and the comprehensive care plan will be completed by Administrative Nursing to ensure appropriate fall management interventions are documented.</p> <p>Resident #2 Staff will be Inserviced by Administrative Nursing to ensure that gait belt is properly applied when utilizing the gait belts in transfers. Staff will be inserviced by Administrative Nursing to ensure that they are aware Resident #2 is a two-person assist with transfers. Staff will be inserviced on following CNA care plans by Administrative Nursing.</p>	

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F 323	<p>Continued From page 7</p> <p>#1's care, on 06/21/11 and 06/22/11. She was not aware the alarm was not in place on the bathroom door. She stated, "I must have missed it." She further revealed the sensor alarm to the resident's bed had been "missed" and she was not aware the connector was broken. Additionally, CNA #1 revealed she was unaware the "smart pad" alarm was under the bed. She stated all alarms were supposed to be checked for proper functioning, at the beginning of the shift.</p> <p>An interview with CNA #4, on 06/22/11 at 10:35 AM, revealed she was responsible for the Resident #1's care on 06/22/11. She revealed the resident's bathroom door alarm had not been in place for "a few days", and she did not report the information to the charge nurse. She further revealed she had not been in the resident's room and had not checked the resident's alarms for functioning, on 06/22/11.</p> <p>An interview with LPN #2, on 06/22/11 at 7:20 AM, revealed the alarm on the resident's bathroom door was broken and had not been replaced.</p> <p>2. A record review revealed Resident #3 was admitted to the facility, on 03/28/11, with diagnoses to include a History of Falls. A review of the initial MDS assessment, dated 04/03/11, revealed the resident was identified as cognitively intact and required limited assistance of one staff for transfers. A review of the Fall Assessment Screening Tool (FAST), dated 03/28/11 and 06/10/11, revealed the facility assessed the resident at a high risk for falls.</p>	F 323	<p>Criteria #2: An audit will be done by Administrative Nursing to ensure that residents who utilize alarms for fall management are being provided with the alarm that is designated by the CNA and Comprehensive Care Plan. The audit will also consist of ensuring that alarm is on and functioning. Any malfunctioning alarms will be replaced by Administrative Nursing.</p>		

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F 323	<p>Continued From page 8</p> <p>A review of the Nurse Log Report, dated 05/13/11 at 8:05 AM, revealed the resident was found sitting on the floor in front of the wheelchair. The resident had transferred him/herself from the bed to the wheelchair, but slid out of the chair.</p> <p>An interview with LPN #2, on 06/22/11 at 3:25 PM, revealed she was the nurse for Resident #3 on 05/13/11. She revealed the resident had the magnetic personal alarm clipped to him/her at the time of the fall, but the "alarm box" was sitting on the resident's dresser which allowed the resident to transfer, without the alarm sounding.</p> <p>A review of the CNA Care Plan Record, dated June, 2011, revealed fall interventions included a magnetic personal alarm was to be applied to the resident's wheelchair and bed. However, a review of the "Falls/injury" Comprehensive care plan revealed the resident should have a sensor alarm to the wheelchair, initiated on 05/20/11.</p> <p>A review of the Nurse Log Report, dated 06/02/11 at 11:11 AM, revealed a staff member found the resident in the floor between the wheelchair and recliner. There were no alarms on the resident at the time of the fall.</p> <p>An interview with CNA #6, on 06/22/11 at 10:55 AM, revealed she was ambulating another resident when she noticed Resident #3 on the floor. She revealed the resident slid out of the wheelchair, and there were no alarms sounding.</p> <p>An observation, on 06/22/11 at 7:45 AM, revealed Resident #3 was sitting on the side of the bed with a sensor alarm attached to the bed. The resident was assisted to transfer from the bed</p>	F 323	<p>Criteria #3:</p> <p>A staff/in-service will be conducted by Administration on following care plans, how to follow the CNA care plan, location of care plans, that the CNA care plans must be reviewed each shift, and how to read the CNA care plan. Staff were also provided education on ensuring that alarms are turned on and functioning. Examples of the alarms the facility utilizes for fall management will also be reviewed with staff. The practice of fall management and purpose of it will be reviewed with staff. Staff will be in-serviced that alarms are to be checked every two hours to ensure that they are functioning and in good repair. Previously they were being checked one time a shift.</p>	

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F 323	<p>Continued From page 9 and the sensor alarm did not sound and was noted in the off position. There was no magnetic personal alarm observed. The resident's wheelchair had a sensor alarm in place.</p> <p>An interview with Resident #3, on 06/22/11 at 7:45 AM, revealed he/she did not need assistance with transfers and stated, "I get up by myself." The resident was not aware of any personal alarms to be applied to the bed or wheelchair.</p> <p>An interview with CNA #1, on 06/22/11 at 10:05 AM, revealed she was responsible for ensuring the correct personal alarms were used for Resident #3. She was not aware the resident was supposed to have a magnetic personal alarm to the bed and chair.</p> <p>An interview with CNA #4, on 06/22/11 at 10:35 AM, revealed she was responsible for the resident's care, on 06/22/11. She revealed she was unsure of the location of the magnetic personal alarms and stated the resident had used the magnetic alarm in the past. She revealed she was responsible for ensuring the resident's alarms were on and functioning, but she had not checked the alarms that morning.</p> <p>An interview with the Director of Nursing (DON), on 06/22/11 at 4:10 PM, revealed she expected the CNA's to ensure the personal alarms are on and functioning at the beginning of their shift and as needed. She was aware Resident #1 and #3 could take off or disable their personal alarms. She further revealed she was aware the interventions for these residents were ineffective and stated that the facility was "working on</p>	F 323	<p>Criteria #4: One time a week Administrative nursing will do an audit of alarm usage to ensure that residents that utilize these devices are being provided with the alarm designated on the comprehensive and CNA care plan. Staff will be trained to check alarms every two hours to ensure that it is properly placed and functioning. One time a month CNA and Comprehensive Care Plans will be reviewed to ensure that appropriate supports for fall management are documented on both documents</p> <p>Criteria #5</p>	August 5, 2011	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/22/2011
NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42066		
(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 making the system better."</p> <p>3. A record review revealed Resident #2 was admitted to the facility, on 08/09/09 and readmitted 02/25/11, with diagnoses to include Hypertension, Chronic Back Pain, Osteoporosis, Osteoarthritis, Cerebral Vascular Accident, and Anxiety.</p> <p>A review of the quarterly MDS assessment, dated 05/17/11, revealed the facility assessed the resident as severely cognitively impaired and required extensive assist of two staff for transfers. A review of the CNA Care Plan Record, dated March 2011, revealed the resident required the assistance of two staff and a gait belt, during transfers.</p> <p>A review of the Nurse Log Report, dated 03/25/11 at 1:04 PM, revealed the resident sustained a fall while being transferred from the bed to the chair.</p> <p>An interview with CNA #7, on 06/22/11 at 11:00 AM, revealed she attempted to transfer Resident #2 from the bed to the chair, on 03/25/11. She was aware the resident required two assistance for transfers, but was unable to find another staff member to assist and stated, "I was trying to get done." She used the gait belt for the transfer, but not apply the gait belt properly. The resident began to slide down when lifted from the bed, and CNA #7 stated she had to be lower Resident #2 to the floor.</p> <p>An interview with the DON, on 06/22/11 at 4:10 PM, revealed CNA #7 did not follow the resident's care plan, which resulted in the fall, on 03/25/11. She stated she expected two staff to transfer the</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/22/2011
NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055	
(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 resident at all times.	F 323		