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

PRINTED: 05/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185463		C 04/25/2014

NAME OF PROVIDER OR SUPPLIER: RICHMOND PLACE REHABILITATION AND HEALTH CENTER

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 000	INITIAL COMMENTS An Abbreviated Survey to investigate #KY00021478 was initiated on 3/22/14 and concluded on 4/25/14. The allegations were unsubstantiated; however, related deficiencies were cited. #KY00021590 was initiated on 4/22/14 and concluded on 04/25/14. The allegation was substantiated and deficient practice was identified and cited.	F 000	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies dated 4/25/2014. 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.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure services were provided in accordance with each resident's Comprehensive Care Plan (CCP) for one (1) of twelve (12) sampled residents, Resident #6. Resident #6's CCP indicated he/she was to be weighed daily; however, there was no documented evidence the weight was obtained on nineteen (19) days in March and April of 2014. In addition, Resident #6's CCP was not followed on 04/25/14 when staff failed to use the Hoyer Lift (a sling device used to move residents from one resting place to another) to transfer the resident to the shower chair. The findings include:	F 282	RECEIVED MAY 19 2014 It is the policy of Richmond Rehabilitation and Health Center that the services provided or arranged by the facility are in accordance with each resident's written plan of care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beverly Dickerson
TITLE: Administrator
(X6) DATE: 5-19-14

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.

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F 282	Continued From page 1 Interview with the Administrator, on 04/24/13 at 4:50 PM, revealed there was not a specific facility policy for obtaining and/or documentation of daily weights. Continued interview revealed there was not a policy that addressed facility staff following the CCP. She stated it fell under the scope of accepted Nursing Practice. She stated her expectation was for staff to follow each resident's CCP. Review of the clinical record revealed the facility admitted Resident #6 on 10/19/12 with diagnoses which included Congestive Heart Failure, Alzheimer's Disease, Anxiety, Depression, Arthritis and General Debility. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/07/14, revealed the facility assessed Resident #6 as having a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), which indicated the resident was moderately impaired in cognitive function. Review of the CCP, revised 03/16/14, revealed Resident #6 was to be transferred using the mechanical lift and (2) staff assistance. Continued review of the CCP revealed he/she was to be a daily weight. Review of the State Registered Nurse Aide (SRNA) Care Plan Record indicated Resident #6 was to be transferred using the mechanical lift and assist of (2). Continued review did not indicate the resident required a daily weight. 1. Interview with Resident #6's daily sitter, during the initial tour on 04/22/14 at 1:40 PM, revealed she had observed staff in the past to transfer	F 282	Resident #6 was reweighed on 4/25/14 and reassessed by the Unit Coordinator (Licensed Practical Nurse) with no injuries noted. The physician was notified on 4/25/14 by the Unit Coordinator regarding the resident's weight and regarding assistive devices not utilized per the plan of care for resident #6 with no new orders noted. The weights for all residents requiring daily weights were reassessed by each Unit Coordinator (1 RN, 2 LPN's) and reweighed and reassessed prior to 4/29/14. The Assistant Director of Nursing, Director of Nursing, and 3 Unit Coordinators will audit all care plans related to transfers to verify they are appropriate and assistive devices are utilized per the plan of care by May 23, 2014 and update as needed. On 4/28/14, the Director of Nursing re-inserviced the 3 Unit Coordinators and the Assistant Director of Nursing regarding the community's policies relating to care and services including following physicians orders for daily weights, and transferring each patient per care plan. All direct care staff	

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F 282	Continued From page 2 him/her without using the Hoyer Lift. Subsequent interview, on 04/25/14 at 12:15 PM, revealed staff had not used the mechanical lift to transfer Resident #6 into a shower chair earlier that day. Interview with SRNA #24, on 04/25/14 at 2:50 PM, revealed she had not used the mechanical lift to transfer Resident #6 to the shower chair that morning. She stated she failed to bring the shower chair lift pad with her and did not go to obtain one before the transfer. Continued interview revealed she should have used the mechanical lift because Resident #6 was care planned to require the lift. Interview with Licensed Practical Nurse (LPN) #1, on 04/25/14 at 3:28 PM, revealed she had entered Resident #6's room to administer a medication, noticed he/she was in the shower and asked SRNA #24 if the Hoyer Lift had been used to transfer the resident. She stated SRNA #24 responded that she had done a "2 man transfer", indicating the lift had not been used. Continued interview revealed she had notified the Unit Coordinator and stated her expectation was for staff to use the lift if the resident was care planned to require the lift. Interview with LPN #3, Unit Coordinator, on 04/25/14 at 3:28 PM, revealed her expectation was for staff to follow each resident's CCP. 2. Review of Resident #6's Medication Administration Record (MAR) for March and April 2014 revealed a total of nineteen (19) dates without a documented weight. Those dates included: March 6,9,11,15,18,19,23,24,28,29 and April 2,3,6,9,12,15,16,17,22.	F 282	(Registered Nurses, Licensed Practical Nurses, and Nurse Aides) will be re-inserviced on the community's policies relating to care and services including following physicians orders for daily weights, and transferring each patient per the plan of care and utilizing the appropriate assistive devises by the Director of Nursing, the Assistant Director of Nursing, and/or the 3 Unit Coordinators by June 6, 2014. Daily weights in six (6) charts per week will be audited weekly for six weeks and then monthly for three months for compliance by the Quality Assurance Nurse, the Assistant Director of Nursing, Evening / Weekend Supervisor and/or the Director of Nursing. Three (3) patient transfers will be observed during daily environmental rounds by the Director of Nursing, Assistant Director of Nursing, and/or Quality Assurance Nurse five days a week for four weeks and then again monthly for three months to verify appropriate transfers and assistive devices are utilized per the plan of care.	

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F 282	Continued From page 3 Interview with LPN #3, Unit Coordinator for North, on 04/25/13 at 5:10 PM, revealed the facility had identified the concern of undocumented weights on 04/10/14 and began in-servicing staff that day. However, after the in-service, there were five (5) dates (April 12th, 15th, 16th, 17th and 22nd) with no documented weights.	F 282	In addition, all Comprehensive Care Plans will be audited by the Director of Nursing or the Assistant Director of Nursing quarterly for one year to verify the services provided or arranged by the facility are in accordance with each resident's written plan of care.	
F 309 SS=E	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 each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, for two (2) of twelve (12) sampled residents (#1 and #7) and three unsampled residents (B,C and D). Record review revealed no documented evidence a pain assessment was completed each time pain medications were administered. The findings include: Review of the facility's policy titled "Pain Management", revised 03/01/2011, revealed the	F 309	The audits of daily weights, observation of patient transfers and the Comprehensive Care Plans will be forwarded to the Quality Assurance Committee, (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review to maintain compliance. Completion Date: June 6, 2014 It is the policy of Richmond Place Rehabilitation and Health Center to provide the necessary care to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	

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F 309	Continued From page 4 purpose of the Pain Assessment and Management Program was to provide a systematic assessment and objective measurement of the resident's pain level and effectiveness of pain relief medication. Continued review revealed when PRN (as needed) pain medications were administered, documentation on the back of the Medication Administration Record (MAR) or on the Pain Intervention Flow Sheet should reflect the location and intensity of the resident's pain, and the effectiveness of the medication. Further review revealed the resident's pain should be scored numerically before and after administration of the medication for a quantitative measurement of the resident's pain. 1. Clinical record review revealed Resident #7 was admitted by the facility on 03/26/14 with diagnoses which included Depression, Anxiety, and Hypertension. Continued review revealed Resident #7 was admitted to the facility for rehabilitation after a hospitalization and functional decline. Review of the Pain Evaluation, completed as part of the Admission Assessment on 03/26/14, revealed Resident #7 reported frequent back and bone pain with a score of 10 on a 1-10 scale, indicating the pain was severe in intensity. Review of the Physician's Order, dated 03/26/14, revealed Resident #1 was to receive Norco 5/325 mg. every eight (8) hours as needed. (Norco is a narcotic pain reliever.) Review of the Comprehensive Care Plan, effective date 04/03/14, revealed interventions for the problem of pain included the following:	F 309	On 4/28/14, a pain assessment and plan of care review was completed for resident #1, resident #7, and residents B, C and D. On 4/28/14, the physician was notified related to Pain Management for resident #1, #7, B, C, and D with no new orders noted. The Assistant Director of Nursing, Quality Assurance Nurse, and Unit Managers will review current MARS and Pain Intervention Flow Sheets for residents receiving PRN Pain medications to verify that a Pain Assessment is completed for each occurrence of PRN pain medication given per policy by May 23, 2014. The Minimum Data Set (MDS) Coordinators will review all care plans including those related to Pain Medication/ PRN Pain Medication and update as indicated by June 6, 2014. The three (3) Unit Coordinators, and Weekend/Evening Supervisor will be re-inserviced regarding the community's policies relating to care and services including the policy for Pain Management by the Assistant Director of Nursing and the Director of Nursing by June 6, 2014. Remaining care staff (Registered	

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F 309	Continued From page 5 "evaluate location, nature, intensity, and duration of pain". Review of the Controlled Drug Record (a document for accounting for narcotic medications) revealed the drug Norco was signed out for Resident #7 twelve (12) times between 04/01/14 and 04/20/14. Review of the back side of the MAR for April 2014, and the Pain Intervention Flow sheet for the same period, revealed a pain assessment was completed only twice, on 04/01/14 and 04/05/14. 2. Review of the clinical record revealed the facility admitted Resident #1 on 01/06/14 with diagnoses which included Osteoarthritis, Debility, Anxiety and Depression. Review of the Admission Minimum Data Set (MDS)Assessment, dated 01/17/14, revealed the facility assessed Resident #1 to have occasional pain with an intensity score of 6 on a scale of 1-10. Review of the Physician's Orders for 01/08/14 revealed Resident #1 was to receive Percocet 10/325 mg, one or two half tablets every eight (8) hours as needed for pain. (Percocet is a narcotic pain reliever.) Review of the Comprehensive Care Plan for Resident #1, dated 01/17/14, revealed the nurses were to evaluate the location, nature and intensity of Resident #1's pain, and they were to assess the effectiveness of the pain medication. Review of the Controlled Drug Record for March 2014 revealed Percocet was signed out for Resident #1 twenty-three (23) times between 03/14/14 and 03/24/14. Review of the back of the	F 309	Nurses, Licensed Practical Nurses, and Nurse Aides) will be re-inserviced on the community's policies relating to care and services including Pain Management and associated care plans by the Assistant Director of Nursing and/or the Director of Nursing and/or the Quality Assurance nurse and/or the Unit Manager by June 2, 2014. The three (3) MDS Coordinators will be re-inserviced by the Regional MDS Coordinator regarding the community's policy and procedures relating to the care planning process by June 6, 2014. MARS and the Pain Flow Sheets/Pain Assessments and protocol associated with the Pain Management policy will be audited (six (6) charts per week) weekly for six weeks and then monthly for three months for compliance by the Quality Assurance Nurse and the Assistant Director of Nursing. These audits will be forwarded to the Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review. Completion Date: June 6, 2014	

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F 309	Continued From page 6 MAR for March 2014, and the Pain Intervention Flow Sheet for the same period, revealed a pain assessment was completed and documented only seven (7) of the twenty-three (23) times the medication was administered. 3. Review of the Controlled Drug Record for April 2014 revealed Percocet 5/325 mg was signed out for Unsampled Resident B seven (7) times between 04/09/14 and 04/16/14. Review of the back of the MAR and the Pain Intervention Flow Sheet for the same period revealed no documented evidence a pain assessment was completed when the medication was administered. 4. Review of the Controlled Drug Record for April 2014 revealed Norco 5/235 mg was signed out for Unsampled Resident C twelve (12) times between 04/08/14 and 04/22/14. Review of the MAR and the Pain Intervention Flow Sheet for the same period revealed a pain assessment was completed and documented for four (4) of the twelve (12) doses administered. 5. Review of the Controlled Drug Record for April 2014 revealed Percocet 7.5/325 mg was signed out twelve (12) times, for Unsampled Resident D, between 04/19/14 and 04/22/14. Review of the MAR and the Pain Intervention Flow Sheet for the same period revealed only two (2) pain assessments were completed for the twelve (12) doses administered. Interview with Licensed Practical Nurse (LPN) #2, on 04/25/14 at 1:00 PM, revealed when narcotic pain medications were administered to a resident they were to be signed out on the Controlled Drug Record and documented on the MAR. She	F 309		

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F 309	Continued From page 7 stated the facility's protocol included the Pain Intervention Flow Sheet should be completed with each dose. Continued interview revealed documentation should include why the medication was given and how effective it was in controlling the resident's pain. LPN #2 acknowledged she was responsible for some of the missing documentation and had failed to document a pain assessment with every dose she had administered. She stated it was an oversight on her part and she just missed that step. Interview with Registered Nurse (RN) #4, on 04/25/14 at 1:06 PM, revealed she was the Rehabilitation Unit Director. She stated the protocol for administering pain medications was as follows: sign out the medication on the Controlled Drug Record; administer the medication; document on the MAR; document a pain assessment on the Pain Intervention Flow Sheet; and follow up with the resident to ensure the medication was effective. Continued interview revealed the nurses were not consistently following the protocol. Interview with the Director of Nursing (DON), on 04/25/14 at 3:00 PM, revealed a resident's pain was to be assessed and documented on the Pain Intervention Flow Sheet each time a PRN pain medication was administered. She stated the facility's protocol included the initial assessment and a follow-up assessment in order to track and evaluate the effectiveness of pain medications, to provide the best possible care for the residents. She further stated it was her expectation the protocol be followed; however, she acknowledged it was not being followed consistently.	F 309		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 8 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide adequate supervision and assistive devices to prevent accidents for one (1) of twelve (12) sampled residents, Resident #6. Resident #6 was assessed to be transferred by mechanical lift and extensive staff assistance of two (2); however, on 04/25/14 staff transferred without the mechanical lift. In addition, the facility failed to provide a safe environment when a tube of medicated arthritis cream for one (1) sampled resident (Resident #1), was left in another Unsampled resident's room. The findings include: 1. Review of facility's policy titled " Resident Safety and Accident Prevention-Accidents and Incidents- Investigating and Reporting", revised December 2011, revealed the policy failed to address transfer procedures or the use of assistive devices to prevent accidents.	F 323	It is the policy of Richmond Place Rehabilitation and Health Care Center to verify that the resident environment remains as fee of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident #6 was assessed by the Unit Coordinator (Licensed Practical Nurse) on 4/25/14 with no injuries noted. The physician was notified on 4/25/14 by the Unit Coordinator regarding assistive devices not utilized per the plan of care for resident #6 with no new orders noted. The Assistant Director of Nursing, Director of Nursing, and 3 Unit Coordinators will audit all care plans related to transfers to verify they are appropriate and are being followed per the physicians order by May 23, 2014 and update as needed. On 4/25/14, the two State Registered Nursing Assistant's (SRNA's) (SRNA #24 and one other) were re-inserviced by the Unit Coordinator	

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F 323	Continued From page 9 Interview with the Director of Nursing (DON), on 04/24/14 at 4:50 PM, revealed her expectation was for the facility to provided care and services to utilize assistive devices if a resident was assessed and care planned as requiring an assistive device. Review of the clinical record revealed the facility admitted Resident #6 on 10/19/12 with diagnoses which included Congestive Heart Failure, Alzheimer's Disease, Anxiety, Depression, Arthritis and General Debility. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/07/14, revealed the facility assessed Resident #6 as having a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), indicating the resident was moderately impaired in cognition. Continued review revealed Resident #6 was assessed to need extensive assist of (2) staff for transfers. Review of the quarterly Fall Risk evaluations from 01/15/13 through 03/07/14, revealed Resident #6 maintained a constant fall risk score of "14", indicating the resident was assessed as high risk for falls. Additionally, review of the Physician's orders for April 2014 indicated Resident #6 was to be transferred with a mechanical lift and assist of (2) staff, related to the non-weight bearing status of Resident #6. Interview with Resident #6's daily sitter, during initial tour on 04/22/14 at 1:40 PM, revealed she had observed staff to transfer the resident in the past without using the mechanical lift. An additional interview, on 04/25/14 at 12:15 PM, revealed staff had not used the mechanical lift to transfer Resident #6 into a shower chair that morning.	F 323	and the Assistant Director of Nursing regarding transfer procedures and use of assistive devices relating to resident #6. On 4/28/14, the Director of Nursing re-inserviced the 3 Unit Coordinators and the Assistant Director of Nursing regarding the community's policies relating to Resident Safety and Accident Prevention and the expectation for the facility to utilize assistive devices and transfer techniques per the resident plan of care. Direct care staff (Registered Nurses, Licensed Practical Nurses, and Nurse Aides) will be re-inserviced on the community's policies relating to Resident Safety and Accident Prevention including following, and transferring each patient per care and utilization of assistive devices by the Director of Nursing, the Assistant Director of Nursing, and/or the 3 Unit Coordinators by June 6, 2014. Three (3) patient transfers will be observed during daily environmental rounds by the Director of Nursing, Assistant Director of Nursing, and/or Quality Assurance Nurse five days a	

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	185463		C 04/25/2014

NAME OF PROVIDER OR SUPPLIER: RICHMOND PLACE REHABILITATION AND HEALTH CENTER

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F 323	Continued From page 10 Interview, on 04/25/14 at 2:50 PM with State Registered Nursing Assistant (SRNA) #24, revealed she had not used the mechanical lift to transfer Resident #6 to the shower chair that morning. She stated she failed to bring the shower chair lift pad with her and did not go get one before the transfer. Continued interview revealed she should have used the mechanical lift because Resident #6 was assessed and care planned to require a mechanical lift for transfers. Interview with Licensed Practical Nurse (LPN) #1, on 04/25/14 at 3:28 PM, revealed she entered Resident #6's room to administer a medication, and noticed the resident was in the shower. She stated she asked SRNA #24 if the mechanical lift had been used to transfer the resident. Continued interview revealed SRNA #24 responded that she and another SRNA had done a "2 man transfer", without the use of the mechancial lift. Continued interview revealed it was her expectation for staff to use the lift if the care plan indicated it. She further stated she notified the Unit Coordinator of the incident. Interview with LPN #3, Unit Coordinator, on 04/25/14 at 3:28 PM, revealed it was her expectation was for staff to perform transfers according to each resident's assessment and CCP in order to prevent accidents. 2. Observation during the initial tour, on 04/22/14 at 1:17 PM, revealed a tube of medicated arthritis cream prescribed and labeled for Resident #1 was sitting on the room divider in an Unsampled resident's room, Room 203. Interview with LPN #1, on 04/22/14 at 4:05 PM,	F 323	week for four weeks and then again monthly for three months to ensure the care plan is followed and assistive devices utilized per the plan of care. In addition, all Comprehensive Care Plans will be audited by the Director of Nursing or the Assistant Director of Nursing quarterly for one year to verify the services provided or arranged by the facility are in accordance with each resident's written plan of care. The observation of patient transfers and the Comprehensive Care Plans will be forwarded to the Quality Assurance Committee, (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review to maintain compliance. Completion Date: June 6, 2014	

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F 323	Continued From page 11 revealed she was going to Resident #1's room to apply the cream when she stopped to answer the call light in Room 203 and layed Resident #1's cream on the room divider. Further interview revealed she should not have left the cream in the room because it was a safety hazard for residents. Interview with the DON, on 04/24/14 at 4:50 PM, revealed all medications should be secured at all times.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure each resident was provided sufficient fluid intake to maintain proper hydration and health for one (1) of twelve (12) sampled residents. Observation revealed Resident #12 did not take any fluids with the noon meal on 04/22/14, and had no water or other fluids available in his/her room. Staff did not notice the resident had no fluid intake with the meal, and were not aware there was no water pitcher in the room. In addition, there was no documented evidence the resident was assessed for beverage preferences. The findings include:	F 327	It is the policy of Richmond Place Health and Rehabilitation Center to provide each resident with sufficient fluid intake to maintain proper hydration and health. Resident #12 was provided additional fluids on 4/22/14 via a water pitcher replacement by the State Registered Nursing Assistant. On 4/22/14 the Unit Coordinator, LPN assessed Resident #12 with no signs of dehydration noted. The Unit Coordinator (LPN) notified the Consulting Registered Dietician on 4/22/14 with new recommendations noted. The Certified Dietary Manager completed a dietary interview related to beverage and meal preference for Resident #12 on 4/22/14 and updated beverage and food preferences were noted.	

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F 327	Continued From page 12 Review of the facility's policy titled "Hydration Protocol", updated 10/2012, revealed it was the facility's policy that each resident be provided sufficient fluid intake to maintain hydration and health. Continued review revealed the facility would obtain beverage preferences from the resident and serve those beverages as permitted by the resident's diet orders. In addition, if a resident refused the liquids offered, other beverages or foods with high fluid content were to be offered. Observation during the initial tour, on 04/22/14 at 1:10 PM, revealed Resident #12 was lying in bed. The resident's lunch tray was on the overbed table and had been pushed away from the bed. Continued observation of the tray revealed the resident had eaten 100% of the meal; however, a cup of tea and a cup of milk were untouched. No other fluids were present on the tray. Further observation of the room revealed no evidence of a water pitcher, cup or any other accessible fluids. Interview with Resident #12, at the time of the observation, revealed the resident did not drink milk due to being lactose intolerant. In addition, the resident reported he/she did not like unsweetened iced tea because you couldn't get sugar to dissolve in it. The resident stated sometimes the facility served soda, juice or coffee and he would drink those fluids. Review of the tray ticket revealed no indication the resident was lactose intolerant and no notation regarding beverage preferences. Continued interview revealed the resident did not have a water pitcher or other accessible source of fluids in his/her room. The resident stated he/she arrived at the	F 327	SRNA #15 and #2 were educated by the Director of Nursing on 4/22/14 regarding the necessity of accurate documentation of meal consumption. On 4/22/14 all resident water pitchers were audited by the three (3) Unit Coordinators to verify that each resident had a water pitcher available and within reach as appropriate. All resident charts and diet cards were audited by May 23, 2014 by the Certified Dietary Manager to verify that beverage and meal preferences are updated based on the current quarterly and admission/readmission interviews. A "Fluid Intake Addendum" (see attached) has been added to the Hydration Protocols indicating the following: Intake will be tracked using an electronic tracking system to include fluids consumed during meals and snacks for all residents. Fluid intake will be monitored daily for all residents. Poor consumption will be noted and a nurse assessment will be initiated to assess for signs and symptoms of dehydration. The results will be reported to the Registered Dietician and/or the physician as clinically appropriate.	

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F 327	Continued From page 13 facility on Friday (04/18/14) and had not had a water jug since admission. The resident denied any recollection of being asked about beverage preferences. Observation, on 04/22/14 at 1:20 PM, revealed a staff member entered Resident #12's room and picked up the meal tray. The staff did not lift the lid to see how much the resident consumed, nor lift the lidded drinks to see if the resident drank anything. Continued observation revealed the staff member carried the tray into the hall, placed it on the tray cart and walked away. Review of the clinical record revealed the facility admitted Resident #12 on 04/18/14 with diagnoses which included Hypertension, Hyperlipidemia, and Anemia. Continued review revealed the resident was admitted for rehabilitation after undergoing back surgery with a resultant functional decline. Interview with State Registered Nurse Aide (SRNA) #15, on 04/22/14 at 1:48 PM, revealed she was not assigned to care for Resident #12 that day, but was assisting to pick up meal trays. She stated the SRNAs were to document meal consumption for each resident at every meal. She further stated if the SRNA who picked up the tray did not document the resident's intake, they should tell the SRNA assigned to the resident so they could document it. Continued interview revealed she did not observe Resident #12's tray for consumption of food or fluids for the noon meal and had no idea how much or how little the resident ate or drank. Interview with SRNA #2, on 04/22/14 at 1:55 PM, revealed she was assigned to care for Resident	F 327	The Director of Nursing re-inserviced the 3 Unit Coordinators, Assistant Director of Nursing, and Evening/Weekend Supervisor regarding the Hydration Protocols including the Guidelines for documenting Meal Consumption as well as the added Fluid Intake Addendum and the necessity of water at bedside as appropriate on May 23, 2014. Direct care staff (Registered Nurses, Licensed Practical Nurses, and Nurse Aides) will be re-inserviced on the community's policies relating to the Hydration Protocols including the Guidelines for Percentage of Meal as well as the added Fluid Intake Addendum and the necessity of water at bedside as appropriate by June 6, 2014. The Registered Dietician has re-inserviced the Certified Dietary Manager and the Kitchen Manager on the community's Hydration Protocol including completing the Beverage Preferences interview within 72 hours of admission, readmission and quarterly on April 24, 2014.	

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F 327	Continued From page 14 #12 that day. She stated the aides were to document meal intake for every meal, but did not document how much fluid was consumed. Continued interview revealed every resident should have a water pitcher. She further stated she thought she saw one in Resident #12's room earlier in the day, but she did not know what happened to it. Interview with Licensed Practical Nurse (LPN) #3, on 04/22/14 at 2:00 PM, revealed she did not know Resident #12 did not have a water pitcher. She stated it could have been in the kitchen for washing. She further stated the resident should have a Styrofoam cup for water if that was the case. Further interview revealed fluids were provided through the dietary department based on the recommended daily fluid requirements for each resident. She stated the SRNAs were not responsible for counting or documenting the amount of fluids consumed, but should let the nurse know if a resident was not drinking. Review of the medical record with LPN #3 revealed the Admission Nursing Evaluation was completed, with "no" recorded under the section related to food allergies. Continued review revealed no documented evidence the resident informed the facility of being lactose intolerant. Interview with the Administrator, on 04/23/14 at 4:10 PM, revealed there was not a facility process for recording fluid consumption unless it was ordered by the physician. Interview with the Director of Nursing (DON), on 04/25/14 at 3:00 PM, revealed the dietary department assessed each resident's daily fluid needs and provided that amount on the meal trays. She stated the facility did not document the	F 327	The 3 Unit Coordinators, and Evening/ Weekend Supervisor will review all fluid intake entered into the electronic tool daily on an ongoing basis to verify adequate fluid intake and initiate the nursing assessment/intervention as needed. The 3 Unit Managers will audit all Admissions and Readmissions to verify that beverage and meal preferences are noted for six weeks and quarterly thereafter. The 3 Unit Coordinator, Director of Nursing, Assistant Director of Nursing, and Evening/Weekend Supervisors will audit during daily rounds to verify that water pitchers are present and that fresh water is provided shiftly on the Environmental Rounds Checklist (see attached). The results of all audits and the Environmental Rounds will be forwarded to the Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review to maintain compliance. Completion Date: June 6, 2014	

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F 327	Continued From page 15 amount of fluid consumption. She further stated water should be passed every shift, although it was not a formal policy. Continued interview revealed when water pitchers were collected for washing, they should be changed out with a clean pitcher at that time. Interview with LPN #7, on 04/25/14 at 5:00 PM, revealed when a new resident was admitted, nursing staff filled out the Diet Order and Communication slip, based on the initial assessment and the Physician's orders. She stated the slip was co-signed by the dietary manager, who was to follow up with the resident related to dietary preferences, e.g. likes and dislikes. Review of the Diet Order and Communication slip with LPN #7 revealed it had been completed related to the resident's diet order and was co-signed by the dietary manager; however, there was no documented evidence an assessment for beverage preferences or special requests had been completed. Continued interview revealed the facility did not have a tool for assessing hydration status. LPN #7 stated the SRNAs should let the nurse know if the resident wasn't drinking or had decreased urine output, which could be a sign of dehydration. Further interview, and review of the Skilled Nurses Notes daily flow sheet, revealed other indicators of a resident's hydration status, e.g. an assessment of skin turgor (elasticity) and moistness of the mucous membranes, were not included as part of the daily nursing assessment. (Persons with poor hydration may exhibit poor skin turgor and dry mucous membranes.) LPN #7 stated she probably would not assess a resident's skin turgor unless she was alerted of a possible problem by another means.	F 327		

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F 327	Continued From page 16 An attempt to interview the dietary manager, who had left the facility for the day, was unsuccessful. The dietary manager could not be reached by phone.	F 327		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain complete and accurately documented clinical records in accordance with accepted professional standards and practices for one (1) of twelve (12) sampled residents and one unsampled resident. Review of the Medication Administration Records (MARs) for Resident #7 and Resident E revealed they were incompletely documented. The findings include:	F 514	It is the policy of Richmond Rehabilitation and Health Center to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. On 4/25/14, the Unit Manager notified the physician regarding missing documentation of medications for resident #7 and resident E with no new orders noted. The Assistant Director of Nursing, Quality Assurance Nurse, and Unit Managers will audit current Medication Administration Records (MARS) for all residents and the results will be forwarded to the Medical Director for review by May 23, 2014.	

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F 514	Continued From page 17 Review of the facility's policy titled "Charting and Documentation", revised April 2007, revealed all services provided to the resident were to be documented in the resident's medical record. Continued review revealed services provided included all medications administered, and must be documented. Review of the facility's policy titled "Documentation of Medication Administration", revised April 2007, revealed the facility was to maintain a medication administration record to document all medications administered. Continued review revealed minimum documentation requirements included the date and time of administration, a reason why if any medication was withheld, not administered, or refused by the resident, and a signature and title of the person administering the medication. 1. Review of the medical record revealed Resident #7 was admitted by the facility on 03/26/14 with diagnoses which included Depression, Anxiety, and Hypertension. Continued review revealed Resident #7 was admitted to the facility for rehabilitation after a hospitalization and functional decline. Review of the Medication Administration Record (MAR) for Resident #7 revealed multiple instances between 04/01/14 and 04/22/14 of a failure to document scheduled medications as being administered. Continued review revealed no documented evidence why the medications may not have been administered. Missing documentation included the following medications: two (2) Synthroid 112 mcg; three (3) Lisinopril 2.5 mg; two (2) Megestrol 40 mg; two (2) Symbicort inhalers; four (4) Metoprolol 25 mg;	F 514	The 3 Unit Coordinators and Assistant Director of Nursing were re-inserviced regarding the community's policies relating to Charting and Documentation including complete documentation on the MAR by the Director of Nursing on April 28, 2014. Remaining nursing staff (Weekend/Evening Supervisor, Registered Nurses, Licensed Practical Nurses, and Certified Medication Aides) will be re-inserviced on the community's policies relating to Charting and Documentation including complete documentation on the MAR by the Assistant Director of Nursing and/or the Director of Nursing and/or the Quality Assurance nurse and/or the Unit Manager by June 6, 2014. MARS will be audited to verify documentation is complete each shift as part of change of shift by the oncoming nurse for six months. The Unit Managers and/or Evening/Weekend Supervisor will audit six MARS daily for six weeks and then monthly for three months for compliance by the Quality	

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F 514	Continued From page 18 four (4) Zofran 4 mg; one (1) Protonix 40 mg; five (5) Probiotic capsules; and eight (8) Multiple Vitamins. 2. Review of the Admission Face Sheet revealed the facility admitted Resident E on 03/18/14 with diagnoses which included Debility, End Stage Renal Disease, Anemia, Diabetes, Hypertension, Anxiety and Depression. Review of the MAR for Unsampled Resident E revealed the following medication doses were not documented as being given: four (4) Norvasc 5 mg; two (2) aspirin 81 mg; and two (2) Nephrovite. Continued review revealed no documented evidence the doses were held by the nurse for any reason, or refused by the resident. Interview with Licensed Practical Nurse (LPN) #3, on 04/25/14 at 1:20 PM, revealed when the MARs were not documented completely and accurately, there was the potential scheduled medications were not given, with a resultant increased risk to the resident for health status changes. Interview with the Director of Nursing, on 04/25/14 at 3:00 PM, revealed nurses were supposed to check their MARs at the end of each shift to ensure all medications had been given and documented. She acknowledged, based on the examples cited, these checks had not been effective. She stated more education and auditing was indicated to correct the deficiency.	F 514	Assurance Nurse and the Assistant Director of Nursing. These audits will be forwarded to the Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review. Completion Date: June 6, 2014	