

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2014
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 000	INITIAL COMMENTS **Amended** A Recertification/Abbreviated Survey (KY#22211, KY#22212, KY#22213 and KY#22234) was conducted on 09/23/14 through 09/26/14 to determine the facility's compliance with Federal requirements. The failed to meet minimum requirements for recertification with the highest Scope and Severity of "D". KY#22211 was substantiated with a deficiency cited, KY#22212, KY#22213 and KY#22234 were unsubstantiated with no deficiencies cited.	F 000	Disclaimer: Preparation, submission and implementation of this REVISED 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.	
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.	F 280	F 280 Comprehensive Care Plans A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, which 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. N 192 902 KAR 20:300-7(4)(b)3. Section 7. Resident Assessment	11/10/14

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

TITLE

(X6) DATE

Dani E Anderson JD, LHA Administrator 11/12/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies and investigation it was determined the facility failed to revise the care plan for one (1) of twenty-eight (28) sampled residents (Resident #10) and one (1) Unsampled Resident (Resident A). Resident #10's care plan was not revised related to a change of code status and Unsampled Resident A's care plan was not revised when he/she attempted to elope from the facility and refused to wear a wanderguard bractlet. The findings include: Review of the facility's Development of a Care Plan document, no date, revealed the care plan is to be reviewed/revised as per the Resident Assessment Instrument (RAI) manual with significant changes, and changes in orders as received by the Minimum Data Set (MDS) coordinator. Review of CMS' s RAI Manual revealed care plans should be revised on an on-going basis to reflect changes in the resident and the care the resident is receiving. The care plan must be periodically reviewed and revised, and the services provided or arranged must be in accordance with each resident ' s written plan of care. Review of the facility's policy titled, "Wander Risk Precautions", last revised 09/2002, revealed a plan of care will be developed and implemented with specific approaches and goals for the wanderer. The care plan will be reviewed and revised quarterly and as needed.	F 280	Criteria 1: The care plan for resident #10 has been reviewed and revised as appropriate by the Care Plan Team on 10/20/2014 to ensure that it addresses the resident's current code status. Un-sampled Resident #A is no longer a resident of the facility. Criteria 2: All residents have the potential to be affected. All resident care plans were audited for compliance. The care plans for current residents were reviewed and revised as appropriate by the Care Plan Team on 10/13/2014 to determine that they address each resident's current code status. All Care Plans for residents assessed to be a wander risk will be revised as appropriate by the Care Plan Team beginning on 10/13/2014 and completed by 10/24/2014 to determine that appropriate interventions addressing this risk are addressed on their care plans.		

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F 280	<p>Continued From page 2</p> <p>1. Record review revealed the facility admitted Unsampled Resident A on 11/07/13 with diagnosis which included Abnormality of Gait, Muscle Weakness, Senile Dementia, Congestive Heart failure, Atrial Fibrillation, Muscular Wasting and Disuse Atrophy NEC and Chronic Kidney Disease Stage 3 (Moderate). Review of the admission Minimum Data Set (MDS) assessment, dated 11/14/13, revealed the facility assessed Unsampled Resident A's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fourteen (14) which indicated the resident was interviewable. The resident required one to two assist for ambulation, transfers with walker and wheelchair.</p> <p>Review of the Wander Assessments, dated 11/13/13 and 11/21/13, revealed the facility assessed Unsampled Resident A was not at risk for wandering..</p> <p>Review of the Nurse's Note, dated 12/02/13 at 12:00 PM, revealed Unsampled Resident A while in the wheelchair was able to open the back exit door and get to the locked gate before staff was able to reach him/her. Unsampled Resident A stated he/she "was looking for spouse". Unsampled Resident A refused a wanderguard and stated "does not need that", "codes changed to the door".</p> <p>Review of the Comprehensive Care Plan, dated November 2013, revealed there was no documented evidence the care plan was revised related to wandering/elopement and no interventions to prevent another elopement.</p> <p>Review of the facility's investigation, dated 12/02/13 at 12:00 PM, revealed a staff member</p>	F 280	<p>On admission, each resident is assessed for their Wander Risk status by the admitting nurse and/or the MDS nurse. The admitting nurse utilizes an assessment tool as part of the admission assessment and the tool is utilized quarterly, annually and with any significant change in condition by the MDS nurse. Further, the Assessment Tool can be utilized when the IDT team identifies that a resident is exhibiting unusual behavior that could lead to a wander risk.</p> <p>On Admission, each patient's Code Status is identified and appropriate forms are completed and resident's Code Status is added to the care plan by the Social Services Director and/or her designee. Resident's Code Status is reviewed at the quarterly care plan, annually and at significant change of condition. Additionally, a resident's Code Status is discussed by the IDT team at such time that resident's condition changes, when there is a change in discharge plan, or any other situations where a Code Status change may provide more appropriate care.</p> <p>The facility uses auditing tools to monitor the Wander Risk Assessments and Advanced Directives and those tools will be presented, analyzed and discussed at the monthly QAPI meeting. Any deficiencies will be noted and addressed and new processes put in place to ensure continued compliance.</p>		

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F 280	<p>Continued From page 3</p> <p>observed the resident going out the back door on Marina Hall after entering code. Unsampld Resident A stated "was looking for spouse". Resident A wheeled self to latched back gate before staff was able to reach him/her. Resident A was within line of sight of staff at all times, Readily redirected and assisted back into building. No injuries noted. Root cause analysis revealed: confused, looking for spouse (diagnosis Senile Dementia), self-directed with poor insight and poor safety awareness, (spouse is long term resident of this facility). Interventions: refused application of Wanderguard. Code changed to door keypad.</p> <p>Observation of the Marina Exit Door, on 09/26/14 at 2:10 PM, revealed fenced area (approximately 6 foot high) in the courtyard with a locked gate.</p> <p>Interview with the Director of Nursing (DON), on 09/26/14 at 2:10 PM and 3:00 PM, revealed Unsampld Resident A went out the Marina Exit via wheelchair to the courtyard. The DON stated previously before Unsampld Resident A became a resident at the facility he/she would visit and take spouse out to the courtyard and was used to coming and going out the door. The DON stated the resident knew the code and just wanted to go outside, he/she was not exit seeking. She stated Unsampld Resident A knew he/she was only there for therapy and would be returning home. She stated the resident was alert and oriented and refused the wanderguard bracelet. The DON stated the code to the door was changed, and they had talked with the resident about being independent and to let someone know if he/she wanted to go outside. She stated the resident was seen by staff walking back from lunch, staff went out and got him/her and the resident was</p>	F 280	<p>Criteria 3: The Care Plan Team received in-service education by the Nurse Consultant on 10/13/2014, regarding the necessity of appropriately addressing the indicated interventions for all residents on their Care plans, including but not limited to code status and wander risk interventions. The Care Plan Team includes but is not limited to: the Social Services Director, the Activities Director, the Registered Dietician, the MDS nurses, the QA nurse, the ADONs, the DON and the Staff Development Coordinator.</p> <p>Criteria 4: The facility uses auditing tools to monitor the Wander Risk Assessments and Advanced Directives and those tools will be presented, analyzed and discussed at the monthly QAPI meeting. Any deficiencies will be noted and addressed and new processes put in place to ensure continued compliance. The QAPI Committee includes but is not limited to: Administrator, DON, Medical Director, Nurse Practitioner, ADONs, Director of Case Management, MDS Coordinator, Social Services Director, Activities Director, Dietary Director, Environmental Services Director, and Pharmacy Consultant.</p> <p>The CQI Indicator for the monitoring of care plan documentation for advance directives and wander risk will be presented monthly for three months and then quarterly as per the established CQI calendar under the supervision of the DON.</p>		

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F 280	<p>Continued From page 4</p> <p>upset because he/she didn't want people to think he/she was stupid. The DON stated they did not care plan him/her for going outside and there was no interventions to prevent him/her from going outside again. The DON stated he/she was alert and oriented and understood to let someone know he/she wanted to go outside.</p> <p>2. Record review revealed the facility admitted Resident #10 on 12/14/13 with diagnoses which included Chronic Kidney Disease Stage III, Essential Hypertension, Hypothyroidism, and Dementia with Behaviors. Review of the quarterly MDS assessment, dated 08/27/14, revealed the facility assessed Resident #10's cognition as cognitively intact with a BIMS score of "13" indicating the resident was interviewable.</p> <p>Review of a Kentucky Emergency Medical Services Do Not Resuscitated (DNR) order, revealed Resident #10's Power of Attorney (POA) signed and check marked "NO" for the use of Cardiopulmonary Resuscitation on the Directives of Care document on 05/27/14 and review of the Physician's Order sheet, dated 05/28/14, revealed an order for "Do Not Resuscitate". However, review of the Comprehensive Care Plan, last revised 03/20/14, revealed Full Code status for Resident #10.</p> <p>Interview, on 09/15/14 at 8:30 AM with Resident #10, revealed he/she changed advance directives to a no code status several months ago following a hospital stay.</p> <p>Interview, on 09/25/14 at 9:05 AM with Certified Nurse Aide (CNA) #1, revealed she was Resident #10's CNA and she was unsure of Resident #10's code status and stated "thinks this resident is a</p>	F 280	Criteria 5: November 10, 2014		

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F 280	Continued From page 5 full code". Interview on 09/25/14 at 9:13 PM with Licensed Practical Nurse (LPN) #2 revealed the MDS Coordinator and Social Services updated the care plans. Interview on 09/25/14 at 9:18 AM with Social Services Manager revealed she was responsible for updating the code status on care plans and whoever took the DNR order should have notified Social Services. Interview on 09/25/14 at 12:45 PM with Assistant Director of Nursing (ADON) over the Pier/Cove Neighborhoods revealed physician orders were entered in Point Click Care then printed and placed on chart and the MDS nurses review the orders daily and update care plans accordingly.	F 280			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedures,	F 315	F 315 Urinary Incontinence 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. N 214 902 KAR 20:300-8(4)(c) Section 8. Quality of Care Criteria 1: Administrative nursing observations conducted on 10/20/2014 indicate that resident #13 is provided catheter care in accordance with infection control standards of practice.	11/10/14	

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F 315	<p>Continued From page 6</p> <p>it was determined the facility failed to ensure appropriate treatment and services to prevent urinary tract infections for one (1) of twenty-eight (28) sampled residents (Resident #13). CNA #3 performed supra pubic catheter care for Resident #13 without changing her gloves and washing her hands after touching items in the resident's room which included a trash bin.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedures, titled "Prevention and Treatment of UTI's" (urinary tract infections), (no date), revealed incontinent, peri, and catheter care would be provided for all residents requiring assistance utilizing proper infection control techniques.</p> <p>Record review revealed the facility admitted Resident #13 on 02/25/14 with diagnoses which included Type II Diabetes Mellitus, Urinary Retention, Lumbago, Hypertension, Hyperlipidemia, Anxiety, Coronary Artherosclerosis, and Osteoarthritis. Review of a quarterly Minimum Data Set (MDS) assessment, dated 07/21/14, revealed the resident had a Brief Interview for Mental Status (BIMS) score of fourteen (14) revealing the resident's cognition was intact and was able to be interviewed.</p> <p>Observation of supra pubic catheter care for Resident #13, on 09/24/14 at 11:05 AM, revealed Certified Nurse Aide (CNA) #3 failed to wash her hands and put on a clean pair of gloves prior to beginning catheter care after she had gathered supplies which included a trash bin.</p> <p>Interview with CNA #3, on 09/24/14 at 11:15 AM, revealed she was aware of the need to remove</p>	F 315	<p>Criteria 2: Administrative nursing observations on a representative sample of 8 residents conducted on 10/20/14 indicate that residents are provided catheter care in accordance with infection control standards of practice. These observations were done pursuant to a check off tool developed and adopted by the facility's QAPI committee.</p> <p>Administrative nursing observations were performed by the QA Nurse, the ADONs and a second shift charge nurse. Observations were performed on day shift (7A-7P) and night shift (7P-7A).</p> <p>This tool will be utilized during the Administrative nursing observations over the next three months and these tools will be presented, analyzed and discussed at the monthly QAPI meeting. Any deficiencies will be noted and addressed and new processes put in place to ensure continued compliance.</p> <p>Criteria 3: Nursing assistants have received in-service education on the provision of catheter care, including but not limited to hand-washing and changing of gloves in accordance with infection control standards of practice as provided by the Staff Development Coordinator or her designee on beginning on 09/23/2014 and continuing through 10/24/2014 to ensure all Nursing Assistants have been adequately trained.</p>		

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F 315	Continued From page 7 the soiled gloves, wash her hands, and place new gloves prior to performing catheter care but she forgot. She was aware of the potential for infection by not doing so. Interview with the Assistant Director of Nursing (ADON), on 09/24/14 at 11:22 AM, revealed she would have expected CNA #3 to change her gloves and wash her hands prior to beginning catheter care after touching dirty items. Interview with the Director of Nursing (DON), on 09/28/14 at 3:00 PM, revealed she would have expected CNA #3 to change her gloves and wash her hands prior to beginning catheter care.	F 315	Criteria 4: The CQI Indicator Tool for the monitoring of peri-care/catheter care and Hand Washing, in accordance with infection control standards of practice, will be utilized during the Administrative nursing observations over the next three months and these tools will be presented, analyzed and discussed at the monthly QAPI meeting. Any deficiencies will be noted and addressed and new processes put in place to ensure continued compliance. This tool will be utilized monthly for three months and then quarterly in accordance with the established CQI calendar under the supervision of the DON. Criteria 5: November 10, 2014		
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 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	F 441 Infection Control The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. N 144 902 KAR 20:300-6(7)(b)2.a. Section 6. Quality of Life Criteria 1: Administrative nursing observations conducted 10/20/2014 indicate nursing staff perform catheter and peri-care, including but not limited to hand-washing and changing of gloves, in accordance with infection control standards of practice when providing care for residents #11 and #13.	11/10/14	

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F 441	<p>Continued From page 8</p> <p>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 REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy and procedures, it was determined the facility failed to maintain an effective infection control program related to proper hand-washing and glove changing procedures for two (2) of twenty eight (28) sampled residents (Residents #11 and #13).</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Infection Control", (no date), revealed the facility's infection control policies and procedures apply equally to all personnel and residents. Objectives of the policy included to investigate, control, and prevent infections in the facility.</p> <p>Review of the facility's Hand-washing policy, no date, revealed employees should wash hands with either a non-antimicrobial soap and water or</p>	F 441	<p>and peri-care, including but not limited to hand-washing and changing of gloves, in accordance with infection control standards of practice.</p> <p>These observations were done pursuant to a check off tool developed and adopted by the facility's QAPI committee.</p> <p>Administrative nursing observations were performed by the QA Nurse, the ADONs and a second shift charge nurse. Observations were performed on day shift (7A-7P) and night shift (7P-7A).</p> <p>This tool will be utilized during the Administrative nursing observations over the next three months and these tools will be presented, analyzed and discussed at the monthly QAPI meeting. Any deficiencies will be noted and addressed and new processes put in place to ensure continued compliance.</p> <p>Criteria 3: Nursing assistants have received in-service education on the provision of catheter care, including but not limited to hand-washing and changing of gloves in accordance with infection control standards of practice as provided by the Staff Development Coordinator or her designee on beginning on 09/23/2014 and continuing through 10/24/2014 to ensure all Nursing Assistants have been adequately trained.</p>		

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F 441	<p>Continued From page 9</p> <p>an antimicrobial soap and water when hands are visibly or obviously soiled with blood or other body fluids, after contact with a resident ' s intact skin, after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings and if moving from a contaminated-body site to a clean-body site during resident care and after removing gloves.</p> <p>1. Record review revealed the facility admitted Resident #11 on 02/04/2013 with diagnoses, which included Cerebral Vascular Accident, Unspecified Hemiplegia non-dominant side, and Dementia with psychotic agitated features, Anxiety, Depression, and Hypothyroidism. Review of the annual Minimum Data Set (MDS) Assessment, dated 08/27/14, revealed the facility assessed Resident #11's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of "99" indicating the resident was not interviewable.</p> <p>Observation of perineal care, on 09/25/14 at 9:35 AM, revealed Certified Nurse Aide, (CNA) #1 and Certified Nurse Aide (CNA) #2 washed hands and donned gloves. CNA # 1 pulled privacy curtain and explained procedure to resident, unfastened soiled brief and used wet wipes to remove stool and cleanse perineal area. Further observation revealed CNA # 1 removed the soiled brief, opened a multi-use container of Balmex ointment, inserted fingers into the ointment and applied to Resident #11's buttocks without removing her gloves and washing her hands.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 09/25/14 at 12:45 PM, revealed she expected staff to remove gloves, wash hands, and re-glove prior to applying ointment.</p>	F 441	<p>Administrative nursing observations were performed by the QA Nurse, the ADONs and a second shift charge nurse. Observations were performed on day shift (7A-7P) and night shift (7P-7A).</p> <p>Criteria 4: The CQI Indicator tool for the monitoring infection control standards/hand-washing/glove changing during care will be utilized during the Administrative nursing observations over the next three months and these tools will be presented, analyzed and discussed at the monthly QAPI meeting. Any deficiencies will be noted and addressed and new processes put in place to ensure continued compliance.</p> <p>This tool will be utilized monthly for three months and then every six months in accordance with the established CQI calendar under the supervision of the DON.</p> <p>Criteria 5: November 10, 2014</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2014
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 861 KIMSEY LANE HENDERSON, KY 42420		
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F 441	Continued From page 10 Interview with the Director of Nursing (DON), on 09/25/14 at 2:40 PM, revealed she expected staff to wash hands and change gloves after providing incontinent care and prior to applying ointment. 2. Record review revealed the facility admitted Resident #13 on 02/25/14 with diagnoses which included Type II Diabetes Mellitus, Urinary Retention, Lumbago, Hypertension, Hyperlipidemia, Anxiety, Coronary Artherosclerosis, and Osteoarthritis. Review of a quarterly MDS assessment dated 07/21/14, revealed the resident had a BIMs score of fourteen (14) revealing the resident's cognition was intact and was able to be interviewed. Observation of supra pubic catheter care for Resident #13, on 09/24/14 at 11:05 AM, revealed Certified Nurse Aide (CNA) #3 failed to wash her hands and put on a clean pair of gloves prior to beginning catheter care after she had gathered supplies which included a trash bin. Interview with CNA #3, on 09/24/14 at 11:15 AM, revealed she was aware of the need to remove the soiled gloves, wash her hands, and place new gloves prior to performing catheter care but she forgot. She was aware of the potential for infection by not doing so. Interview with the Assistant Director of Nursing (ADON), on 09/24/14 at 11:22 AM, revealed she would have expected CNA #3 to change her gloves and wash her hands prior to beginning catheter care after touching dirty items. Interview with the Director of Nursing (DON), on 09/26/14 at 3:00 PM, revealed she would have	F 441			

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F 441	Continued From page 11 expected CNA #3 to change her gloves and wash her hands prior to beginning catheter care.	F 441			

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NAME OF PROVIDER OR SUPPLIER REDBANKS	STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMBEY LANE HENDERSON, KY 42420
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K 000	<p>INITIAL COMMENTS</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 1967 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 on 09/24/14 and concluded on 09/25/14. 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-one (181) on the day of the survey.</p>	K 000	<p>Disclaimer:</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>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeri E. Anderson, J.D., LNHA Administrator TITLE: Administrator (X6) DATE: 10/20/2014

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

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K 000	Continued From page 1 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 052 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on fire alarm testing record review and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has 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	K 052	K052 The main fire alarm control panel did not have a smoke detector installed in the immediate area of the panel. Criteria 1: A smoke detector was installed by our fire alarm vendor in the immediate area of the fire alarm panel on 10/20/2014. Criteria 2: There are no other areas affected by this deficiency. Criteria 3: The Maintenance Supervisor and the Director of Environmental Services have received in-service education from the Executive Director on 10/20/2014 to assure compliance with this requirement. Criteria 4: The CQI indicator tool, (ES-3) will be utilized by the Director of	10/20/14

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K 052	Continued From page 2 and at the time of the survey, the census was one-hundred eighty-one (81). The findings include: Observation, on 09/25/14 at 10:30 AM, with the Environmental Services Director and the Maintenance Technician, revealed the main fire alarm control panel did not have a smoke detector installed in the immediate area of the panel. Interview, on 09/25/14 at 10:31 AM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware a smoke detector was not installed near the fire alarm control panel. The census of one-hundred eighty-one (181) was verified by the Administrator on 09/25/14. The findings were acknowledged by the Administrator and verified by the Environmental Services Director at the exit interview on 09/25/14. Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052	Environmental Services to identify potential issues with this requirement on a quarterly basis. Findings of the audit will be brought to the QA meeting by the director or designee each month it is completed. If an accepted threshold of compliance is not achieved, the director or designee will immediately develop and oversee a corrective plan of action. The details of the corrective plan of action will be reported to the QA committee with the updated audit results at the following meeting. The QA Committee includes but is not limited to the Executive Director, DON, Medical Director, and other Department Managers. Criteria 5: October 20, 2014	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	K062 – Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.	10/31/2014

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K 062	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the sprinklers were installed, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice has the potential to affect thirteen (13) of fourteen (14) smoke compartments, all residents, staff and visitors. The facility has the capacity for two-hundred twenty-two (222) beds and at the time of the survey, the census was one-hundred eighty-one (181). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems. The findings include: Observation, on 09/24/14 at 11:35 AM with the Environmental Services Director and the Maintenance Technician, revealed the sprinklers installed in 200 Hall attic "Central Bay", closest to the eaves were blocked from developing a full spray pattern by blow-in type insulation covering the sprinkler heads. Interview, on 09/24/14 at 11:36 AM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the insulation was covering the sprinkler heads in the attic. Observation, on 09/24/14 at 11:50 AM with the Environmental Services Director and the Maintenance Technician, revealed the sprinklers installed in 300 Hall "The Pier" attic, closest to the eaves were blocked from developing a full spray pattern by blow-in type insulation covering	K 062	Criteria 1: Sprinkler heads in the 200 Hall attic of Central Bay, attic above 300 Hall of The Pier, attic above room #416, attic above room #408, attic above room #400, attic above the therapy department, attic above the 500 Halls, attic above the 600 Halls will be cleared of any and all blown-in insulation that are covering the sprinkler heads. Storage in the closet of room #213 has been corrected to assure nothing is within 18" of the sprinkler head. Criteria 2: All sprinkler heads in all attic spaces will be checked by the Maintenance Supervisor to assure there are no sprinkler heads blocked from developing a full spray pattern from the blown-in insulation. Closet spaces will be checked by nursing assistants, housekeeping assistants and maintenance staff to assure there is no storage within 18" of a sprinkler head. Criteria 3: The Maintenance Supervisor, the Director of Environmental Services, nursing staff and the housekeeping staff have received in-service education from the Executive Director on 10/20/2014 to assure compliance with this	

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K 062	<p>Continued From page 4 the sprinkler heads.</p> <p>Interview, on 09/24/14 at 11:51 AM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the insulation was covering the sprinkler heads in the attic.</p> <p>Observation, on 09/24/14 at 11:55 AM with the Environmental Services Director and the Maintenance Technician, revealed the sprinklers installed in the attic above room #416, closest to the eaves were blocked from developing a full spray pattern by blow-in type insulation covering the sprinkler heads.</p> <p>Interview, on 09/24/14 at 11:56 AM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the insulation was covering the sprinkler heads in the attic.</p> <p>Observation, on 09/24/14 at 12:00 PM with the Environmental Services Director and the Maintenance Technician, revealed the sprinklers installed in the attic above room #408, closest to the eaves were blocked from developing a full spray pattern by blow-in type insulation covering the sprinkler heads.</p> <p>Interview, on 09/24/14 at 12:01 PM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the insulation was covering the sprinkler heads in the attic.</p> <p>Observation, on 09/24/14 at 12:15 PM with the Environmental Services Director and the Maintenance Technician, revealed the sprinklers</p>	K 062	<p>requirement.</p> <p>Criteria 4: The CQI indicator tool, (ES-3) will be utilized by the Director of Environmental Services to identify potential issues with this requirement on a quarterly basis. Findings of the audit will be brought to the QA meeting by the director or designee each month it is completed. If an accepted threshold of compliance is not achieved, the director or designee will immediately develop and oversee a corrective plan of action. The details of the corrective plan of action will be reported to the QA committee with the updated audit results at the following meeting. The QA Committee includes but is not limited to the Executive Director, DON, Medical Director, and other Department Managers.</p> <p>Criteria 5: October 31, 2014</p>		

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K 062	<p>Continued From page 5</p> <p>installed in the attic above room #400, closest to the eaves were blocked from developing a full spray pattern by blow-in type insulation covering the sprinkler heads.</p> <p>Interview, on 09/24/14 at 12:16 PM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the insulation was covering the sprinkler heads in the attic.</p> <p>Observation, on 09/24/14 at 1:10 PM with the Environmental Services Director and the Maintenance Technician, revealed the sprinklers installed in the attic above the Therapy Room, closest to the eaves were blocked from developing a full spray pattern by blow-in type insulation covering the sprinkler heads.</p> <p>Interview, on 09/24/14 at 1:11 PM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the insulation was covering the sprinkler heads in the attic.</p> <p>Observation, on 09/24/14 at 1:20 PM with the Environmental Services Director and the Maintenance Technician, revealed the sprinklers installed in the attic of both 500 Halls, closest to the eaves were blocked from developing a full spray pattern by blow-in type insulation covering the sprinkler heads.</p> <p>Interview, on 09/24/14 at 1:21 PM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the insulation was covering the sprinkler heads in the attic.</p>	K 062		
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K 062	<p>Continued From page 6</p> <p>Observation, on 09/24/14 at 1:45 PM with the Environmental Services Director and the Maintenance Technician, revealed the sprinklers installed in the attic of both 600 Halls, closest to the eaves were blocked from developing a full spray pattern by blow-in type insulation covering the sprinkler heads.</p> <p>Interview, on 09/24/14 at 1:46 PM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the insulation was covering the sprinkler heads in the attic.</p> <p>Observation, on 09/24/14 at 3:50 PM with the Environmental Services Director and the Maintenance Technician, revealed storage within eighteen (18) inches of a sprinkler head located in the closet of room #213.</p> <p>Interview, on 09/24/14 at 3:51 PM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware of the storage in the closet.</p> <p>The census of one-hundred eighty-one (181) was verified by the Administrator on 09/25/14. The findings were acknowledged by the Administrator and verified by the Environmental Services Director at the exit interview on 09/25/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 13 (1999 Edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall).</p>	K 062		

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K 062	<p>Continued From page 7</p> <p>Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)</th> <th>Obstruction (in.)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm)</p>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Obstruction (in.)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 062		
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K 062	Continued From page 8 from a wall.	K 062			
K 066 SS=D	<p>Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the International symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p>	K 066	<p>K066 – The facility failed to ensure the designated outdoor smoking area for the staff was properly equipped for safe smoking. Metal containers with self-closing cover devices into which ashtrays can be emptied were not readily available to all areas where smoking is permitted.</p> <p>Criteria 1: A metal container with a self-closing cover into which ashtrays can be emptied into will be purchased and installed for use for the employee smoking area on 10/13/2014.</p> <p>Criteria 2: No other area is affected by this deficiency as this is the only designated smoking area.</p>	10/20/2014	

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K 066	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for the staff was properly equipped for safe smoking, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect staff using the smoking area. The facility has the capacity for two-hundred twenty-two (222) beds and at the time of the survey, the census was one-hundred eighty-one (81).</p> <p>The findings include:</p> <p>Observation, on 09/25/14 at 9:05 AM, with the Environmental Services Director and the Maintenance Technician revealed the designated outdoor smoking area for staff did not have an approved metal container with a self-closing lid to empty ashtrays into for disposal.</p> <p>Interview, on 09/25/14 at 9:06 AM, with the Environmental Services Director and the Maintenance Technician revealed they were not aware of the requirement that the designated, outdoor smoking area for residents was to be equipped with an approved metal container with a self-closing lid to empty ash trays into for disposal.</p> <p>The census of one-hundred eighty-one (181) was verified by the Administrator on 09/25/14. The findings were acknowledged by the Administrator and verified by the Maintenance Technician at the exit interview on 09/25/14.</p>	K 066	<p>Criteria 3: The Maintenance Supervisor and the Director of Environmental Services has received in-service education from the Executive Director on 10/20/2014 to assure compliance with this requirement.</p> <p>Criteria 4: The CQI indicator tool, (ES-3) will be utilized by the Director of Environmental Services to identify potential issues with this requirement on a quarterly basis. Findings of the audit will be brought to the QA meeting by the director or designee each month it is completed. If an accepted threshold of compliance is not achieved, the director or designee will immediately develop and oversee a corrective plan of action. The details of the corrective plan of action will be reported to the QA committee with the updated audit results at the following meeting. The QA Committee includes but is not limited to the Executive Director, DON, Medical Director, and other Department Managers.</p> <p>Criteria 5: October 20, 2014</p>		

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K 066	Continued From page 10 Actual NFPA Standard: Reference: NFPA 101 Life Safety Code (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066			

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K 066	Continued From page 11 Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066			
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the manual hood suppression pull was readily available, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of fourteen (14) smoke compartments and kitchen staff. The facility has the capacity for two-hundred twenty-two (222) beds and at the time of the survey, the census was one-hundred eighty-one (81). The findings include: Observation, on 09/25/14 at 9:10 AM, with the Environmental Services Director and the Maintenance Technician revealed the manual pull for the kitchen hood suppression system was blocked by a table making it not readily available for use in an emergency. Interview, on 09/25/14 at 9:11 AM, with the Environmental Services Director and the Maintenance Technician revealed they were not aware the table had been moved in front of the manual pull for the hood suppression making it not readily available.	K 069	K069 - The manual pull for the dietary hood suppression systems was not readily available as it was blocked by a table. Criteria 1: The table near the manual pull for the hood suppression system has been moved. Criteria 2: There are no other areas in the dietary department affected by this deficiency. Criteria 3: The Maintenance Supervisor, the Director of Environmental Services, the Dietary Manager, Dietary Director and Dietary Staff have received in-service education from the Executive Director on 10/20/2014 to assure compliance with this requirement.	10/20/2014	

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K 069	Continued From page 12 The census of one-hundred eighty-one (181) was verified by the Administrator on 09/25/14. The findings were acknowledged by the Administrator and verified by the Maintenance Technician at the exit interview on 09/25/14. Actual NFPA Standard: NFPA 96 (1998 edition)7-6.2 Where a fire alarm signaling system is serving the occupancy where the extinguishing system is located, the activation shall activate the fire alarm signaling system. Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.	K 069	Criteria 4: The CQI indicator tool, (ES-3) will be utilized by the Director of Environmental Services to identify potential issues with this requirement on a quarterly basis. Findings of the audit will be brought to the QA meeting by the director or designee each month it is completed. If an accepted threshold of compliance is not achieved, the director or designee will immediately develop and oversee a corrective plan of action. The details of the corrective plan of action will be reported to the QA committee with the updated audit results at the following meeting. The QA Committee includes but is not limited to the Executive Director, DON, Medical Director, and other Department Managers. Criteria 5: October 20,2014		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147 - Electrical wiring and equipment was not in accordance with NFPA 70.	10/20/2014	

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K 147	Continued From page 13 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with 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 and at the time of the survey, the census was one-hundred eighty-one (181). The findings include: Observations, on 09/24/14 at 4:00 PM with the Environmental Services Director and the Maintenance Technician, revealed two (2) refrigerators plugged into a power strip located in the MDS Office. Interview, on 09/24/14 at 4:01 PM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the power strips had been misused. Observations, on 09/25/14 at 8:50 AM with the Environmental Services Director and the Maintenance Technician, revealed the hydro collator located in the Therapy Office was not plugged into a ground fault protected outlet. Interview, on 09/25/14 at 8:51 AM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the hydro collator was to be plugged into a ground fault protected outlet.	K 147	Criteria 1: The two (2) power strips used with refrigerators in the MDS office have been removed as of 09/25/2014 and the refrigerators are plugged directly into the receptacle. A ground fault protected outlet (GFI) has been installed for use in the therapy department to plug in the hydro collator. The power strips used at the 500 Hall Marina Nurses Station have been removed. The electrical junction box near the main sprinkler riser has had a cover installed on 10/20/2014. Criteria 2: The Maintenance Supervisor has checked all areas of the facility to assure if power strips are used, it is within the regulation. All areas have been checked to assess the need for a GFI; any noted will have a GFI installed. All junction boxes have been checked to assure they have covers; any noted without will have covers installed. Criteria 3: The Maintenance Supervisor and the Director of Environmental Services have received in-service education from the Executive Director on 10/20/2014 to assure compliance with this requirement.	

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K 147	<p>Continued From page 14</p> <p>Observations, on 09/25/14 at 9:15 AM with the Environmental Services Director and the Maintenance Technician, revealed a power strip plugged into another power strip located in the 500 Hall Mariner Nurses ' Station.</p> <p>Interview, on 09/25/14 at 9:16 PM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware the power strips had been misused.</p> <p>Observations, on 09/25/14 at 10:10 AM with the Environmental Services Director and the Maintenance Technician, revealed an open electrical junction box located on the main sprinkler riser.</p> <p>Interview, on 09/25/14 at 10:11 PM with the Environmental Services Director and the Maintenance Technician, revealed they were not aware of the open electrical junction box.</p> <p>The census of one-hundred eighty-one (181) was verified by the Administrator on 09/25/14. The findings were acknowledged by the Administrator and verified by the Environmental Services Director at the exit interview on 09/25/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p>	K 147	<p>Criteria 4: The CQI indicator tool, (ES-3) will be utilized by the Director of Environmental Services to identify potential issues with this requirement on a quarterly basis. Findings of the audit will be brought to the QA meeting by the director or designee each month it is completed. If an accepted threshold of compliance is not achieved, the director or designee will immediately develop and oversee a corrective plan of action. The details of the corrective plan of action will be reported to the QA committee with the updated audit results at the following meeting. The QA Committee includes but is not limited to the Executive Director, DON, Medical Director, and other Department Managers.</p> <p>Criteria 5: October 20, 2014</p>	

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K 147	<p>Continued From page 15</p> <p>Reference: NFPA 70 (1999 Edition) 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ul style="list-style-type: none"> (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference NFPA 70 (1999) edition National Electric Code, relating to ground fault protection for electric outlets near sinks in resident rooms. NFPA: 70 210.8 Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G).</p> <ul style="list-style-type: none"> (6) Kitchens - where the receptacles are installed to serve the countertop surfaces (7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink. 	K 147		

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K 147	Continued From page 16 Reference NFPA 70 (1999 edition) 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel. FPN: See 215.9 for ground-fault circuit-interrupter protection for personnel on feeders. (A) Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Garages, and also accessory buildings that have a floor located at or below grade level not intended as habitable rooms and limited to storage areas, work areas, and areas of similar use Exception No. 1: Receptacles that are not readily accessible. Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8). Receptacles installed under the exceptions to 210.8(A)(2) shall not be considered as meeting the requirements of 210.52(G). (3) Outdoors Exception: Receptacles that are not readily accessible and are supplied by a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426. (4) Crawl spaces - at or below grade level (5) Unfinished basements - for purposes of this section, unfinished basements are defined as	K 147		

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K 147	Continued From page 17 portions or areas of the basement not intended as habitable rooms and limited to storage areas, work areas, and the like Exception No. 1: Receptacles that are not readily accessible. Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8). Exception No. 3: A receptacle supplying only a permanently installed fire alarm or burglar alarm system shall not be required to have ground-fault circuit-interrupter protection. Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G). (6) Kitchens - where the receptacles are installed to serve the countertop surfaces (7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink. (8) Boathouses (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1), (2), and (3) shall have ground-fault circuit-interrupter protection for personnel: (1) Bathrooms (2) Rooftops Exception: Receptacles that are not readily accessible and are supplied from a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426. (406.8 Receptacles in Damp or Wet Locations.	K 147		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2014
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 18 (A) Damp Locations. A receptacle installed outdoors in a location protected from the weather or in other damp locations shall have an enclosure for the receptacle that is weatherproof when the receptacle is covered (attachment plug cap not inserted and receptacle covers closed). An installation suitable for wet locations shall also be considered suitable for damp locations. A receptacle shall be considered to be in a location protected from the weather where located under roofed open porches, canopies, marquees, and the like, and will not be subjected to a beating rain or water runoff. (B) Wet Locations. (1) 15- and 20-Ampere Outdoor Receptacles. 15- and 20-ampere, 125- and 250-volt receptacles installed outdoors in a wet location shall have an enclosure that is weatherproof whether or not the attachment plug cap is inserted. (2) Other Receptacles. All other receptacles installed in a wet location shall comply with (a) or (b): (a) A receptacle installed in a wet location where the product intended to be plugged into it is not attended while in use (e.g., sprinkler system controller, landscape lighting, holiday lights, and so forth) shall have an enclosure that is weatherproof with the attachment plug cap inserted or removed. (b) A receptacle installed in a wet location where the product intended to be plugged into it will be attended while in use (e.g., portable tools, and so forth) shall have an enclosure that is weatherproof when the attachment plug is removed. (C) Bathtub and Shower Space. A receptacle shall not be installed within a bathtub or shower space.	K 147		

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K 147	Continued From page 19 3) Kitchens Reference NFPA 70 (1999) edition 370-28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception. Reference: NFPA 70 (1999 Edition) 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147		