

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

PRINTED: 08/25/2015
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 R 08/21/2015
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 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance on 08/20/15, as alleged.</p>	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 185209	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/21/2015
Name of Facility RIVERSIDE CARE & REHABILITATION CENTER		Street Address, City, State, Zip Code 190 EAST HWY. 136 CALHOUN, KY 42327

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

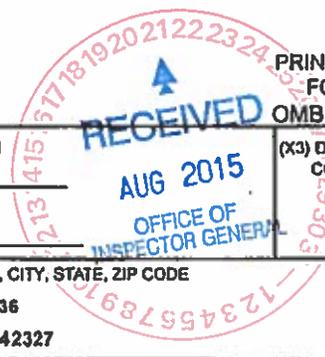
(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0278</u> Reg. # <u>483.20(a) - (l)</u> LSC _____	Correction Completed <u>08/20/2015</u>	ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(I)</u> LSC _____	Correction Completed <u>08/20/2015</u>	ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(II)</u> LSC _____	Correction Completed <u>08/20/2015</u>
ID Prefix <u>F0328</u> Reg. # <u>483.25(k)</u> LSC _____	Correction Completed <u>08/20/2015</u>	ID Prefix <u>F0334</u> Reg. # <u>483.25(n)</u> LSC _____	Correction Completed <u>08/20/2015</u>	ID Prefix <u>F0371</u> Reg. # <u>483.35(I)</u> LSC _____	Correction Completed <u>08/20/2015</u>
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>DH</u>	Date: <u>08/25/15</u>	Signature of Surveyor: <u>Deborah Anderson, NLS, OK</u>	Date: <u>08/25/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>7/16/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327
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F 000	INITIAL COMMENTS	F 000	This Plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverside Care & Rehabilitation Center does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	8/20/15
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	<u>F278</u> 1. The Minimum Data Sets (MDS) have been modified by MDS Coordinator for resident #6 on 7/15/15 and resident #9 on 7/14/15. A modified Minimum Data Set has been transmitted on 7/24/15. 2. The facility interdisciplinary team (consisting of licensed nurses, therapy, activities, and social services) will review the most current Minimum Data Set for each resident to assess for accuracy and correct any information determined to be inaccurate. This was completed on 7/17/15. 3. The Director of Nursing in serviced the MDS Coordinator and Case Manager on accuracy of the information coded on Section "G" on each Minimum Data Set prior to affixing their signatures on 7/17/15.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sydney Winchell</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/16/15</i>
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F 278	<p>Continued From page 1</p> <p>Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure the assessment accurately reflected the resident's status for two (2) of fifteen (15) sampled residents (Residents #8, and #9) related to ability to ambulated in room.</p> <p>The findings include:</p> <p>Review of the "Resident Assessment Instrument (RAI) Manual Version 3.0", Section G0110 (Activities of Daily Living Assistance), revealed the definition for total dependence was "if there was full staff performance of any activity with no participation by the resident for any aspect of the ADL activity and the activity occurred three (3) or more times. The resident must be unwilling or unable to perform any part of the activity over the entire seven (7) day look back period".</p> <p>1. Record review revealed the facility admitted Resident #8 on 01/01/14 with the diagnoses which included Convulsions, Chronic Respiratory Failure, Diabetes Mellitus type two (2), Hypertension, Chronic Pain, Atrial Fibrillation, Dementia without behavior disturbance, and Congestive Heart Failure.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/09/15, revealed under GO110C, the facility coded Resident #8 as totally dependent for ambulation while in room requiring the assistance of two (2) persons.</p> <p>2. Record review revealed the facility admitted Resident #9 on 07/09/10 with diagnoses which included Aftercare Traumatic Fractured Hip, Fractured Femur, Moderate Intellect Disability, Chronic Airway Obstruction, and Dementia</p>	F 278	<p>4. The Case Manager or MDS Coordinator will monitor through observation and record review at least monthly for 3 months to assure accurate assessment and coding of the Minimum Data Set. Any coding errors will be reported to the Quality Assurance Performance Improvement Committee which includes; (Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Social Services Director, Quality Of Life Director, Medical Records Director, Dietary Services Manager, Business Office Manager, Central Supply and Staffing, Minimum Data Set Coordinator, Plant Ops Director & Facility Medical Director) for tracking and trending purposes with follow up action taken as needed.</p> <p>5. Completion Date: 8/20/15</p>	8/20/15

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F 278	Continued From page 2 without Behavior Disturbance. Review of the quarterly MDS assessment, dated 07/03/15, revealed under GO110C, the facility coded Resident #9 as totally dependent for ambulation while in room requiring the assistance of two (2) persons. Interview with MDS Coordinator, on 07/15/15 at 02:20 PM, revealed she expected MDS assessments to be coded accurately and to reflect the residents' true status. She stated the MDS assessments for Resident #6 and Resident #9 were inaccurately coded related to walking while in room (Section G0110-C). She stated if a resident was totally dependent for walking that would mean the resident was unable to walk which would mean the resident should have been coded as "as activity did not occur".	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of Lippincott's Nursing Procedures Sixth Edition, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality for one (1) of of fifteen (15) sampled residents (Resident #11) and one (1) unsampled resident (Resident A). Registered Nurse (RN) #1 failed to check placement of a percutaneous endoscopic gastrostomy (peg) tube prior to the administration	F 281	<u>F281</u> 1. Registered Nurse given education by Staff Development Coordinator on G-Tube administration with emphasis on checking G-Tube placement prior to administration. Resident A was assessed by Staff Development Coordinator without abnormal findings on 7/16/15. Certified Medication Aide given education by Staff Development Coordinator on steroid inhaler administration, with emphasis on resident to rinse mouth after use by swish & spit method on 7/16/15. Resident # 11; Staff Development Coordinator assessed oral mucosa without any observations or complaints of thrush on 7/16/15. 2. Staff Development Coordinator completed audit on residents receiving steroid inhalers and feeding tube medication administration with no concerns identified on 7/16/15.	

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F 281	<p>Continued From page 3 of medication to Unsampled Resident A, and Certified Medication Aide (CNA) #1 failed have Resident #11 rinse his/her mouth after the administration of a steroid inhaler.</p> <p>The findings include:</p> <p>Review of the facility's Standards of Practice, (Lippincott's Nursing Procedures, Sixth Edition), no date, and the facility's policy and procedure, titled "Medication Administration Enteral Tubes", dated 2007, revealed staff should check peg tube placement before and after medication administration.</p> <p>Record review revealed the facility admitted Unsampled Resident A on 01/28/13, with diagnoses which included Dysphagia, Hypertension, Congestive Heart Failure, Hyperlipidemia, Non-Alzheimer's Dementia, Anxiety, Depression, Psychotic Disorder, Esophageal Reflux, Psychosis, and Gastrostomy Status.</p> <p>Observation of a medication pass for Unsampled Resident A, on 07/15/15 at 9:45 AM, revealed RN #1 prepared the resident for medication administration by placing the feeding tube pump on hold and taking the peg tube apart in order to administer medications. Before RN #1 began to flush the peg tube, and when asked if she was going to check the placement of the peg tube prior to flushing the tube, she replied she forgot. When asked if the peg tube placement was to be checked prior to flushes or medication administration, she replied "yes".</p> <p>Review of the July 2015 Medication Administration Record (MAR) revealed the</p>	F 281	<p>3. Staff Development Coordinator educated all Certified Medication Aides and Licensed Nurses on proper administration of steroid inhaler with emphasis on resident rinsing mouth after use by swish and spit method initiated on 7/16/15 and ongoing. Staff Development Coordinator educated all Licensed Nurse on G-Tube administration with emphasis on checking G-Tube placement prior to administration of medications, 7/16/15 and ongoing.</p> <p>4. Staff Development Coordinator and Pharmacia Representative will audit staff administering steroid inhaler and G Tube medication administration weekly for 4 weeks, then monthly for 3 months. Will report to the Quality Assurance Performance Improvement Committee for tracking and trending purposes with follow up action taken as needed.</p> <p>5. Completion Date: 8/20/2015</p>	8/20/15

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F 281	Continued From page 4 medications administered were Lasix (Diuretic) 20 milligrams (mgs), Potassium Chloride (Mineral and electrolyte) 10 milliequivalents (meqs), and Nexium (Heartburn medication), 40 mgs. Interview with RN #1, on 07/15/15 at 10:05 AM, revealed she was aware of the need to check peg tube placement prior to flushing/medication administration and the potential consequences of not doing it. 2. Review of the Manufacturer's Guidelines, not dated, and the facility's Standards of Practice and policy and procedure, titled "Medication Administration, Oral Inhalations", dated 2007, revealed "For steroid inhalers, provide the resident with cup of water and instruct him/her to rinse mouth and spit water back into cup". Observation of a medication administration, on 07/15/15 at 4:12 PM, revealed CMA #1 administered an oral steroid inhaler (Advair Diskus) to Resident #11 and did not have the resident rinse and spit after the inhalation. Interview with CMA #1, on 07/16/15 at 8:20 AM, revealed she knew after the inhalation of a steroidal inhaler, the resident was to rinse and spit with water to prevent potential Thrush (mouth rash). Interview with the Director of Nursing (DON), on 07/15/15 at 1:30 PM, revealed she expected nursing staff to follow the facility's policy and procedure related to checking placement of a peg tube prior to medication administration and the administration of steroid inhalers.	F 281			
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282			

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F 282 SS=D	<p>Continued From page 5 PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services provided by the facility were in accordance with the written plan of care for one (1) of fifteen (15) sampled residents (Resident #7). Resident #7 was care planned for continuous oxygen at three (3) liters via nasal cannula, however, observations on 07/14/15 and 07/15/15 revealed the resident was not wearing oxygen via nasal cannula.</p> <p>The findings include:</p> <p>Review of the facility's Standards of Practice, (Lippincott's Nursing Procedures, Sixth Edition), not dated, revealed oxygen should be applied per physician's order.</p> <p>Record review revealed the facility admitted Resident #7 on 06/17/15 with diagnoses which included Diabetes Mellitus Type I, Shortness of Breath, Hypertension, Cough, Dyspnea of Exertion, Altered Mental Status, and Confusion. Review of the admission Minimum Data Set (MDS) assessment, dated 06/24/15, revealed the facility assessed Resident #7's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of two (2), which indicated the resident was not interviewable.</p>	F 282	<p><u>F282</u></p> <ol style="list-style-type: none"> 1. Resident # 7 assessed by Licensed Nurse on 7/15/15, oxygen sat noted on room air at 92% no distress noted. Physician notified of self-removal of oxygen, Physician visit noted on 7/15/15 regarding self-removal of nasal cannula. 2. Licensed Practical Nurse provided education on following Physicians orders and care plans on 7/16/15. Assistant Director of Nursing completed audit on 7/17/15 on all residents with oxygen orders; Physician oxygen orders and care plans accordingly. Oxygen available, and nasal cannulas in place with no concerns identified. 3. All Staff will be educated by the Staff Development Coordinator on Residents with oxygen orders to ensure following Physicians orders and residents care plans. Education started on 7/16/15 and ongoing. 4. Staff Development Coordinator and Assistant Director of Nursing will audit residents identified with oxygen orders verify oxygen is in place, as ordered and that the care plan is being followed for 4 weeks, then monthly for 3 months. Any findings from audit will be reported to the Quality Assurance Performance Improvement Committee for tracking and trending purposes with follow up action taken as needed. 5. Completion date 8/20/2015. 	8/20/15

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F 282	Continued From page 6 Review of Resident #7's Comprehensive Care Plan, not dated, revealed an intervention for oxygen to be administered as ordered and review of the Physician's Order, dated 06/16/15, revealed an order for continuous oxygen at three (3) liters via nasal canula. Observations on 07/14/15 at 10:09 AM and 2:09 PM and on 07/15/15 on 7:58 AM, revealed Resident #7 was sitting in a wheelchair in the hallway or the Physical Therapy Room and there was no oxygen available for administration. Interview with Licensed Practical Nurse (LPN) #4, on 07/15/15 at 2:19 PM, revealed she should be following the care plan and physician's orders. She stated she obtained the resident's oxygen saturation levels and would apply oxygen if needed. Interview with the Director of Nursing (DON), on 07/16/15 at 9:30 AM, revealed she would expect nursing staff to follow the care plan and physician's orders.	F 282		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and	F 328	<u>F328</u> 1. Resident # 7 assessed on 7/15/15, oxygen sat noted on room air at 92% no distress noted. Physician notified of self-removal of oxygen, Physician visit noted on 7/15/15 regarding self-removal of nasal cannula. 2. Licensed Practical Nurse provided education on following Physicians orders and care plans on 7/16/15. Assistant Director of Nursing completed audit on 7/17/15 on all residents with oxygen orders, Physician oxygen orders and care plans accordingly. Oxygen available, and nasal cannulas in place with no concerns identified.	

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F 328	<p>Continued From page 7 Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of fifteen (15) sampled residents (Resident #7) received proper treatment and care related to oxygen therapy. Resident #7 had a physician's order and was care planned for continuous oxygen at three (3) liters via nasal cannula, however, observations on 07/14/15 and 07/15/15 revealed the resident was not wearing oxygen via nasal cannula.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #7 on 06/17/15 with diagnoses which included Diabetes Mellitus Type I, Shortness of Breath, Hypertension, Cough, Dyspnea of Exertion, Altered Mental Status, and Confusion. Review of the admission Minimum Data Set (MDS) assessment, dated 06/24/15, revealed the facility assessed Resident #7's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of two (2), which indicated the resident was not interviewable.</p> <p>Review of Resident #7's Comprehensive Care Plan, not dated, revealed the resident was oxygen dependent and had potential for difficulty breathing and included an intervention for oxygen was to be administered as ordered. Review of the Physician's Order, dated 06/16/15, revealed an order for continuous oxygen at three (3) liters via nasal canula; however, observations on 07/14/15 at 10:09 AM and 2:09 PM and on</p>	F 328	<p>3. All Staff will be educated by Staff Development Coordinator on residents with oxygen orders – ensure following Physicians orders and resident care plan. Education started on 7/16/15 and ongoing.</p> <p>4. Staff Development Coordinator and Assistant Director of Nursing will audit residents identified with oxygen orders verify oxygen is in place, as ordered and that the care plan is being followed for 4 weeks, then monthly for 3 months. Any findings from audit will be reported to the Quality Assurance Performance Improvement Committee for tracking and trending purposes with follow up action taken as needed.</p> <p>5. Date completed 8/20/2015</p>	8/20/15	

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

PRINTED: 07/30/2015
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 07/16/2015
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 328	Continued From page 8 07/15/15 on 7:58 AM, revealed Resident #7 was sitting in a wheelchair in the hallway or the Physical Therapy Room and there was no oxygen available for administration. Interview with Licensed Practical Nurse (LPN) #4, on 07/15/15 at 2:19 PM, revealed she would obtain oxygen levels on the resident and would determine if the resident needed to have the oxygen. She stated she should be following the physician's orders and care plan related to the oxygen order. She said the resident could become more confused without the use of oxygen.	F 328			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334	<u>F334</u> 1. Resident #3 informed of risk and benefits of pneumonia vaccine on 7/15/15 Resident refused pneumonia vaccine on 7/15/15. 2. Assistant Director of Nursing / Infection Control Nurse audited all 68 resident charts on 7/18/15 to identify any pneumonia vaccine that had not been documented as given or refused- no concerns identified. 3. Staff Development Coordinator to educate all Licensed Nurses regarding Pneumonia Vaccine information and documenting offer of the immunization initiated on 7/16/15 and on-going. Assistant Director of Nursing / Infection Control Nurse will audit new admission	8/20/15	

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F 334	<p>Continued From page 9</p> <p>documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of Influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second</p>	F 334	<p>or readmissions to facility weekly for 3 months to ensure immunization records accuracy.</p> <p>4. Assistant Director of Nursing / Infection Control Nurse will audit new admission or readmission to facility weekly for 3 months. Findings from audit will be reported to the Quality Assurance Performance Improvement Committee for tracking and trending purposes with follow up action taken as needed.</p> <p>5. Date Completed 8/20/2015.</p>	8/20/15	

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F 334	<p>Continued From page 10</p> <p>pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and the facility's policy review, it was determined the facility failed to ensure the medical record included documentation to indicate residents either received the pneumonia vaccine or did not due to medical contraindication or refusal for one (1) of fifteen (15) sampled residents (Resident #3).</p> <p>The findings include:</p> <p>Review of facility's policy "Pneumococcal Vaccine", last revised 12/2012, revealed, prior to or upon admission, residents will be assessed for the eligibility to receive the Pneumovax (Pneumococcal Vaccine), and when indicated, will be offered the vaccine within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated.</p> <p>Record review revealed the facility admitted Resident #3 on 02/28/13 with diagnoses which included Hemiplegia, Depression, Diabetes, and Anxiety.</p> <p>Review of Resident #3's medical record revealed there was no documentation or notation of</p>	F 334		8/20/15	

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F 334	Continued From page 11 whether or not Resident #3 was informed about the benefits and risks of the pneumonia vaccine, if the vaccine was medically contraindication, or if the resident refused the vaccine since being admitted to the facility. Interview with the Assistant Director of Nursing (ADON), on 07/14/15 at 3:30 PM, revealed she expected when resident's were admitted to the facility there should be immunization records, consents and or refusals in place as part of the admission process. Interview with the Director of Nursing (DON), on 07/16/15 at 9:30 PM, revealed she expected staff to obtain consent for immunizations and offer pneumococcal vaccine if the resident meets the criteria. She further stated, she would expect the resident or legal representative to receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine upon admission to the facility.	F 334		8/20/15	
F 371 SS=E	483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	<u>F371</u> 1. Dietary Aide and Dietary Cook educated by dietary manager and registered dietician on 7/14/15 regarding maintain sanitary conditions during tray line service. 2. Dietary Manager / Registered Dietician provided education to all dietary staff on 7/14/15 regarding Infection Control and maintaining sanitary conditions during tray line service. Review by dietary manager and Registered Dietician of last 6 months of health inspections without any concerns identified regarding food borne illness last inspection date 4/17/15.		

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F 371	<p>Continued From page 12</p> <p>by: Based on observation, interview, and review of the facility policy and procedure, it was determined the facility failed to ensure food was served under sanitary conditions. Observation revealed Dietary Aide #1 licked her fingers while sorting through tray cards and continued to serve food from the tray line without washing her hands. In addition, the Dietary Cook broke tray line to retrieve items from a refrigerator and did not wash her hands prior to returning to the tray line.</p> <p>Review of the Census and Condition, dated 07/14/15, revealed there were sixty-seven (67) residents in the building and two (2) residents with tube feedings.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Dietary Services, Hand-Washing", dated 10/2009, revealed staff should wash hands after handling soiled dishes and utensils and after using the bathroom, sneezing, coughing, touching face or hair, scratching, and using a handkerchief.</p> <p>Observation of tray line service during a lunch meal, on 07/14/15 at 11:35 AM, revealed Dietary Aide #1 licked her fingers to sort through tray cards during tray line meal pass and did not wash or sanitize her hands. Further observation revealed the Dietary Cook left the tray line to go to the refrigerator and returned to the tray line and did not wash her hands prior to continuing to serve food.</p> <p>Interview with the Dietary Cook, on 07/14/15 at 1:02 PM, revealed she should have washed her</p>	F 371	<p>3. Dietary Manager / Registered Dietician will audit tray line service weekly for 4 weeks, then monthly for 3 months identifying concerns, addressed at that time.</p> <p>4. Dietary Manager / Registered Dietician will report results of audits monthly, any concerns identified, results of audits, will be reviewed monthly by Quality Assurance Performance Improvement Committee for tracking and trending purpose with follow action taken as needed.</p> <p>5. Date Completed 8/20/2015.</p>	8/20/15

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F 371	<p>Continued From page 13</p> <p>hands prior to returning to the tray line to serve food to prevent food contamination.</p> <p>Interview with the Dietary Aide, on 07/14/15 at 1:05 PM, revealed she understood she should have washed her hands after licking her fingers and should not have licked her fingers to sort the tray cards initially.</p> <p>Interview with the Dietary Manager, on 07/14/15 at 1:07 PM, revealed the dietary staff should be conscientious of breaking tray line and washing hands and the dietary staff are to wear gloves when they are directly touching food and not during tray line.</p>	F 371		8/20/15

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NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327	
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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 08/04/15, as alleged.	{K 000}		

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

TITLE

(X6) DATE

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

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 185209	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 8/4/2015
Name of Facility RIVERSIDE CARE & REHABILITATION CENTER		Street Address, City, State, Zip Code 190 EAST HWY. 136 CALHOUN, KY 42327

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # <u>NFPA 101</u> LSC <u>K0062</u>	Correction Completed 08/04/2015	ID Prefix _____ Reg. # <u>NFPA 101</u> LSC <u>K0144</u>	Correction Completed 08/04/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>DH</u>	Date: <u>08/20/15</u>	Signature of Surveyor: <u>Deborah A. Hudson NCFE</u>	Date: <u>08/20/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 7/14/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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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: 1982.</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 twenty-six (26) smoke detectors and forty-three (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 07/14/15. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Giffany W. Wicker* TITLE *Administrator* (X5) DATE *8/16/15*

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 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	This Plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverside Care and Rehabilitation Center does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. <u>K 062</u> Spoke With Glen Martin, Life Safety Code Inspector with the Cabinet for Health and Family Services, (606) 330-2030 x 233 on 8/5/2015 at 1445, confirms received copy of 10/2014 Inspection by Century Fire Protection which contains record of a Full Flow Sprinkler Trip Test. Life Safety Inspector states to place this statement on the Plan of Correction this is in compliance during annual survey.	
K 082 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 an interview and record review, the facility failed to maintain their sprinkler system by National Fire Protection Association (NFPA) standards. This deficient practice affected five (5) of five (5) smoke compartments, staff and all of the residents. The facility has the capacity for seventy-nine (79) beds with a census of sixty-nine (69) on the day of the survey. The findings include: During the Life Safety Code tour, on 07/14/15 at 2:10 PM with the Director of Maintenance (DOM), a review of the facility's quarterly sprinkler system report revealed no record for a full flow sprinkler trip test. This test helps to ensure the sprinkler system is working correctly. Interview with the DOM, on 07/14/15 at 2:10 PM, revealed he was not aware this test was due to be performed.	K 062		

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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 062	Continued From page 2 The findings were revealed to the Administrator on exit. Reference: NFPA 25 1998 edition Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Trip test Annually Full flow trip test 3 years NFPA 101 LIFE SAFETY CODE STANDARD	K 062	<u>K144</u> 1. 8/4/2015 Nixon Power Services Company installed a switch to the generator to allow for a manual test on a monthly basis. 2. Nixon Power Services Company service technician educated Director of Maintenance, Reps Beals on manually test transfer switch installed on 8/4/2015. 3. Director of Maintenance, Reps Beals, will monthly exercise the generator under load for 30 minutes started on 8/4/2015- document findings on generator log form. 4. Director of Maintenance, Reps Beals will document monthly manual test of generator exercise under load for 30 min on generator log form addressing any concerns identified at that time. The findings will be reported monthly in the Quality Assurance Performance Improvement Committee Meeting for 4 months for tracking and trending purposes with follow up action taken as needed. 5. Completion Date: 8/4/2015	8/4/15	
K 144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on interview, the facility failed to maintain the generator set by National Fire Protection Agency (NFPA) standards. This deficient practice affected five (5) of five (5) smoke compartments, staff and all the residents. The facility has the capacity for seventy-nine (79) beds with a census of sixty-nine (69) on the day of survey. The findings include:	K 144			

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: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2015
NAME OF PROVIDER OR SUPPLIER RIVERSIDE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 CALHOUN, KY 42327		
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K 144	<p>Continued From page 3</p> <p>Interview with the Director of Maintenance, on 07/14/15 at 1:00 PM, revealed he was not aware he was required to manually test the generator transfer switch on a monthly basis to ensure the generator transfer switch is operating as intended.</p> <p>The findings were revealed to the Administrator on exit.</p> <p>Reference: NFPA 110 1999 edition</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p>	K 144		8/4/15	