

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

PRINTED: 02/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/10/2016
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NAME OF PROVIDER OR SUPPLIER BROOKDALE RICHMOND PLACE SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
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(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
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{F 000}	INITIAL COMMENTS An offsite revisit survey was conducted and based on the facility's acceptable plan of correction, the facility was deemed to be in compliance as alleged on 01/23/16.	{F 000}		
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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.

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F 000	INITIAL COMMENTS	F 000	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies dated 12/28/2015. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.	1/23/16
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the comprehensive Care Plan described the services to be furnished to attain or maintain each resident's highest practicable	F 279		It is the policy of Brookdale Richmond Place SNF to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment.

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

TITLE

(X6) DATE

Benita Dickerson

Healthcare Administrator 2-2-16

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F 279	<p>Continued From page 1</p> <p>physical well-being for one (1) of six (6) sampled residents. Resident #1 experienced four (4) episodes without a BM for three (3) or more days between 10/25/15 and 11/22/15. In addition, the Advanced Registered Nurse Practitioner (ARNP) assessed the resident to have constipation on 10/29/15 and again on 12/01/15. However, the facility did not develop a care plan to address the resident's constipation and did not initiate interventions to promote regular bowel function.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plans - Comprehensive", revised December 2010, revealed a comprehensive care plan was to be maintained for each resident that identified the highest level of functioning the resident could be expected to attain. Continued review revealed resident assessments were ongoing and not limited to the Minimum Data Set (MDS) assessments. Further review revealed the care plan was to be updated as information about the resident and the resident's condition changed.</p> <p>Review of the clinical record revealed Resident #1 was admitted by the facility on 10/13/15 with diagnoses which included General Muscle Weakness and Dementia.</p> <p>Review of the ARNP's assessment and progress notes, dated 10/29/15 and 12/01/15, revealed Resident #1's "Problem List" included Constipation.</p> <p>Review of the Medication Administration Record (MAR) for 10/13/15 through 12/05/15 revealed Resident #1 received a daily scheduled dose of Senna at bedtime "for constipation". Continued</p>	F 279	<p>A Bowel Care Protocol was developed to monitor bowel status regularly with progressive actions identified regarding constipation.</p> <p>Resident #1 was discharged prior to these findings. The MDS Coordinator responsible for updating the care plan for Resident #1 was educated regarding the "Care Plans- Comprehensive " policy to ensure the care plan meets the resident's medical, nursing and psychosocial needs (including constipation) and as identified in the comprehensive assessment by the Director of Clinical Services on December 10, 2015.</p> <p>The care plans for all residents will be reviewed to ensure a care plan that meets the resident's medical, nursing and psychosocial needs (including constipation and incorporating the newly identified bowel care protocol) and as identified in the comprehensive assessment has been developed by January 22, 2016 by 3 MDS Coordinators (2 RN/1 LPN).</p>		

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F 279	<p>Continued From page 2</p> <p>review revealed beginning 11/21/15, Resident #1 received Milk of Magnesia 30 milliliters every other day "for constipation". Further review of the MAR revealed the facility did administer medications for constipation PRN (as needed), on 10/16/15, 10/31/15, 11/17/15, and 11/23/15; however, the PRN medications were not administered strictly as ordered by the Physician (refer to F309).</p> <p>Review of the BM Report for the period between 10/15/15 and 12/05/15 revealed no documented evidence Resident #1 had a BM 10/22/15 through 10/24/15, 10/26/15 through 10/28/15, 11/11/15 through 11/14/15 or 11/19/15 through 11/21/15.</p> <p>Review of the comprehensive Care Plan, initiated on 10/13/15, revealed the facility did not assess Resident #1 to have the problem of constipation throughout his/her stay at the facility, and no interventions were developed or implemented to address the concern to promote good bowel health and function.</p> <p>Interview with the MDS nurse, on 12/10/15 at 2:10 PM, revealed she was responsible for updating the Care Plan as indicated by each resident's status and any change in condition. She explained the MDS assessments themselves and some assessments utilized by the staff nurses fed directly into the care plan. Continued interview revealed issues discussed in the daily morning meeting also were an indicator for necessary revisions to the Care Plan. Subsequent interview with the MDS nurse, on 12/10/15 at 7:00 PM, revealed she did not recall any discussions in the morning meetings regarding Resident #1's constipation. She stated the only way she would have known to revise the</p>	F 279	<p>The MDS Coordinators will be educated regarding the "Care Plans-Comprehensive" policy to ensure the care plan meets the resident's medical, nursing and psychosocial needs (including constipation) and as identified in the comprehensive assessment by the Regional MDS Specialist on January 12, 2016.</p> <p>The Director of Clinical Services (DCS), (RN), the Assistant Director of Clinical Services (RN), will audit a minimum of 6 charts per week for 4 weeks to ensure a care plan that meets the resident's medical, nursing and psychosocial needs (including constipation) and as identified in the comprehensive assessment has been developed.</p> <p>The results of the audit will be forwarded monthly to the Quality Assurance Committee, (Medical Director, Director of Clinical Services, Administrator, Assistant Director of Nursing, and Pharmacy Consultant) for review to maintain compliance.</p>	1/23/16	

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F 279	Continued From page 3 Care Plan for constipation was if someone told her to. Interview with the Director of Nursing, on 12/10/15 at 5:30 PM, revealed identified problems should be careplanned. However, regarding Resident #1, the DON stated she did not think the resident's bowel status indicated a problem.	F 279			
F 309 SS=0	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to ensure one (1) of six (6) sampled residents received the necessary care and services to attain or maintain the highest practicable physical well-being. Resident #1 did not have a bowel movement (BM) for the four-day period between 11/10/15 and 11/15/15. The facility did not administer the resident's prescribed PRN (as needed) medications for constipation, as ordered by the Physician, during this period. The findings include:	F 309	It is the policy of Brookdale Richmond Place SNF for each resident to receive and the facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A Bowel Care Protocol was developed by the Director of Clinical Services, RN with guidance from the Medical Director on January 7, 2016. The bowel care protocol indicates that we will monitor bowel status regularly with progressive actions identified regarding no Bowel Movement in 3 days. The Bowel Protocol indicates that the bowel status to be monitored regularly by the charge nurse and/or the Unit Manager. If no BM in 3	1/23/16	

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F 309	<p>Continued From page 4</p> <p>Interview with the Administrator on 12/10/15 at 7:40 PM, and the Director of Nursing (DON) on 12/10/15 at 7:55 PM, revealed the facility did not have a written policy related to a bowel management program which included interventions to be initiated when a resident exhibited signs of constipation, or an inability to have a regular BM.</p> <p>Review of the clinical record revealed Resident #1 was admitted by the facility on 10/13/15 with diagnoses which included General Muscle Weakness and Dementia.</p> <p>Review of the admission Physician Orders revealed the following directives: Milk of Magnesia 30 cubic centimeters (cc) orally every twenty-four hours as needed for constipation if no BM in three (3) days; Bisocodyl Laxative Suppository 10 milligrams (mg) every twenty-four hours as needed for constipation, to be administered the next day if no results from the Milk of Magnesia; Fleet Mineral Oil Enema to be administered rectally on the next shift if no results after suppository given; Lactulose Solution 30 mg orally every twenty-four hours as needed for constipation; Docusate Sodium 100 mg by mouth every twelve hours as needed for constipation; and MiraLax Powder 17 grams by mouth every twenty-four hours as needed for constipation.</p> <p>Review of the Advanced Registered Nurse Practitioner's (ARNP) assessment and progress notes dated 10/29/15 revealed Resident #1's "Problem List" included Constipation.</p> <p>Review of the BM Report for November 2015 revealed no documented evidence Resident #1 had a BM for four (4) consecutive days between</p>	F 309	<p>days, administer medication and/or nutritional interventions to promote BM patterns as ordered and if no results to contact the physician to obtain further orders.</p> <p>Resident #1 was discharged prior to these findings. The Unit Manager (LPN) responsible for monitoring bowel care was educated by the Director of Clinical Services on December 10, 2015 regarding expectations of bowel care monitoring and follow up (including ensuring PRN medications are administered).</p> <p>The records for all residents were reviewed to ensure that they had not gone over three days without a bowel movement and without follow up intervention as ordered by the Unit Managers within the past 30 days (2 RN, 1LPN) by January 22, 2015.</p> <p>The Director of Clinical Services (RN) will educate the Assistant Director of Clinical Services (RN), the 3 Unit Managers (3 RN/1LPN) regarding appropriate bowel protocol on January 8, 2016.</p>		

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F 309	Continued From page 5 11/10/15 and 11/15/15. Review of the November Medication Administration Record (MAR) revealed no documented evidence Resident #1 was given any PRN (as needed) medications for constipation after three (3) days with no BM, as ordered by the Physician. Interview with the Unit Manager and the DON, on 12/10/15 at 5:30 PM, revealed the facility's process for bowel management was based on the Physician's orders, not a written protocol that applied to every resident. Continued interview revealed after three (3) days with no documented BM, the facility's computer documentation system generated a list of residents who fell in that category. On the fourth day, PRN medications were to be administered as ordered, according to the computer-generated list printed by the night shift nurse on the third day without a BM. Further interview revealed the Unit Manager was responsible for follow-up of residents who appeared on the list. No explanation was given as to how none of the ordered medications for constipation were given to Resident #1 after three (3) days with no BM. Interview with the Administrator, on 12/10/15 at 7:40 PM, revealed it was her expectation for all medications, including PRN medications, to be administered as ordered by the Physician.	F 309	All nurses RNs/LPNs will be educated by the Director of Clinical Services (RN) and the Assistant Director of Clinical Services (RN) and the Unit Managers (2 RN/1LPN) by January 22, 2016 regarding bowel care protocol including monitoring for no BM and actions following identification of no BM in 3 days. The Director of Clinical Services (DCS), (RN), the Assistant Director of Clinical Services (RN), will audit a minimum of 6 charts per week for 4 weeks to ensure that bowel care monitoring and protocol for no BM in 3 days has been followed. The results of the audit will be forwarded monthly to the Quality Assurance Committee, (Medical Director, Director of Clinical Services, Administrator, Assistant Director of Nursing, and Pharmacy Consultant) for review to maintain compliance.		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312	It is the policy of Brookdale Richmond Place SNF to provide the necessary services to maintain good nutrition, grooming, and oral hygiene.	1/23/16	

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F 312	<p>Continued From page 6 and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of photographs provided by the complainant, it was determined the facility failed to ensure two (2) of six (6) sampled residents (Residents #1 and #6) received adequate nail care to maintain good grooming when the residents were unable to carry out the activities of daily living (ADLs) independently. (Activities of daily living refers to self care tasks, including personal hygiene and grooming).</p> <p>The findings include:</p> <p>Interview with the Administrator, on 12/10/15 at 7:40 PM, revealed the facility did not have a specific written policy related to nail care.</p> <p>1. Review of the closed clinical record revealed Resident #1 was admitted by the facility on 10/13/15 with diagnoses which included Status Post Right Femur (thigh bone) Fracture, General Muscle Weakness, and Dementia. Continued review revealed the resident was discharged from the facility on 12/05/15.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 10/20/15, revealed Resident #1 required extensive assistance with personal hygiene. Review of the comprehensive Care Plan related to ADLs, initiated on 10/14/15 and revised on 10/27/15, revealed Resident #1 was impaired for self-performance of ADLs and staff were to provide assistance as indicated.</p>	F 312	<p>The nails of resident #6 were cleaned on 12/10/15 by the Unit Manager (LPN). Resident #1 was transferred out of the center on 12/05/15. The Unit Manager (LPN) was educated regarding monitoring of nails on the unit by the Director of Clinical Services on 12/10/15. The SRNA was educated on 12/10/15 by the Unit Manager regarding provision of nail care for Resident #6.</p> <p>On 12/10/15, the 3 Unit Managers (1 LPN, 2 RN) checked the nails of all residents to ensure all nails were trimmed and cleaned.</p> <p>The Director of Clinical Services and the Assistant Director of Clinical Services educated the Unit Managers (2 RN/1LPN) on December 10, 2015 regarding monitoring nail care and personal grooming during daily rounds to ensure appropriate personal care is provided to all residents.</p>		

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F 312	<p>Continued From page 7</p> <p>Interview with the Complainant, on 12/10/15 at 3:55 PM, revealed Resident #1 did not receive nail care from the date of admission on 10/13/15 until 11/09/15 when the Complainant reported his/her concern during a meeting with the facility. The Complainant stated the resident's nails were cleaned and trimmed after the meeting, but reported no regular nail cleaning was provided after that date, up to and including the day Resident #1 transferred to another facility (12/05/15).</p> <p>Review of a photograph dated 11/07/15, provided by the Complainant, revealed the resident's nails were long with rough edges and a large amount of dark brown substance underneath the nails.</p> <p>Interview with the Ombudsman, on 12/09/15 at 1:30 PM, revealed she attended a meeting with the Complainant and Resident #1 on 11/09/15. Continued interview revealed the DON, the Unit Manager (UM) and the Social Worker (SW) were also present at the meeting. The Ombudsman stated she observed the resident's nails to be "long and dirty".</p> <p>Interview with the UM, on 12/10/15 at 5:30 PM, revealed she observed Resident #1's nails to be long and jagged on 11/09/15. She stated she trimmed and filed the resident's nails after the meeting, but did not recall if the nails were dirty.</p> <p>Interview with the DON, on 12/10/15 at 5:30 PM, revealed she monitored Resident #1's nails after the meeting on 11/09/15 when she made rounds, and despite the Complainant's report, did not feel there was any continued problem with nail care for the resident.</p>	F 312	<p>The Director of Clinical Services, the Assistant Director of Clinical Services and the 3 Unit Manager (2 RN/1LPN) will educate all SRNA that nail care should be provided twice weekly (on shower days) and as needed on any other day by January 22, 2016.</p> <p>The Unit Managers (2 RN/1LPN) will audit personal care including nails during rounds on each unit at a minimum of 10 residents per week for 4 weeks to ensure that personal care including nail care is provided.</p> <p>The results of the audit will be forwarded monthly to the Quality Assurance Committee, (Medical Director, Director of Clinical Services, Administrator, Assistant Director of Nursing, and Pharmacy Consultant) for review to maintain compliance.</p>	1/23/16	

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F 312	Continued From page 8 2. Clinical record review revealed Resident #6 was admitted by the facility on 07/24/14 with diagnoses which included Alzheimer's Disease. Review of the Significant Change MDS Assessment, dated 09/11/15, revealed Resident #6 required extensive assistance for ADLs. Observation, on 12/09/15 at 1:10 PM, revealed Resident #6 sitting in a Broda chair in the common area lounge. Continued observation revealed a black substance beneath the resident's fingernails. Subsequent observation, on 12/10/15 at 2:30 PM, revealed Resident #6 lying in bed. The resident's fingernails were noted to be long with jagged edges, and a black substance beneath the nails. Interview with Certified Nursing Assistant (CNA) #1, on 12/10/15 at 2:35 PM, revealed she was assigned to care for Resident #6, and acknowledged the resident's nails were long and dirty. She stated she had not cleaned or trimmed the resident's nails. She further stated she had been trained on how to provide nail care, but she did not know the facility's policy related to her responsibility for providing the care. Continued interview revealed CNA #1 thought staff working "light duty" were assigned to make rounds and provide nail care. Interview with Licensed Practical Nurse (LPN) #1, on 12/10/15 at 2:58 PM, revealed she had not observed Resident #6's nails. She stated the CNAs should check the nails every shift and provide cleaning and trimming daily as needed. Interview with the Unit Manager, on 12/10/15 at	F 312			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE RICHMOND PLACE SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
(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 312	Continued From page 9 5:30 PM, revealed nail care should be provided twice weekly on shower days, and as needed on other days. Further interview with the Administrator, on 12/10/15 at 7:40 PM, revealed it was her expectation for each resident's nails to be cleaned and trimmed if necessary on shower days, and anytime between shower days as needed.	F 312			