RECEIVED JUN 2013 OFFICE OF INSPECTOR GENERAL

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

PRINTED: 06/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185410		C 05/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER'S BEND RETIREMENT COMMUNITY	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 An abbreviated survey (KY #20175) was conducted on 05/15/13 through 05/17/13 to determine the facility's compliance with Federal requirements. KY #20175 was substantiated with deficiencies cited.	F 000	F157 Criteria #1 Resident #1's POA and physician were notified, via fax, on 4/29/2013 by an LPN.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	The LPN documented that MD faxed back to facility on 4/29/2013 at approximately 1300 concerning Resident #1's dinner roll incident, and the physician wrote no additional orders, at that time On 4/29/2013 Resident #1 was still complaining of choking, per the LPN's documentation. A call was placed to MD and POA, by the LPN. An order was received to send Resident #1 to the hospital.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dawn Tedder, Administrator | 6·6·13

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

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to immediately consult with the resident's physician when there was an accident involving a resident that had the potential for requiring physician intervention for one resident (#1), in the selected sample of three (3) residents. Resident #1 was ordered a diet of nil per os (NPO), meaning "nothing by mouth." On 04/28/13, the resident took a bite from a dinner roll on another resident's tray and began coughing. The resident required encouragement from staff to cough and spit the dinner roll out of his/her mouth. Licensed Practical Nurse (LPN) #1 did not immediately notify the resident's physician of the incident. Additionally, the facility failed to consult the physician with a significant change in the resident's physical status for Resident #1. Two days after the incident with the dinner roll, the facility assessed Resident #1 as having a fever of 101.2 degrees Fahrenheit (F) and blood pressure of 89/54 mm/hg; however, the physician was not notified of the findings. Findings include: A review of the Physician/Legal Representative Notification and Physician Follow Up policy/procedure, undated, revealed physician notification would occur immediately when: 1. There was an accident involving the resident which resulted in injury and had the potential for	F 157	Resident #1 remains at the hospital at this time. Administrative Nursing (for the purpose of this document is the Director of Nursing and Assistant Director of Nursing) will care plan Resident #1 for grabbing food items when in reach. The first full day of compliance will be June 30, 2013. The cart that Resident #1 grabbed the roll from was an open cart that was accidentally used for dinner/hall trays that evening. The open cart has been disposed of and is no longer in the building. River's Bend Retirement Community currently only allows closed carts to be utilized when meal	

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F 157	Continued From page 2 requiring physician intervention. 2. There was a significant change in the resident's physical, mental, or psychosocial status, life threatening conditions, or clinical complications. A record review revealed the facility admitted Resident #1 on 12/08/11 with diagnoses to include Alzheimer's Disease, Dysphagia, and Gastroesophageal Reflux Disease (GERD). A review of the quarterly Minimum Data Set (MDS), dated 04/15/13, revealed the facility identified the resident as severely cognitively impaired and required total assistance with feeding (per feeding tube). A review of the comprehensive care plan for Alteration in Nutrition/Hydration, dated 01/17/13, revealed the resident would attain/maintain nutrition/hydration through means of a feeding tube as the resident was to remain NPO. A review of the Nurse Log Report, dated 04/28/13 at 5:45 PM, revealed Licensed Practical Nurse (LPN) #1 heard Resident #1 coughing and clearing his/her throat. LPN #1 observed the resident holding a dinner roll with a bite taken out of the item. She leaned the resident forward and encouraged the resident to cough the dinner roll up, and assessed the resident after the incident. The resident remained at the nurse's desk "spitting up", but no further complications. A review of a fax to Resident #1's primary physician, dated 04/28/13, revealed Resident #1 took a bite of a dinner roll. The resident spit up, lung sounds were clear, and the facility was monitoring the resident. The fax indicated no additional orders were given on 04/29/13, the day	F 157	trays go into the residential areas. During Resident snack pass the facility is also using an enclosed container so items are not within reach of residents or in their eye sight. This will be completed by June 29, 2013, with first full day of compliance being June 30, 2013. Criteria #2 River's Bend Retirement Community Administrative Nursing will provide training to Licensed Nurses on the physician notification policy to strive to ensure appropriate physicians' notifications. Licensed Nurses will also be provided a competency test on the physician notification policy. This will be provided by Administrative Nursing. Nurses' notes' documentation will be reviewed by Nursing Home Department Heads, which	

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F 157	Continued From page 3 after the incident. An interview with LPN #1, on 05/15/13 at 12:40 PM, revealed she assessed the resident after the incident and the resident's lungs were clear. She faxed the physician as the resident was in no distress; however, she stated she should have called the physician after the incident. Further review of the Nurse Log Report, dated 04/30/13 at 2:19 PM, revealed the resident had a fever of 101.2 degrees F with Tylenol given to reduce the fever. The resident's blood pressure was 89/54 mm/hg at the time of the assessment. There was no evidence the physician was made aware of the findings. Further interview with LPN #1, on 05/16/13 at 11:30 AM, revealed she knew the resident had a chest x-ray on 04/29/13 that showed no pneumonia; therefore, she was not concerned with the resident's vital signs on 04/30/13. She was unsure of the signs/symptoms of aspiration. An interview with Resident #1's Primary Physician, on 05/16/13 at 3:00 PM, revealed faxes were acceptable for non-life threatening issues; however, he expected staff to call him if there was a potential for him to send a resident out for treatment. If the staff had notified him of the resident's low blood pressure and fever on 04/30/13, he would have assumed, at that point, it was pneumonia or aspiration. Therefore, he would have "probably" sent the resident to the emergency room. An interview with the interim Director of Nursing (DON), on 05/17/13 at 12:40 PM, revealed she	F 157	includes Administrative Nursing, 3x a week to ensure that appropriate notifications to physicians, and appropriate responsible parties are completed as indicated, per facility's policy. Each specific resident's nursing notes will be reviewed at this time to assist in identifying any notifications that were not completed according to policy. Administrative Nursing will ensure that appropriate action or notification is completed. Department Heads, including Administrative Nursing, will be provided training from the Administrator on this plan of correction, the physician notification policy and actions to be taken by June 20, 2013. The above described will be how the facility will identify	

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F 157	Continued From page 4 expected LPN #1 to call the "on-call physician" of the incident that occurred on 04/28/13 as it was not sufficient to fax the primary physician. On 04/30/13, she would expect the nurse to administer the Tylenol to reduce the resident's fever; however, she should have notified the physician of the abnormal findings.	F 157	other residents that could be affected by the deficient practice. First full day of compliance will be June 30, 2013. Criteria #3	
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, 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined	F 280	The policy regarding physician notification will be reviewed by the Administrator and Administrative Nursing to ensure that there are not any needed revisions to the policy. This will be completed by June 29, 2013. with first full day of compliance being June 30, 2013. Licensed Practical Nurses and Registered Nurses that are employed by the facility will be provided training, by Administrative Nursing, on the physician notification policy. First full day of compliance will be June 30, 2013. Administrative Nursing	

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F 280	Continued From page 5 the facility failed to ensure each resident's care plan was revised for one resident (#1), in the selected sample of three (3) residents. Resident #1 was ordered a diet of nil per os (NPO), meaning "nothing by mouth." The resident had exhibited behaviors of non-compliance with the diet order, obtaining food and fluids from various places in the facility; however, the resident's care plan was not revised to ensure food/fluids were not in the resident's reach. Findings include:	F 280	will also conduct a competency test with Licensed Nurses on the physician notification policy. Any Licensed Nurses hired by the facility will be provided training on policy by Administrative Nursing. First full day of compliance will be June 30, 2013. Nurses' notes' documentation will be reviewed by Nursing Home	
	A review of the facility's Comprehensive Care Plan policy, revised 04/17/13, revealed the comprehensive care plan would be periodically reviewed and revised by a team of qualified persons periodically and as indicated. A record review revealed the facility admitted Resident #1 on 12/08/11 with diagnoses to include Alzheimer's Disease, Dysphagia, and Gastroesophageal Reflux Disease (GERD). A review of the quarterly Minimum Data Set (MDS), dated 04/15/13, revealed the facility identified the resident as severely cognitively impaired and required total assistance with feeding (per feeding tube). A review of the comprehensive care plan for Alteration in Nutrition/Hydration, dated 01/17/13, revealed the resident would attain/maintain nutrition/hydration through means of a feeding tube as the resident was to remain NPO. A review of the Nurse Log Report, dated 02/05/13 at 10:30 AM, revealed a staff member heard the resident coughing and found him/her at the nurse's desk holding an oatmeal pie. The food		Department Heads, which includes Administrative Nursing 3x a week to ensure that appropriate notifications to physicians, and appropriate responsible parties were completed as indicated, per facility's policy. Each specific resident's nursing notes will be reviewed at this time to assist in identifying any notifications that were not completed according to policy.	

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F 280	Continued From page 6 Item was noted in the resident's mouth as well. A review of the comprehensive care plan, dated 02/05/13, revealed a new intervention to ensure the snacks were placed behind the nurse's station. A review of the Nurse Log Report, dated 02/18/13 at 11:36 AM, revealed the resident was observed in the hallway holding a glass (half full) of a house supplement. A review of the comprehensive care plan, dated 02/18/13, revealed the staff member was terminated for leaving the house supplement on the roommate's bedside table; however, there were no new interventions to ensure food/fluids were out of the resident's reach. A review of the Nurse Log Report, dated 04/20/13 at 3:10 PM, revealed staff observed the resident eating a bag of crackers. A review of the comprehensive care plan, dated 04/20/13, revealed to ensure the snacks were placed in the nourishment room. The care plan also indicated the resident was non-compliant with his/her diet; however, there were no interventions in place to ensure food/fluids were out of the resident's reach. A review of the Certified Nurse Aide (CNA) care plan record, undated, revealed no interventions to ensure food/fluids were not in reach of the resident. A review of the Nurse Log Report, dated 04/28/13 at 5:45 PM, revealed Resident #1 obtained a dinner roll from an open dinner cart left at the nurse's station. The resident took a bite of the roll and had to be encouraged to cough and spit it out. A review of the History and Physical, dated	F 280	Administrative Nursing will ensure that appropriate action or notification is completed. The disciplinary policy will be utilized if the physician notification policy is not followed. Department Heads, including Administrative Nursing, will be provided training from the Administrator on this plan of correction, the physician notification policy and actions to be taken by June 20, 2013. Licensed Practical Nurses and Registered Nurses will be provided training on the shift report process. A shift report should be printed from our electronic documentation system at the end of each shift, and at the beginning of each shift. The on-coming nurse should review the shift report with the nurse that is ending her/his shift. They should	

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F 280	Continued From page 7 05/01/13, revealed the resident was admitted to the hospital with Aspiration Pneumonia, recurrent. An interview with the Administrator, on 05/17/13 at 12:50 PM, revealed an incident review committee meets at least three days a week to review all incidents in the facility. Resident care plans were reviewed during the meeting and interventions added, as indicated. She did not feel an intervention to ensure food was out of the resident's reach was necessary, as the resident was NPO. She felt the interventions in place were adequate as the resident does not wander into other resident's rooms or reach out for other resident's food. An interview with the interim Director of Nursing, on 05/17/13 at 12:40 PM, revealed she would have expected the CNA care plan to include an intervention to alert staff not to leave food in reach of the resident, due to the resident's past behaviors.	F 280	review it to ensure that all appropriate notifications were made during that shift, as indicated per policy. The Licensed Nurses are to make notifications for incidences/ changes that occurred on their shift. The Licensed Nurses reviewing the shift report will sign off on the report that they have reviewed it, and will give this copy to the Director of Nursing. Licensed Nurses will be provided training on these expectations by Administrative Nursing with June 30, 2013 being the first full day of compliance.	
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 by:	F 323	A copy of the physician notification policy will also be placed in the front of the nurses' clinical book for easy reference. As part of the orientation process, any Licensed Nurses hired will be provided training, and a competency test on the physician notification policy to demonstrate understanding of the policy.	

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F 323	Continued From page 8 Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents for one (1)resident (#1), in the selected sample of three (3) residents. Resident #1 was ordered a diet of nil per os (NPO), meaning "nothing by mouth." The resident had exhibited behaviors of non-compliance with the diet order, obtaining food and fluids from various places in the facility. On 04/28/13, the resident took a bite from a dinner roll on another resident's tray and began coughing. The resident required encouragement from staff to cough and spit the dinner roll out of his/her mouth. On 05/01/13, the resident was admitted to the hospital with a diagnosis of Aspiration Pneumonia. Findings include: A review of the facility's policy/procedure for Meal Times, undated, revealed the facility would strive to meet nutritional needs of residents, while maintaining safety for residents. Residents would be provided a diet as indicated, per the physician. A record review revealed the facility admitted Resident #1 on 12/08/11 with diagnoses to include Alzheimer's Disease; Dysphagia, and Gastroesophageal Reflux Disease (GERD). A review of the quarterly Minimum Data Set (MDS), dated 04/15/13, revealed the facility identified the resident as severely cognitively impaired and required total assistance with feeding (per feeding tube). A review of the comprehensive care plan for Alteration in Nutrition/Hydration, dated 01/17/13, revealed the resident would attain/maintain nutrition/hydration through means	F 323	First full day of compliance will be June 30, 2013. Criteria #4 Nurses' notes' documentation will be reviewed by Nursing Home Department Heads, which includes Administrative Nursing, 3x a week to ensure that appropriate notifications to physicians, and appropriate responsible parties were notified as indicated, per facility's policy. Each specific resident's nursing notes will be reviewed at this time to assist in identifying any notifications that were not completed according to polic	

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F 323	Continued From page 9 of a feeding tube as the resident was to remain NPO. A review of the Nurse Log Report revealed the following: On 02/05/13 at 10:30 AM, a staff member heard the resident coughing and found him/her at the nurse's desk holding an oatmeal pie. The food item was noted in the resident's mouth as well. On 02/18/13 at 11:36 AM, the resident was observed in the hallway holding a glass (half full) of a house supplement. On 04/20/13 at 3:10 PM, staff observed the resident eating a bag of crackers. A review of the Alteration in Nutrition/Hydration care plan, dated 01/17/13, revealed interventions to ensure the "snack cart" was taken back to the nourishment room after snacks were passed; however, there were no interventions to ensure food/drinks were not left in sight of the resident. A review of the Nurse Log Report, dated 04/28/13 at 5:45 PM, revealed Licensed Practical Nurse (LPN) #1 heard Resident #1 coughing and clearing his/her throat. LPN #1 observed the resident holding a dinner roll with a bite taken out of the item. She leaned the resident forward and encouraged the resident to cough the dinner roll up. On 04/29/13 at 7:32 PM, the resident was sent to the emergency room as he/she continued to complain of "choking." A review of the X-ray report, dated 04/29/13 at 9:20 PM, revealed no evidence of pneumonia. On 04/30/13 at 2:19 PM, the Nurse Log Report revealed the resident had a fever of 101.2 degrees Fahrenheit (F) with Tylenol given to reduce the fever. The resident's blood	F 323	Administrative Nursing will ensure that appropriate action or notification is completed. If notification is not completed by the Licensed Nurse as indicated per policy, the disciplinary policy will be followed. Administrative Nursing will do an audit of signed shift reports 2x's a month for one quarter to ensure that Licensed Nurses are completing shift report as they were trained by Administrative nursing. First full day of compliance will be June 30, 2013. F280 Criteria #5 Criteria #1 Resident #1's comprehensive care plan will be addended to reflect that Resident #1 will grab food items when in reach.	June 30, 2013

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F 323	Continued From page 10 pressure was 89/54 mm/hg at the time of the assessment. Further review of the Nurse Log Report, dated 05/01/13 at 4:02 AM, revealed the resident had a fever of 102 degrees F. At 9:42 AM, the resident's blood pressure was 56/34 mm/hg with a low oxygen saturation. The resident was transferred to the emergency room for treatment. A review of the History & Physical, dated 05/01/13, revealed an impression of Aspiration Pneumonia, recurrent.	F 323	Resident #1's care plan will also be addended that she is non-compliant with NPO status, and interventions will be provided. This will be completed by Administrative Nursing with the first full day of compliance being June 30, 2013.	
	An Interview with LPN #1, on 05/15/13 at 12:40 PM, revealed she was the nurse for Resident #1 on 04/28/13. She was standing at the treatment cart near the nurse's station when she heard Resident #1 "clearing [his/her] throat." The resident was holding a dinner roll from the open food cart at the nurse's station. She took the dinner roll from the resident and noticed a "bite" had been taken. She prompted the resident to cough and "spit" it out. She revealed staff was not suppose to bring the open food cart from the dining room onto the hall. She stated the trays should have been transferred to the hall cart (the metal cart with a door).		Criteria #2 River's Bend Retirement Community has developed a Dining Assessment to be completed by Administrative Nursing. The assessment will assess if the resident has a history/or is currently at risk of grabbing or taking food that is not intended for that particular Resident. If a resident is assessed	
	An interview with State Registered Nurse Aide (SRNA) #1, on 05/16/13 at 10:50 AM, revealed she pushed the open food cart of resident trays up to the nurse's station on 04/28/13. She left the cart unattended as she went back to the dining room to feed other residents. She was aware of Resident #1's history of obtaining food from other carts; however, she did not think about it when she pushed the open cart onto the hall. She revealed it was never relayed to her to keep the			

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	185410		C 05/17/2013

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F 323	Continued From page 11 open cart in the dining room. An interview with the interim Director of Nursing (DON), on 05/17/13 at 12:40 PM, revealed she expected staff to ensure food was not made available for the resident due to his/her previous behaviors; however, there was no intervention in place to ensure the open food cart was not taken onto the hall. She revealed it could not be predicted the resident would take a dinner roll from the cart. She revealed with previous incidents, the resident had taken food from the snack cart and his/her roommate's bedside table. An interview with the Emergency Room (ER) Physician, on 05/16/13 at 8:30 AM, revealed if a resident having dysphagia ate something they were not suppose to, the risk for aspiration would be much higher for that resident. He revealed it would not be unusual, if a small amount was aspirated, to show symptoms such as a fever days later. An interview with the Attending Physician at the hospital, on 05/16/13 at 8:45 AM, revealed he examined Resident #1 on 05/01/13. He revealed the incident with the dinner roll on 04/28/13 corollated well with the resident's aspiration pneumonia on 05/01/13. He revealed [he/she] "probably" aspirated on that dinner roll. He verified it would not be unusual for the first x-ray, on 04/29/13 to show no pneumonia.	F 323	to display this behavior during the assessment or per history individualized interventions to address the behavior will be noted on that particular Resident's comprehensive care plan. All residents at the facility will be assessed utilizing the dining assessment tool by June 29, 2013, with first full day of compliance being June 30, 2013. This will be completed by Administrative Nursing. The Dining Assessment will then be completed by Administrative Nursing upon admission, quarterly, and PRN for each resident. Administrative Nursing will also provide training on the Dining Assessment tool to Licensed Nurses.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185410		C 05/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER'S BEND RETIREMENT COMMUNITY	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 open cart in the dining room. An interview with the interim Director of Nursing (DON), on 05/17/13 at 12:40 PM, revealed she expected staff to ensure food was not made available for the resident due to his/her previous behaviors; however, there was no intervention in place to ensure the open food cart was not taken onto the hall. She revealed it could not be predicted the resident would take a dinner roll from the cart. She revealed with previous incidents, the resident had taken food from the snack cart and his/her roommate's bedside table. An interview with the Emergency Room (ER) Physician, on 05/16/13 at 8:30 AM, revealed if a resident having dysphagia ate something they were not suppose to, the risk for aspiration would be much higher for that resident. He revealed it would not be unusual, if a small amount was aspirated, to show symptoms such as a fever days later. An interview with the Attending Physician at the hospital, on 05/16/13 at 8:45 AM, revealed he examined Resident #1 on 05/01/13. He revealed the incident with the dinner roll on 04/28/13 corollated well with the resident's aspiration pneumonia on 05/01/13. He revealed [he/she] "probably" aspirated on that dinner roll. He verified it would not be unusual for the first x-ray, on 04/29/13 to show no pneumonia.	F 323	June 30, 2013. This will be completed by Administrative Nursing. The Dining Assessment will then be completed by Administrative Nursing upon admission, quarterly, and PRN for each resident. Administrative Nursing will also provide training to Licensed Nurses on this assessment. Criteria #3 River's Bend Retirement Community has developed a Dining Assessment to be completed by Administrative Nursing. The assessment will assess if the resident has a history or is currently at risk of grabbing or taking food that	

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RIVER'S BEND RETIREMENT COMMUNITY	300 BEECH ST. KUTTAWA, KY 42055

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165410

(X2) MULTIP
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED C 05/17/2013

NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND RETIREMENT COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE: 2055

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