

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

PRINTED: 12/07/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185124</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/21/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>REDBANKS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>851 KIMSEY LANE</b> <b>HENDERSON, KY 42420</b>		
(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  Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance 12/21/15, as alleged.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X8) DATE	

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185124	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/21/2015
Name of Facility REDBANKS	Street Address, City, State, Zip Code 851 KIMSEY LANE HENDERSON, KY 42420	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0221</u> Reg. # <u>483.13(a)</u> LSC _____	Correction Completed 12/21/2015	ID Prefix <u>F0254</u> Reg. # <u>483.15(h)(3)</u> LSC _____	Correction Completed 12/21/2015	ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(i)</u> LSC _____	Correction Completed 12/21/2015
ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(ii)</u> LSC _____	Correction Completed 12/21/2015	ID Prefix <u>F0315</u> Reg. # <u>483.25(d)</u> LSC _____	Correction Completed 12/21/2015	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed 12/21/2015
ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed 12/21/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

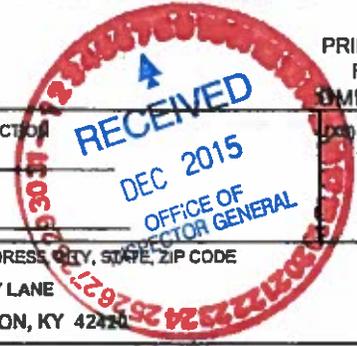
Reviewed By _____ State Agency	Reviewed By <u>OH</u>	Date: <u>12/07/15</u>	Signature of Surveyor: <u>Rebecca A. [Signature]</u>	Date: <u>12/07/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 11/6/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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NAME OF PROVIDER OR SUPPLIER  REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>A Recertification Survey was conducted on 11/04/15 through 11/06/15 with deficiencies cited at the highest Scope and Severity of a "D".</p> <p>F 221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>SS=D</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, and review of manufacturer's recommendations, it was determined the facility failed to ensure one (1) of twenty-nine (29) sampled residents was free from a physical restraint that was not required to treat a medical symptom (Resident #11).</p> <p>Resident #11 was observed on 11/05/15 to be restrained with a soft fabric belt while seated in a wheelchair for an extended period of time (three {3} hours) without release of the resident to provide Incontinent care, repositioning, motion, and to skin check.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Use of Restraints", last revised 12/2007, revealed restraints shall only be used for the safety and well-being of the resident(s) and only after other</p>	F 000	<p><b>Disclaimer:</b></p> <p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with 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.</p> <p><b>F 221 Physical Restraints</b></p> <p><b>Criteria 1:</b> The safety device/restraint for resident #11 has been reviewed by the Interdisciplinary Care Plan team- which includes the Unit Manager RN, Director of Nursing, Activities Director, Social Services Director, and Therapy Director- on 12/3/15 to determine the appropriate device release schedule and to reflect this on the orders and care plan. The revised schedule for release with ADL's (transfers, eating, toileting, and bathing) and with repositioning was reviewed by the Unit Manager RN with the C.N.A.s (certified nursing assistants) and licensed nurses</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 12/4/15
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F 221	<p>Continued From page 1</p> <p>alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. The policy included "soft ties" as an example of a device that may be considered a "physical restraint". Further review of the policy revealed physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency and the opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours on all shifts.</p> <p>Review of the Manufacturer's Recommendation Information for the Soft Ties, dated 09/03/1996, revealed to always monitor residents in restrictive devices. Make certain to follow your facility's procedures for periodic release, toileting and exercise.</p> <p>Record review revealed the facility admitted Resident #11 on 11/22/11 with diagnoses which included Alzheimer's Disease and Osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/28/15, revealed the facility assessed Resident #11's cognition as severely impaired. In addition, Resident #11 required extensive assistance with all Activities of Daily Living, was incontinent of bowel and bladder and required assistance with any ambulation.</p> <p>Review of the Physician's Order, dated 11/2015, revealed to use a rear releasing soft belt to wheelchair due to poor safety awareness. Monitor every thirty (30) minutes and release every two (2) hours and as needed for ADL's, ROM and skin checks.</p>	F 221	<p>responsible for Resident #11's direct care on 11/30/15 and 12/2/15.</p> <p><b>Criteria 2:</b> All residents currently utilizing restrictive safety devices have the potential to be affected and have been assessed by the Interdisciplinary Care Plan team on 12/3/15 to determine their specific release schedule is reflected on the orders and the care plan, and is followed by the direct care staff, as determined by the Administrative Nursing team.</p> <p><b>Criteria 3:</b> Facility C.N.As and licensed nursing staff have received inservice education on the use and release of resident safety device interventions in accordance with the resident orders and care plan as provided by the Staff Development Coordinator RN, Weekend Supervisor, Assistant Director of Nursing, Unit Manager RN, Director of Nursing, Quality Assurance RN, or MDS nurse beginning on 12/3/15. Education continued through 12/20/15 until all nursing staff received the education. No nursing staff member will be</p>		

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F 221	<p>Continued From page 2</p> <p>Review of the Care Kardex Monitoring Section revealed on the Safety section: "RESTRAINT USE": 'Apply rear releasing soft belt restraint while up in wheelchair. Check belt every thirty (30) minutes and as needed (prn); release every two (2) hours and prn for incontinence management, repositioning and skin observation. Document restraint use and release as per facility protocols".</p> <p>Continuous observation, on 11/05/15 starting at 7:45 AM through 10:45 AM, revealed Resident #11 was in various areas of the secured unit in which he/she resided; however, staff did not release the restraint or provide incontinent care/reposition/skin observation until 10:30 AM (approximately three {3} hours) when the resident was assisted to the shower room for incontinent care.</p> <p>Observation of Resident #11's incontinent care, on 11/05/15 at 10:45 AM, revealed Certified Nurse Aide (CNA) #8 and CNA #9 provided the incontinent care and Resident #11's incontinent brief was soaked with urine and the resident was very combative and struck CNA #9 several times.</p> <p>Interview with CNA #9, on 11/05/15 at 10:50 AM, revealed Resident #11 is assisted up in the mornings by the 11:00 PM to 7:00 AM staff and the resident was up in the wheelchair when she came on duty this morning. CNA #9 stated she had not provided the every two (2) hour incontinent care or the release of the belt restraint because the morning had been "off" and she did not get to it.</p> <p>Interview with Registered Nurse (RN) #5, on</p>	F 221	<p>allowed to work after 12/20/15 until they have first received the education.</p> <p><b>Criteria 4:</b> The QAPI (Quality Assurance Performance Improvement) indicator for the monitoring of device/physical restraint use will be utilized on both shifts (7am-7pm and 7pm-7am) and on the weekends weekly X 4 weeks, then monthly X 2 months and then quarterly thereafter under the supervision of the Director of Nursing. This tool monitors the correct application and release of safety device interventions in accordance with the resident orders and care plan. Any identified concerns found with completion of this tool will be immediately corrected and be tracked and trended by the QAPI Committee with further action taken as directed by the QAPI Committee. The QAPI Committee meets monthly and consists of the QAPI RN, Administrator, Assistant Administrator, Director of Nursing, Staff Development Coordinator, Medical Director, Environmental Services Supervisor, and other staff members as assigned by the Administrator.</p>	

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F 221	Continued From page 3 11/05/15 at 11:58 AM, revealed she could not assure incontinent care and release of restraints was provided, however, expected it to be done. RN #5 stated prolonged exposure to urine soaked briefs could potentially cause urinary tract infections. RN #5 further stated restraints are supposed to be released every two (2) hours and not doing so could contribute to pressure sores, contractures and agitation.  Interview with the Director of Nursing (DON), on 11/05/15 at 4:30 PM, revealed she would have expected Resident #11's restraint to be released at least every two (2) hours as per the facility policy. The DON stated there had been no trial reduction for the belt restraint since 09/11/15, as the family insisted the resident be restrained to prevent any fall and would not allow a trial reduction.	F 221	<b>Criteria 5: December 21, 2015</b>  <b>Disclaimer:</b>  <b>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with 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.</b>		
F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION  The facility must provide clean bed and bath linens that are in good condition.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide bed linens that were clean and in good condition in two (2) residents' rooms (Room #105-1 and #108-1), during the initial tour of the facility.  The findings include:  Review of the facility's policy titled, "Laundry and	F 254	<b>F 254 Clean Bed/Bath Linens in Good Repair.</b>  <b>Criteria 1: The pillows of resident #19 and unsampled resident D were replaced by laundry on 11/6/15.</b>  <b>Criteria 2: An inspection was completed by housekeeping and laundry staff on 12/1/15, 12/2/15, 12/3/15, and 12/4/15 to determine that all pillows are clean and in good repair, with no cracked or damaged surfaces. All pillows identified with any soiling or defects were cleaned/replaced.</b>		

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F 254	Continued From page 4 Bedding, Soiled", last revised 10/2009, revealed washable pillows should be laundered when soiled and pillows should be discarded when torn, damaged, or permanently stained.  Observation during initial tour, on 11/04/15 at 10:46 AM, revealed a soiled, washable pillow on the bed of resident room #105-1. The pillow was noted to be stained with a brown substance and only partially covered with a pillow case. In addition, observation revealed a ragged, torn pillow without a pillow case on the bed of resident room #108-1.  Interview with Certified Nurse Aide (CNA) #2, on 11/05/15 at 10:33 AM, revealed pillows should be replaced if visibly soiled or torn.  Interview with the Director of Nursing (DON), on 11/08/15 at 12:34 PM, revealed she expected bed linens and pillows to be clean and in good condition. She stated pillows should be washed if soiled and discarded and replaced if torn.	F 254	<b>Criteria 3:</b> The housekeeping and laundry staff have received inservice education on the need to inspect all pillows for any signs of soiling or damage on a quarterly basis, on 12/2/15 as provided by the Director of Environmental Services. Education with housekeeping and laundry staff continued until all were completed on 12/9/15. Facility C.N.As and licensed nursing staff have received inservice education on the need to replace soiled or damaged pillows by the Staff Development Coordinator RN, Weekend Supervisor, Assistant Director of Nursing, Unit Manager RN, Director of Nursing, Quality Assurance RN, or MDS nurse beginning on 12/3/15. Education continued through 12/20/15 until all nursing staff received the education. No nursing staff member will be allowed to work after 12/20/15 until they have first received the education.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed ensure services provided by the facility meet professional standards of quality for one (1) unsampled resident (Resident C). Licensed Practical Nurse (LPN) #1 failed to	F 281	<b>Criteria 4:</b> The housekeeping and laundry staff will conduct a quarterly inspection of all facility pillows. The findings will be reviewed in the quarterly QAPI		

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F 281	Continued From page 5 ensure a gastrostomy tube feeding bag containing Fibersource HN was labeled with the time and date it was initiated.  The findings include:  Review of the facility's policy titled, "Enteral Feedings-Safety Precautions", last revised 03/2015, revealed "on the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order".  Record review revealed the facility admitted Resident C on 02/22/06 with diagnoses which included Alzheimer's Disease, Dysphagia, Paralytic Syndrome, and Aphasia.  Observation during initial tour, on 11/04/15 at 10:50 AM, revealed a container of Fibersource HN tube feeding suspended on a pole and being administered to Resident C, had no date, time or initials on the container.  Interview with LPN #1, on 11/04/15 at 3:46 PM, revealed she hung the feeding, got distracted and forgot to label the container.  Interview with the Director of Nursing (DON), on 11/06/15 at 12:34 PM, revealed she expected the tube feeding containers to be labeled with initials, date, and time when the container is hung.	F 281	(Quality Assurance Performance Improvement) meeting to determine compliance. Any identified concerns found with this inspection will be immediately corrected and be tracked and trended by the QAPI Committee with further action taken as directed by the QAPI Committee. The QAPI Committee meets monthly and consists of the QAPI RN, Administrator, Assistant Administrator, Director of Nursing, Staff Development Coordinator, Medical Director, Environmental Services Supervisor, and other staff members as assigned by the Administrator.  Criteria 5: December 21, 2015		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282			

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F 282	<p>Continued From page 6 care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the care plan was followed for one (1) of twenty-nine (29) sampled residents (Resident #11). Resident #11 was care planned for the use of a restraint and for the restraint to be released every two (2) hours for ADL care, motion, and skin check. In addition, the resident was care planned for the use of geri-sleeves. Observation revealed Resident #11 was restrained for three (3) hours without releasing the restraint and providing incontinence management, repositioning and skin observation. Additionally, geri-sleeves were not in place.</p> <p>The findings include:</p> <p>Interview with the Corporate Nurse, on 11/05/15 at 4:10 PM, revealed there was no facility policy and procedure related to following the care plan. She stated all staff are educated related to following the care plan.</p> <p>Record review revealed the facility admitted Resident #11 on 11/22/11 with diagnoses which included Alzheimer's Disease and Osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/28/15, revealed the facility assessed Resident #11's cognition as severely impaired. In addition, Resident #11 required extensive assistance with all Activities of Daily Living, was incontinent of bowel and bladder and required assistance with any ambulation.</p>	F 282	<p><b>Disclaimer:</b></p> <p><b>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with 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.</b></p> <p><b>F 281 Services Provided Meet Professional Standards</b></p> <p><b>Criteria 1:</b> The enteral feeding formula bag for unsampled Resident C was labeled/dated immediately after identification on 11/4/15 by the Licensed Nurse that had hung it right before the initial tour. The Licensed Nurse was verbally educated at that time by the Director of Nursing.</p> <p><b>Criteria 2:</b> All residents with enteral feedings were reviewed by the Director of Nursing on 11/4/15 to validate formula bags labeled.</p>		

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F 282	Continued From page 7  Review of Resident #11's Comprehensive Care Plan for ADL self-care performance and Restraint Use, dated 03/11/14, revealed interventions for incontinence management maintained per staff every two (2) hours and as needed (pm) with use of adult briefs, apply geri-sleeves, apply rear releasing soft belt restraint while up in wheelchair, check belt every thirty (30) minutes and pm; release every two (2) hours and pm for incontinence management, repositioning and skin observation.  Review of the Care Kardex Monitoring Section revealed on the Safety section: "RESTRAINT USE": "Apply rear releasing soft belt restraint while up in wheelchair. Check belt every thirty (30) minutes and as needed (pm); release every two (2) hours and pm for incontinence management, repositioning and skin observation. Document restraint use and release as per facility protocols".  Continuous observation, on 11/05/15 starting at 7:45 AM through 10:45 AM, revealed Resident #11 was in various areas of the secured unit in which he/she resided; however, staff did not release the restraint or provide incontinent care/reposition/skin observation until 10:30 AM (approximately three {3} hours) when the resident was assisted to the shower room for incontinent care. In addition, the resident was not wearing geri-sleeves.  Observation of Resident #11's incontinent care, on 11/05/15 at 10:45 AM, revealed Certified Nurse Aide (CNA) #8 and CNA #9 provided the incontinent care. Resident #11's incontinent brief was soaked with urine and the resident was very	F 282	<b>Criteria 3:</b> Licensed nurses received training on the need to completely label enteral feeding bags beginning on 12/3/15 as provided by the Staff Development Coordinator RN, Weekend Supervisor, Assistant Director of Nursing, Director of Nursing, Unit Manager RN, Quality Assurance RN, or MDS nurse. Education continued through 12/20/15 until all licensed nursing staff received the education. No licensed nursing staff member will be allowed to work after 12/20/15 until they have first received the education. Compliance rounds were completed by the Unit Manager RNs, Assistant Director of Nursing, Weekend Supervisor, or the Director of Nursing daily X 7 days, weekly X 2 weeks, and then monthly thereafter on both shifts (7am-7pm and 7pm-7am) and on weekends to identify proper labeling of enteral feeding formula bags.  <b>Criteria 4:</b> The QAPI (Quality Assurance Performance Improvement) indicator for the monitoring of complete labeling of	

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F 282	<p>Continued From page 8</p> <p>combative, and struck CNA #9 several times.</p> <p>Interview with CNA #9, on 11/05/15 at 10:50 AM, revealed Resident #11 is assisted up in the mornings by the 11:00 PM to 7:00 AM staff and the resident was up in the wheelchair when she came on duty this morning. CNA #9 stated she had not provided the every two (2) hour incontinent care or the release of the belt restraint because the morning had been "off" and she did not get to it. Further interview with CNA #9, on 11/05/15 at 2:45 PM, revealed she recalled a skin tear to Resident #11's arm in the past and stated the resident's care plan indicated geri-sleeves and they were supposed to be in place. She stated "I guess I just missed it".</p> <p>Interview with Registered Nurse (RN) #5, on 11/05/15 at 11:58 AM, revealed she could not ensure incontinent care and release of restraints was provided, however, expected it to be done. RN #5 stated prolonged exposure to urine soaked briefs could potentially cause urinary tract infections. RN #5 further stated restraints are supposed to be released every two (2) hours and not doing so could contribute to pressure sores, contractures and agitation.</p> <p>Interview with the Director of Nursing (DON), on 11/05/15 at 4:30 PM, revealed she would have expected Resident #11's restraint to be released at least every two (2) hours as per the facility policy. The DON stated there had been no trial reduction for the belt restraint since 09/11/15, as the family insisted the resident be restrained to prevent any fall and would not allow a trial reduction. The DON additionally stated staff should know to look at the Kardex (on the care plan) and follow.</p>	F 282	<p>enteral feeding bags will be utilized monthly under the supervision of the Director of Nursing. Any identified concerns found with completion of this tool will be immediately corrected and be tracked and trended by the QAPI Committee with further action taken as directed by the QAPI Committee. The QAPI Committee meets monthly and consists of the QAPI RN, Administrator, Assistant Administrator, Director of Nursing, Staff Development Coordinator, Medical Director, Environmental Services Supervisor, and other staff members as assigned by the Administrator.</p> <p>Criteria 5: December 21, 2015</p>		

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F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>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 appropriate incontinent care or ensure catheter bags were not on the floor for two (2) of twenty-nine (29) sampled residents (Resident #11 and #3). Observations revealed Resident #11 did not receive incontinent care every two (2) hours and Resident #3 was observed with his/her urinary catheter drainage bag directly in contact with the floor.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled "Urinary Incontinence", not dated, revealed the Centers for Medicare &amp; Medicaid Services (CMS) require appropriate treatment and services for persons who are incontinent. The goals listed included prevent urinary tract infection (UTI), and to keep the perineal area clean and dry.</p> <p>Record review revealed the facility admitted Resident #11 on 11/22/11 with diagnoses which</p>	F 315	<p><b>Disclaimer:</b></p> <p><b>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with 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.</b></p> <p><b>F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p><b>Criteria 1:</b> Resident #11 was provided incontinence care at 10:45am on 11/5/15 as stated in the statement of deficiencies. Resident #11 was provided with geri sleeves on 11/6/15.</p> <p><b>Criteria 2:</b> All residents requiring assistance with incontinence management or with geri sleeves have the potential to be affected. To identify other residents with potential to be affected, care observations were conducted by the Administrative nursing team weekly</p>	

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F 315	<p>Continued From page 10</p> <p>included Alzheimer's Disease and Osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/28/15, revealed the facility assessed Resident #11's cognition as severely impaired. In addition, Resident #11 required extensive assistance with all Activities of Daily Living, was incontinent of bowel and bladder and required assistance with any ambulation.</p> <p>Review of Resident #11's Comprehensive Care Plan for Activities of Daily Living, last revised 03/06/15, revealed an intervention for incontinence management to be maintained by staff every two (2) hours and as needed (pm) with use of adult briefs. The resident requires extensive assist of two (2) staff.</p> <p>Review of Laboratory Results, dated 10/30/15, revealed culture results of Morganella morganii. The resident's physician ordered Ceftin 500 mg two times daily for UTI for 14 days on 11/02/15.</p> <p>Continuous observation of Resident #11 starting at 7:45 AM on 11/05/15, revealed the resident seated in a wheelchair with a belt restraint and no staff offered incontinent care until 10:45 AM (for approximately three (3) hours.</p> <p>Observation of Resident #11's incontinent care, on 11/05/15 at 10:45 AM, revealed Certified Nurse Aide (CNA) #8 and CNA #9 provided the care and Resident #11's incontinent brief was soaked with urine.</p> <p>Interview with Certified Nurse Aide (CNA) #9, on 11/05/15 at 10:50 AM, revealed Resident #11 is assisted up in the mornings by the 11:00 PM to 7:00 AM staff and the resident was up in the wheelchair when she came on duty this morning.</p>	F 315	<p>X 2 weeks, and then monthly X 2 months for 10 randomly selected residents with each observation to determine that these residents are provided incontinence care and geri sleeves by qualified persons in accordance with the written plan of care.</p> <p><b>Criteria 3:</b> All licensed and non-licensed nursing staff have received inservice education by the Staff Development Coordinator RN, Weekend Supervisor, Unit Manager RN, Assistant Director of Nursing, Director of Nursing, Quality Assurance RN, or MDS nurse beginning on 12/3/15 on the need to provide resident care, including but not limited to incontinence care and geri sleeves, in accordance with the resident care plans.</p> <p>Education continued through 12/20/15 until all nursing staff received the education. No nursing staff member will be allowed to work after 12/20/15 until they have first received the education.</p> <p>Compliance rounds monitoring for resident care provision in accordance with the care plan will be utilized by the Unit Manager RNs, Assistant Director of Nursing,</p>	

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F 315	<p>Continued From page 11</p> <p>CNA #9 stated she had not provided the every two (2) hour incontinent care because the morning had been "off" and she did not get to it.</p> <p>Interview with Registered Nurse (RN) #5, on 11/05/15 at 11:58 AM, revealed incontinent care should have been provided every two (2) hours and the prolonged exposure to urine soaked briefs could potentially cause urinary tract infections.</p> <p>Interview with the Director of Nursing (DON), on 11/05/15 at 4:30 PM, revealed she would have expected Resident #11 to have been provided incontinent care every two (2) hours and as needed.</p> <p>2. Review of the facility policy titled, "Catheter Care, Urinary", last revised 09/14, revealed be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>Record review revealed the facility admitted Resident #3 on 08/20/15 with diagnoses which include Urinary Retention. Review of the admission MDS assessment, dated 08/27/15, revealed the facility assessed Resident #3's cognition as intact with a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident was interviewable. Review of the Physician's Orders, dated 08/21/15, revealed to use a twenty two (22) French thirty (30) cubic centimeter (cc) urinary catheter to bedside drainage every shift for Urinary Retention.</p> <p>Observations on 11/04/15 at 12:20 PM, 2:50 PM, and 4:10 PM, and on 11/05/15 at 7:42 AM, revealed Resident #3's urinary drainage bag was</p>	F 315	<p>Director of Nursing, or Weekend Supervisor on both shifts (7am-7pm and 7pm-7am) and on weekends weekly X4 weeks, then monthly X 2 months, and then quarterly under the supervision of the Director of Nursing (DON).</p> <p>Criteria 4: The QAPI (Quality Assurance Performance Improvement ) indicator for the monitoring of resident care provision in accordance with the care plan will be utilized monthly X 2 months, and then quarterly under the supervision of the Director of Nursing (DON).</p> <p>Findings of the completed indicators will be reviewed by the QAPI Committee to determine if any further action plan is indicated. Any identified concerns found with completion of this tool will be immediately corrected and be tracked and trended by the QAPI Committee with further action taken as directed by the QAPI Committee. The QAPI Committee meets monthly and consists of the QAPI RN, Administrator, Assistant Administrator, Director of Nursing, Staff Development Coordinator, Medical Director, Environmental Services Supervisor, and other staff members as assigned by the Administrator.</p>		

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F 315	<p>Continued From page 12</p> <p>not attached to the bed and was laying directly on the floor. Further observations revealed there was a black urinary dignity bag attached to the bed that was not being utilized.</p> <p>Interview with CNA #7, on 11/05/15 at 8:05 AM, CNA #4 at 8:15 AM, CNA #5 at 8:20 AM, and CNA #6 at 9:45 AM, revealed all urinary catheter drainage bags should be off the floor to help prevent the spread of infection to the resident and should be in a dignity bag.</p> <p>Interview with CNA #3, on 11/05/15 at 11:38 AM, revealed urinary drainage bags should always be kept in a dignity bag and kept off the floor for infection control purposes. CNA #3 stated the tubing being stretched tightly from the catheter could cause the catheter to become dislodged.</p> <p>Interview with RN #3, on 11/05/15 at 9:30 AM, revealed urinary catheter bags and tubing should be off the floor to help prevent the risk of urinary tract infections and it's just good infection control practice for the entire facility.</p> <p>Interview with RN #2, on 11/05/15 at 11:42 AM, revealed an indwelling catheter bag should never be allowed to make contact with the floor as this could cause infections in the urinary tract.</p> <p>Interview with the RN, Harbor Unit Manager, on 11/05/15 at 11:43 AM, revealed she expected the staff to ensure a catheter bag was in a dignity bag and not contacting the floor for infection control purposes.</p> <p>Interview with the DON, on 11/06/15 at 12:27 PM, revealed all indwelling catheter bags should be secured off the floor for infection control and to</p>	F 315	<p><b>Disclaimer:</b></p> <p><b>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with 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.</b></p> <p><b>F 315 Urinary Incontinence</b></p> <p><b>Criteria 1:</b> Resident #11 was provided incontinence care at 10:45am on 11/5/15 as stated in the statement of deficiencies. Resident #3 had the catheter placed in the dignity bag on 11/5/15 and Resident #1 had the catheter placed in the dignity bag on 11/5/15.</p> <p><b>Criteria 2:</b> All residents requiring assistance with incontinent care or with indwelling catheters have the potential to be affected. To identify other residents having the potential to be affected, care observations were conducted by the Administrative nursing team weekly X 2 weeks, and then monthly X 2</p>	

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F 315	Continued From page 13 help prevent the catheter from becoming dislodged.	F 315	months for 10 randomly selected residents with each observation to determine that these residents are provided incontinence care and catheter care in accordance with the written plan of care and foley catheter bags are stored in accordance with infection control standards of practice.  <b>Criteria 3:</b> Nursing assistants have received inservice education on the provision of incontinence care in accordance with the plan of care, and have storage of indwelling catheter bags in accordance with infection control standards of practice as provided by the Staff Development Coordinator RN, Weekend Supervisor, Assistant Director of Nursing, Director of Nursing, Unit Manager RN, Quality Assurance RN, or MDS nurse beginning on 12/3/15. Education continued through 12/20/15 until all nursing staff received the education. No nursing staff member will be allowed to work after 12/20/15 until they have first received the education. Compliance rounds for the monitoring of incontinence care in accordance with the plan of care,		
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: Based on observation, interview, review of manufacturer's recommendations, and facility policy review, it was determined the facility failed to ensure the resident environment was free of accident hazards as is possible for one (1) of twenty-nine (29) sampled residents (Resident #11) and one (1) unsampled resident (Resident E). In addition, the facility failed to ensure one (1) of one (1) medication carts was locked when not in view of staff.  The findings include:  1. Review of manufacturer's guidelines for Adjusta-Loop Cushion Belt restraint, dated issued 09/03/96, revealed to place the belt at the patient's waist. Both straps to go behind the patient and pass the ends through the space between the wheelchair seat and backrest. Behind the wheelchair, cross the straps and place the right loop over the left kick-spur and the left loop over the right kick-spur. Use the slider	F 323			

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F 323	<p>Continued From page 14</p> <p>buckles to adjust the straps so the belt fits snugly.</p> <p>Record review revealed the facility admitted Resident #11 on 11/22/11 with diagnoses which included Alzheimer's Disease and Osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/28/15, revealed the facility assessed Resident #11's cognition as severely impaired.</p> <p>Review of Resident #11's Comprehensive Care Plan for Restraint Use, dated 03/11/14, revealed interventions to apply rear releasing soft belt restraint while up in wheelchair, check belt every thirty (30) minutes and pm; release every two (2) hours and pm for incontinence management, repositioning and skin observation.</p> <p>Observation on 11/05/15 starting at 7:55 AM and continuing to 10:45 AM, revealed Resident #11 seated in a wheelchair with a belt restraint in place. The resident's wheelchair had anti-tippers attached to the kick-spurs (about two inches long) on the wheelchair and extended approximately twelve inches. The loops of the restraint belt were located in the middle section of the anti-tippers and not over the left kick-spur and right kick-spur.</p> <p>Further observation, on 11/05/15 at 10:45 AM, revealed Certified Nurse Aide (CNA) #9 had significant difficulty removing the loops from the anti-tipper bars due to having to adjust the slider buckles so the belt would slip over the distance to the end of the anti-tippers. Interview with CNA #9 at the time of the observation revealed it was difficult to put the loops on the anti-tipper bars and difficult to remove them especially if the resident could not follow directions to sit back in</p>	F 323	<p>and indwelling catheter bag storage in accordance with infection control standards of practice will be utilized by the Unit Manager RNs, Assistant Director of Nursing, Weekend Supervisor, or Director of Nursing on both shifts (7am-7pm and 7pm-7am) and on weekends weekly X4, then monthly X 2 months, then quarterly.</p> <p><b>Criteria 4:</b> The QAPI (Quality Assurance Performance Improvement) indicator for the monitoring of incontinence care in accordance with the plan of care, and indwelling catheter bag storage in accordance with infection control standards of practice will be utilized monthly X 2 months and then quarterly in accordance with the established QAPI calendar under the supervision of the Director of Nursing (DON). Any identified concerns found with completion of this tool will be immediately corrected and be tracked and trended by the QAPI Committee with further action taken as directed by the QAPI Committee. The QAPI Committee meets monthly and consists of the QAPI RN, Administrator, Assistant Administrator, Director of Nursing,</p>		

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F 323	<p>Continued From page 15</p> <p>the chair. CNA #9 had no instructions on what to do in an emergency to release the belt restraint.</p> <p>Interview with Registered Nurse (RN) #5, on 11/05/15 at 11:58 AM, revealed she would have to use scissors to remove the restraint in an emergency situation.</p> <p>Interview with the Director of Nursing (DON), on 11/05/15 at 5:00 PM, revealed she was not aware there had ever been an issue with the belt restraint that would require a quick release. She additionally stated she would find a way to get the resident out but gave no example.</p> <p>2. Review of the facility policy titled, "Administating Medications", last revised December 2012, revealed during administration of medications, the medication cart will be kept closed and locked when out of sight if the medication nurse or aide.</p> <p>Observation, on 11/05/15 at 7:50 AM, revealed the medication cart was left unattended and unlocked on the Cove Hallway between the lounge and room #319 and across the hall from room #320-A. Observation further revealed, Certified Medication Aide (CMA) # 5 leaving room #320-A at 7:55 AM. Further observation revealed, one (1) resident in a wheel chair and one (1) house keeper was near the medication cart while unattended.</p> <p>Interview with CMA #5, on 11/05/15 at 7:55 AM, revealed she should always lock the medication cart when going into a resident's room and never leave the medication cart unlocked when unattended.</p>	F 323	<p>Staff Development Coordinator, Medical Director, Environmental Services Supervisor, and other staff members as assigned by the Administrator.</p> <p>Criteria 5: December 21, 2015</p>		

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F 323	<p>Continued From page 16</p> <p>Interview with RN #1, on 11/05/15 at 9:30 AM, revealed she would expect the medication cart to be locked when out of sight and unattended.</p> <p>Interview with the DON, on 11/06/15 at 12:30 PM, revealed she would expect the staff passing medication to always lock the medication cart when the medication cart was out of sight and unattended.</p> <p>3. Review of the facility's policy titled, "Medication Storage in the Facility, 1D1: Storage of Medications", not dated, revealed medication and biologicals are stored safely, securely and properly, following manufactures's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer them.</p> <p>Record review revealed the facility admitted Unsampled Resident E on 08/08/12 with diagnoses which included Parkinson's Disease, Cognitive Communication Deficit, Psychosis, and Anxiety Disorder. Review of the quarterly MDS assessment, dated 09/21/15, revealed the facility assessed Unsampled Resident E as cognitively intact with a BIMS score of thirteen (13) which indicated the resident was interviewable; however, due to the resident's communication deficit, he/she was unable to answer questions.</p> <p>Observation, on 11/04/15 at 10:30 AM and 3:29 PM, revealed there was a bottle of ninety-one percent (91%) Isopropyl Alcohol stored at his/her bedside within reach of the resident. A review of the warning label on the bottle revealed for external use only with a warning that it will cause serious gastric disturbances if taken internally.</p>	F 323	<p><b>Disclaimer:</b></p> <p><b>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with 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.</b></p> <p><b>F323 HAZARDS/ SUPERVISION/ DEVICES</b></p> <p><b>Criteria 1:</b> Resident #11 was reviewed by the Director of Nursing and Unit Manager RN on 11/5/15 for placement of the safety belt straps. The loops of the restraint belt were moved to the kick spurs on the wheelchair which allowed for immediate release by staff in the event of an emergency. Staff were instructed at that time how to apply the loops correctly. CMA (Certified medication aid) #5 was educated by the Director of Nursing on 11/9/15 on keeping the</p>	

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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  11/06/2015
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 17  Interview with RN, Charge Nurse, on 11/04/15 at 3:50 PM, revealed the alcohol should not be stored in the resident's room; it should be stored in the treatment cart. She stated this resident or any resident could consume this and cause serious damage to themselves.  Interview with RN Acting Unit Manager, on 11/04/15 at 3:35 PM, revealed if the alcohol was opened it should be stored in the treatment cart or medication room and be labeled with the resident's information. She stated if the bottle was unopened it should be stored in central supply. She further stated the resident or another resident could consume it. She also stated alcohol is very irritating to the skin and could cause damage to the tissue.  Interview with the DON, on 11/04/15 at 3:33 PM, revealed alcohol should be stored in the treatment room or medication room and not at the resident's bedside. She stated another resident could rub it on, drink it or consume it and cause injury.	F 323	medication cart locked when not in attendance. The lens cleaning spray was removed 11/4/15 from the bedside of unsampled Resident E with education provided for the Family by the Unit Manager on the need to provide this product to the nursing staff for proper storage. The resident was provided with lens cleaning wipes to keep at bedside for eye glass cleaning.  <b>Criteria 2:</b> All current residents with physical restraints were reviewed by the Director of Nursing on 11/6/15 to verify correct placement of device. All resident rooms were checked by Administrative staff on 11/4/15 to identify and remove any chemicals. All medication carts were checked by the Director of Nursing on 11/5/15 to validate they were locked when not in attendance.	
F 441 SS=D	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	F 441	<b>Criteria 3:</b> All licensed and non-licensed nursing staff have received inservice education by the Staff Development Coordinator RN beginning on 12/3/15 on applying	

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NAME OF PROVIDER OR SUPPLIER  REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
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F 441	<p>Continued From page 18 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infection. Observation during initial tour revealed the facility failed to label and properly store oral hygiene</p>	F 441	<p>safety devices/restraints correctly to allow quick release, keeping medication carts locked when not in attendance, identifying environmental hazards, and storage of chemicals. Education continued through 12/20/15 until all nursing staff received the education. No nursing staff member will be allowed to work after 12/20/15 until they have first received the education.</p> <p><b>Criteria 4:</b> The QAPI (Quality Assurance Performance Improvement) indicator for the monitoring of correct resident safety device/restraint application to allow for quick release will be utilized on both shifts (7am-7pm and 7pm-7am) and on the weekends weekly X4, then monthly X 2 months, and then quarterly under the supervision of the Director of Nursing (DON). The Hazards Assessment of the Facility indicator tool will be completed weekly by the Environmental Services Supervisor. Findings of the completed indicators will be</p>		

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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 19 products.</p> <p>The findings include:</p> <p>Review of the facility's policy titled , "Process for Changing Toothbrush Holders", not dated, revealed each resident should have a toothbrush holder, labeled with their name and date and it should be stored in residents drawer or night stand.</p> <p>Observation during the initial tour, on 11/04/15 at 10:19 AM, and additional observation on 11/05/15 at 9:25 AM, revealed two (2) unlabeled toothbrushes, brush side down, inside one (1) small four (4) ounce clear cup, containing a clear liquid, on the sink in resident room #101. Further observation on 11/05/15 at 9:25 AM, revealed there were two (2) residents who occupy room #101.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 11/05/15 at 10:33 AM, revealed toothbrushes should be stored separately and in labeled toothbrush holders.</p> <p>Interview with Registered Nurse (RN) #4, on 11/05/15 at 3:50 PM, revealed toothbrushes should be labeled and stored separately for infection control reasons.</p> <p>Interview with the Director of Nursing (DON), on 11/06/15 at 12:34 PM, revealed she expected oral hygiene products to be labeled and stored in separate containers to prevent infection and contamination.</p>	F 441	<p>reviewed by the QAPI (Quality Assurance Performance Improvement) Committee to determine if any further action plan is indicated. Any identified concerns found with completion of these tools will be immediately corrected and be tracked and trended by the QAPI Committee with further action taken as directed by the QAPI Committee. The QAPI Committee meets monthly and consists of the QAPI RN, Administrator, Assistant Administrator, Director of Nursing, Staff Development Coordinator, Medical Director, Environmental Services Supervisor, and other staff members as assigned by the Administrator.</p> <p><b>Criteria 5: December 21, 2015</b></p>		

**Disclaimer:**

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**F 441 Infection Control**

**Criteria 1: The toothbrushes for the unsampled residents were discarded and replaced with labeled toothbrushes on 11/6/15.**

**Administrative nursing observations conducted on 11/23/15 and 11/30/15 indicate that the toothbrushes of the 2 unsampled residents are covered/labeled in accordance with infection control standards of practice.**

**Criteria 2: Administrative nursing observations conducted on 11/23/15**

and 11/30/15 indicate that all current resident toothbrushes are covered/labeled in accordance with infection control standards of practice.

**Criteria 3:** Nursing staff have received inservice education on the proper storage/labeling of resident hygiene items, including but not limited to toothbrushes, in accordance with infection control standards of practice as provided by the Staff Development Coordinator RN, Weekend Supervisor, Assistant Director of Nursing, Director of Nursing, Quality Assurance RN, Unit Manager RN, or MDS nurse beginning on 12/3/15. Education continued through 12/20/15 until all nursing staff received the education. No nursing staff member will be allowed to work after 12/20/15 until they have first received the education.

**Criteria 4:** The QAPI (Quality Assurance Performance Improvement) indicator for the monitoring infection control standards/storage of resident toothbrushes will be utilized weekly

X 4 weeks, then monthly X 2 months and then quarterly in accordance with the established QAPI calendar under the supervision of the Director of Nursing (DON). Any identified concerns found with completion of this tool will be immediately corrected and be tracked and trended by the QAPI Committee with further action taken as directed by the QAPI Committee. The QAPI Committee meets monthly and consists of the QAPI RN, Administrator, Assistant Administrator, Director of Nursing, Staff Development Coordinator, Medical Director, Environmental Services Supervisor, and other staff members as assigned by the Administrator.

**Criteria 5:** December 21, 2015

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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  Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance 12/21/15, as alleged.	{K 000}			

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

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185124	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 12/21/2015
Name of Facility REDBANKS	Street Address, City, State, Zip Code 851 KIMSEY LANE HENDERSON, KY 42420	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

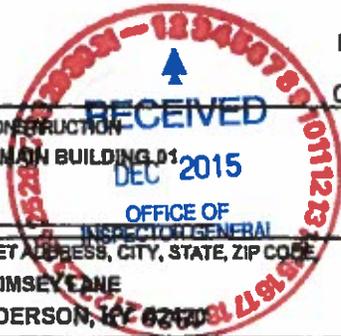
(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 12/21/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <i>OH</i>	Date: <i>12/07/15</i>	Signature of Surveyor: <i>Deborah C. ...</i>	Date: <i>12/07/15</i>
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/4/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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NAME OF PROVIDER OR SUPPLIER  REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1972, 1975.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Fourteen (14) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1987 and upgraded in 2013 with one hundred and forty-seven (147) smoke detectors and three (30) heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1975 and upgraded in 2013.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is propane.</p> <p>A standard Life Safety Code survey was initiated and concluded on 11/04/15. The facility 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-nine (189) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000	<p><b>Disclaimer:</b></p> <p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with 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.</p> <p><b>K 144 Generator</b></p> <p><b>Criteria 1:</b> The emergency generator was tested under load 11/25/15 by the Maintenance Director. Preventative maintenance with checking of all appurtenant components was inspected 11/11/15 by the maintenance staff.</p> <p><b>Criteria 2:</b> The emergency generator is tested under load and preventative maintenance is performed with checking of the hoses and equipment as per the established weekly schedule, as performed by the maintenance staff.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 12/2/15
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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 60 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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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	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	Criteria 3: The maintenance staff has received inservice education on the preventative maintenance schedule and the need to test the generator including all appurtenant components weekly in accordance with the NFPA 110 (National Fire Protection Association) schedule as provided by the Environmental Services Supervisor on 11/11/15. The maintenance director developed a log and initiated documentation of the weekly testing on 11/11/15.  Criteria 4: The QAPI (Quality Assurance Performance Improvement) indicator for the monitoring of the generator preventive maintenance will be utilized monthly as per the established QAPI calendar under the supervision of the Administrator. Findings of the completed indicator will be reviewed by the QAPI (Quality Assurance Performance Improvement) Committee to determine if any further action plan is indicated. Any identified concerns found with completion of this tool will be immediately	
K 144 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to have a written shcdule for routine maintenance for the emergency generator as per National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect fourteen (14) of fourteen (14) smoke compartments, all residents, staff and visitors. The facility has the capacity for two hundred twenty two (222) beds with a census of one hundred eighty nine (189) on the day of the survey.  The findings include:  Generator documentation review, on 11/04/15 at 10:50 AM, with the Environmental Director (ED)	K 144		

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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 144	<p>Continued From page 2</p> <p>revealed the facility did not have a weekly maintenance schedule associated with the generator as required. This type of maintenance helps ensure the generator operates as intended. Interview, on 11/04/15 at 10:51 AM, with the ED revealed she was unaware there should be a written weekly maintenance schedule for the emergency generator.</p> <p>The census of one hundred eighty nine (189) was verified by the Administrator on 11/04/15. The findings were acknowledged by the Administrator and verified by the Environmental Manager at the exit interview on 11/04/15.</p> <p>Reference: NFPA 110 1999 edition 6-1.1*</p> <p>The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction 6-3.3</p> <p>A written schedule for routine maintenance and operational testing of the EPSS shall be established 6-4.1*</p> <p>Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p>	K 144	<p>corrected and be tracked and trended by the QAPI Committee with further action taken as directed by the QAPI Committee. The QAPI Committee meets monthly and consists of the QAPI RN, Administrator, Assistant Administrator, Director of Nursing, Staff Development Coordinator, Medical Director, Environmental Services Supervisor, and other staff members as assigned by the Administrator.</p> <p>Criteria 5: December 21, 2015</p>	