

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

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/23/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 EAST HWY, 136 CALHOUN, KY 42327		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000		6/30/14	
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit</p>	F 431	<p>Riverside Nursing and Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. Riverside Nursing and Rehabilitation Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings, or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Riverside Nursing and Rehabilitation Center reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance, or self-critical examination privilege which Riverside Nursing Rehabilitation does not waive and reserves the right to assert in any administrative, civil or criminal claim, actions or proceedings. Riverside Nursing and Rehabilitation Center offers its responses, credible allegations of compliance as part of its ongoing efforts to provide quality of care to residents.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *John Bentley* TITLE: *Administrator* (X6) DATE: *6/17/14*

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

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

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 1</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure biologicals (peroxide and normal saline) were stored properly, labeled, and contained the opened date with the staff's initials.</p> <p>Findings include:</p> <p>Review of the facility's policy titled "Medication Storage", dated 09/10, revealed all medications and biologicals were stored properly, following manufacturer's and provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration.</p> <p>Observation of treatment carts, on 05/22/14 at 1:40 PM on hallway one (1), at 1:42 PM on hallway two (2), and at 1:46 PM on hallway three (3), revealed sixteen ounce (16 oz) three percent (3%) multidose bottles of Peroxide were being stored opened and undated without staff initials. Additionally, at 1:42 PM on hallway two (2) treatment cart, an observation of a multidose bottle of normal saline was being stored uncovered and undated.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/22/14 at 1:42 PM, revealed when a multidose container was opened such as peroxide and normal saline, it should be dated</p>	F 431	<p><u>F431</u></p> <ol style="list-style-type: none"> The facility staff has removed all undated and uncovered bottles of peroxide and normal saline found on treatment carts from Halls #1, #2, #3 on 5/22/14 Treatment and Medicine Cart audits on all Halls were completed by SDC on 5/23/14 and Pharmacia representative on 5/28 and 6/5/14 to remove any inappropriate labeling of drugs and biologicals. Licensed nurses will label all drugs and biologicals when breaking the seal to use. The Staff Development Coordinator educated Licensed nurses on proper storage and labeling of drugs and biologicals on 5/22/2014 and 6/12/2014. The Staff Development Coordinator will audit treatment carts for improper storage and labeling of drugs and biologicals weekly for 4 weeks and monthly for 3 months and report the findings to the Performance Improvement Committee for tracking and trending purposes with follow up action taken as needed. Date completed 6/30/2014 	6/30/14

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

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 EAST HWY. 136 CALHOUN, KY 42327	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 2 and Initialed. Interview with LPN #2, on 5/22/14 at 1:46 PM, revealed all multidose bottles should be dated when opened and stored in the treatment cart. Interview with the Assistant Director of Nursing (ADON), on 05/22/14 at 3:50 PM, revealed all multidose bottles should be stored in the treatment cart after being opened and should be dated and Initialed when opened. Interview with the Director of Nursing (DON), on 05/22/14 at 4:00 PM, revealed any opened peroxide or normal saline multidose bottles should be labeled with the opened date and Initialed.	F 431		6/30/14
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as Isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	<u>F441</u> 1. Resident #2 had a new dressing change done on 5/22/2014 with RN and LPN following MedPass policy on dry/clean dressing changes. LPN removed the snacks from the storage cabinet in medicine room on Hall # 3 to a separate storage area in a sealed container on 5/22/2014 2. The SDC and ADON reviewed the week ending 5/23/2014 and 5/30/2014 infection control reports for tracking and trending of any new infections that could have been caused by improper hand washing techniques. No concerns were identified. The staff development coordinator will educate licensed nurses reviewing skills competencies for correct infection control procedures, according to MedPass policy on 5/22/2014 and 6/12/2014. On 5/23/2014, Staff Development Coordinator checked Medicine rooms on Halls #1, #2, #3 with storage cabinets for any improper storage of snacks and food.	

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

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 138 CALHOUN, KY 42327		
(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 3</p> <p>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 REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the facility's policy and procedures, it was determined the facility failed to ensure staff washed their hands or changed gloves when providing care to one (1) of fifteen (15) sampled residents (Resident #2), to help prevent the development and transmission of disease and infection. In addition, the facility failed to ensure residents' snacks were sealed in the storage cabinet of the medication room to prevent contamination.</p> <p>Findings include:</p> <p>Review of the facility's "Infection Control Guidelines for All Nursing Procedures", dated 04/2013, revealed all employees must wash their</p>	F 441	<p>3. ADON/ Staff Development Coordinator will do random monitoring of at least 2 Licensed Nurses completing suprapubic catheter care with dressing changes, monthly for 3 months and the audit tool given to Director of Nursing. Any identified issues will be corrected at that time.</p> <p>The staff development coordinator will conduct weekly audits of all Medication rooms with storage cabinets for proper food storage with any identified concerns addressed at that time.</p> <p>4. The Director of Nursing/SDC will report the results of the monthly and weekly audits to the Performance Improvement Committee monthly for three months, or until compliance is sustained, for tracking and trending purposes with follow up action taken as needed.</p> <p>5. Date Completed 6/30/2014</p>	6/30/14	

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

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/23/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST HWY. 136 CALHOUN, KY 42327		
(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 4</p> <p>hands for ten (10) to fifteen (15) seconds using antimicrobial or non- antimicrobial soap and water before and after direct contact with residents; after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin, after removing gloves, and when there is likely exposure to spores. If hands are not visibly soiled they can use alcohol based hand rub containing 60-95% ethanol or isopropanol before handling clean or soiled dressings, gauze pads, etc.; before moving from a contaminated body site to a clean body site during resident care, after handling used dressings, contaminated equipment after contact with objects, and after removing gloves.</p> <p>Review of the facility's "Using Gloves" policy, dated 03/12/12, revealed to change gloves between tasks and procedures on the same resident after contact with material which may contain a high concentration of microorganisms.</p> <p>Review of the facility's "Handwashing" policy, dated 12/2013, revealed staff and residents will wash their hands as necessary to prevent the spread of infections or germs, before and after caring for each resident and/or their units, including handling anything the resident has touched.</p> <p>1. Record review revealed Resident #2 was admitted to the facility on 01/14/14 with diagnoses to include Urinary Tract Infection, Neurogenic Bladder, Atony of Bladder, Abdominal Pain, and Severe Sepsis. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 05/07/14, revealed the facility assessed Resident #2 as having a suprapubic catheter.</p>	F 441		6/30/14	

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

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327	
(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	Continued From page 5 Observation of a skin assessment conducted by Licensed Practical Nurse (LPN) #1, on 05/22/14 at 10:15 AM, revealed LPN #1 applied gloves and closed the privacy curtain. LPN #1 assessed the resident's skin and as she assessed the skin on the sacrum, she pulled at dry flaky skin on the resident's sacrum, then turned the resident over. She then assessed the resident's perineal area touching the suprapubic catheter dressing, and around the site of catheter. The LPN failed to change gloves or wash her hands during the skin assessment. Interview with LPN #1, on 05/22/14 at 10:40 AM, revealed she did not wash her hands prior to gloving and providing care. She further revealed after assessing the sacrum area, she should have washed her hands and reapplied gloves, then assessed the catheter site. Observation of Resident #2's suprapubic catheter care provided by Certified Nurse Aide (CNA) #1, on 05/22/14 at 10:15 AM, revealed she placed wet and dry washcloths on top of the side rails of the resident's bed. She then removed a dry gauze dressing from the suprapubic catheter and placed it on the resident's abdomen. The CNA then completed catheter care using the wet and dry washcloths which were placed on the side rails of the resident's bed. CNA #1 placed the used dressing from his/her abdomen back on the resident's suprapubic site. Interview with CNA #1, on 05/22/14 at 10:45 AM, revealed when she placed the washcloths on the side rail, she risked introducing contaminants and bacteria to the catheter site. The CNA stated the dressing should have been placed somewhere	F 441		6/30/14

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

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 441	<p>Continued From page 6 clean and the bottom of the dressing was facing up to ensure it was not contaminated.</p> <p>Interview with the Director of Nursing (DON), on 05/23/14 at 11:05 AM, revealed she expected the staff to wash their hands and change gloves after touching the resident's sacrum area and prior to touching the catheter site. The DON stated the staff should remove the old dressing from the catheter site, place it in a bag, and then apply a new dressing.</p> <p>2. Review of the facility's "Food Storage" policy, undated, revealed food should be stored to keep food safe by methods designed to prevent contamination.</p> <p>Observation of the medication room, on 05/22/14 at 1:10 PM, revealed there was a large hard shell bug found crawling in the storage cabinet in the Medication Room on hallway three (3). Further observation of the storage cabinet revealed there were syringes, needles and three (3) opened packages of residents' personal snacks which were not in a sealed container.</p> <p>Interview with the Administrator, on 05/22/14 at 3:40 PM, revealed all residents' snacks should be sealed in a container when stored.</p>	F 441		6/30/14	

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

PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327	
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1962.</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: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1962 with 26 smoke detectors and 43 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1962 and upgraded in 2010.</p> <p>GENERATOR: Type II generator installed in 1997. Fuel source is Diesel.</p> <p>A standard Life Safety Code Survey was conducted on 05/21/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-nine (79) beds with a census of sixty-nine (69) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>Riverside Nursing and Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. Riverside Nursing and Rehabilitation Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings, or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Riverside Nursing and Rehabilitation Center reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance, or self-critical examination privilege which Riverside Nursing Rehabilitation does not waive and reserves the right to assert in any administrative, civil or criminal claim, actions or proceedings. Riverside Nursing and Rehabilitation Center offers its responses, credible allegations of compliance as part of its ongoing efforts to provide quality of care to residents.</p>	6/30/14



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Jeffrey Boyler* TITLE: *Administrator* (X6) DATE: *6/30/14*

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

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

PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 062 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. 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 This STANDARD is not met as evidenced by: Based on sprinkler record review and interview it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for seventy-nine (79) beds and at the time of the survey, the census was sixty-nine (69). The findings include: Sprinkler record review, on 05/21/14 at 11:26 AM with the Maintenance Director, revealed the facility failed to provide documentation that the sprinkler system had been inspected internally within the last 5 years. The report showed the last internal pipe investigation was performed in April of 2009. Interview, on 05/21/14 at 11:27 AM with the Maintenance Director, revealed he relied on his	K 062	<u>K 062</u> 1. The 5 year internal sprinkler pipe inspection was completed by Koorsen's (sprinkler contractor) on 5/22/2014. 2. The Maintenance Director will review all routine sprinkler inspection dates during monthly routine Preventive Maintenance. The review checks will be documented in the center's Preventive Maintenance log. 3. All sprinkler inspections shall be reviewed for compliance monthly for functionality and code compliance per Signature Preventive Maintenance policy. The Maintenance director will do inspections. 4. The Maintenance Director will report any sprinkler inspections not in compliance with sprinkler code to Administrator immediately, with appropriate action taken. The Administrator will track and trend monthly for 3 months and report findings to PI committee with appropriate action taken. 5. Completion date 6/30/2014	6/30/14

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

PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 EAST HWY. 136 CALHOUN, KY 42327	
(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 062	<p>Continued From page 2</p> <p>sprinkler company to ensure the system was inspected properly and was unaware the test was over 5 years ago.</p> <p>The census of sixty-nine (69) was verified by the Administrator on 05/21/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 05/21/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <p>Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing)</p>	K 062		6/30/14

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

PRINTED: 08/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185208	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 062	Continued From page 3 weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2	K 062		6/30/14

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

PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 062	Continued From page 4 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1	K 062		6/30/14

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

PRINTED: 08/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 EAST HWY. 136 CALHOUN, KY 42327	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 062	Continued From page 6 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062		6/30/14
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (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.	K 066		

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

PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 138 CALHOUN, KY 42327		
(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 066	<p>Continued From page 6</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> <p>This STANDARD is not met as evidenced by: Based on observation, smoking policy review, and interview, it was determined the facility failed to ensure the use of approved smoking areas, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-nine (79) beds and at the time of the survey, the census was sixty-nine (69).</p> <p>The findings include:</p> <p>Observation, on 05/21/14 at 1:18 PM with the Maintenance Director, revealed the area at the center rear exit was not being used as a smoking area but there were over forty (40) cigarette butts on the ground at the exit. Further observation revealed the facility is a smoke free campus with no one allowed to smoke on the grounds.</p>	K 066	<p><u>K066</u></p> <ol style="list-style-type: none"> The maintenance director removed cigarette butts at the center rear exit of building on 5/22/2014. The Maintenance director inspected all exit areas of the building and removed any cigarette butts in the area on 5/22/2014. The Maintenance Director/Housekeeping supervisor will inspect exit areas of the building weekly to remove any cigarette butts that might be dropped on the ground. The Maintenance director will report any non-compliance findings to Administrator with immediate action taken. The Administrator will track and trend findings monthly for 3 months and report to PI meeting with appropriate action taken. Completion date 6/30/2014 	6/30/14	

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

PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
K 066	Continued From page 7 Interview, on 05/21/14 at 1:19 PM with the Maintenance Director, revealed he was aware the cigarette butts were on the ground but stated "you can't stop people from smoking". Further interview revealed he does sweep up the cigarette butts but he doesn't always have time to keep up with them. The census of sixty-nine (69) was verified by the Administrator on 05/21/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/21/14. Actual NFPA Standard: NFPA 101 (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.	K 066		6/30/14	

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

PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
K 066	Continued From page 8 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		6/30/14	