

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

PRINTED: 03/20/2015
FORM APPROVED
OMB NO. 0938-0391

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| 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 03/09/2015 |
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| NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER | 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} | <p>INITIAL COMMENTS</p> <p>Based on the facility's acceptable plan of correction, the facility was deemed to be in compliance on 02/28/15 as alleged.</p> | {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 An Abbreviated Survey, investigating KY00022768 and KY00022723, was initiated on 02/03/15 and concluded on 02/05/15. KY00022768 was unsubstantiated with no deficiencies cited. KY00022723 was substantiated with deficiencies cited. | F 000 | I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies dated 2/18/2015. 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. | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to revise the Comprehensive Care Plan for one (1) of four (4) | F 280 | It is the policy of Richmond Place Rehabilitation and Health Center that the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. It is also our policy that a comprehensive care plan must be developed within 7 days after the completion of the | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Berita Dickerson</i> | TITLE Administrator | (X6) DATE 3-6-15 |
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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 280 | Continued From page 1 sampled residents (Resident #1). Resident #1 had a Comprehensive Care Plan for dehydration, which was updated on 11/26/14 after a quarterly review. On 01/20/15, Resident #1 had an order for Intravenous (IV) fluids to be started; however review of the care plan revealed no documented evidence the care plan was revised. IV fluids were not started due to staff being unable to start the IV. The Advance Registered Nurse practitioner (ARNP) was notified and new orders were received to encourage oral (PO) intake and repeat Comprehensive metabolic Pane (CMP) on 1/22/15; however the facility failed to ensure the care plan was revised with the new interventions pertaining to dehydration for this time period. The finding include: Review of Resident #1's medical record revealed that facility admitted the resident on 10/19/12 with diagnoses which included Diabetes Mellitus Type II, Congestive Heart Failure, Dementia without behaviors, Dysphagia, Depression, and Alzheimer's. Review of the Quarterly Minimum Data Set (MDS) dated 11/14/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of a three (3) out of fifteen (15) which indicated severe cognitive impairment. Review of Comprehensive Plan of Care with an onset date of 08/26/14, revealed Resident #1 was at risk for dehydration related to use of Diuretic and history of poor PO intake. The goal stated that diuresis would be achieved with no signs or symptoms of dehydration over the next 90 days. Interventions include administering medication as | F 280 | comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs and to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. On 2/6/15, the care plan for resident # 1 was reviewed and revised by Unit Coordinator (LPN#2) to reflect the resident's physician orders, interventions, and changes in condition. Care Plans were audited for all residents by the 3 MDS Coordinators, RN's, and 3 Unit Coordinators (1 RN, 2 LPN's) for accuracy of care plans related to changes in condition including new physician orders by 2/28/15. | |

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| F 280 | <p>Continued From page 2</p> <p>ordered, looking for signs of dehydration and electrolyte imbalance (dry tongue/lips, dizziness upon standing, muscle cramping), encourage PO fluids, weigh resident as directed, and monitor labs as ordered.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 02/05/15 at 3:18 PM, revealed that she received a verbal order on 01/20/15 to start IV fluids on 01/20/15 for Resident #1 from the Advanced Registered Nurse Practitioner (ARNP). She stated it was a "hectic day" and the LPN/ Unit Coordinator (LPN #2) was supposed to write the order for LPN #1. LPN #1 stated Resident #1 was really dehydrated with elevated labs. LPN #1 stated she attempted to start the IV without success. She stated LPN #2 called the ARNP to report the IV could not be started and a new order was obtained to encourage PO fluids and hold the diuretic; however, continued review of the care plan revealed no documented evidence the care plan was revised to include the new orders or interventions.</p> <p>Interview with LPN #2/Unit Coordinator on 02/05/15 at 3:05 PM, revealed that LPN #1 on 01/20/15 was unable to start the IV and she attempted one time without success. She stated the care plan should have been revised with any new orders.</p> <p>Interview with RN #2/ADON, on 02/05/15 at 3:55 PM, revealed Resident #1's care plan should have been revised.</p> <p>Interview with RN #3/ MDS Coordinator on 02/05/15 at 6:50 PM, revealed the nurse who got the order should have update the short term care plan.</p> | F 280 | <p>On 2/11/15, the Interim Director of Nursing re-inserviced the Interdisciplinary Care Plan Team including 3 Unit Coordinators, Assistant Director of Nursing, 3 MDS Coordinators and Dietary Manager regarding the community's policies relating to change of condition as well as the Care Plans Comprehensive Policy including timely updating of care plans to reflect physician orders as appropriate.</p> <p>Direct care staff (Registered Nurses, Licensed Practical Nurses, and Nurse Aides) will be re-inserviced by the 3 Unit Managers (1 RN, 2 LPN), Assistant Director of Nursing (RN) and QA Nurse (LPN) regarding the community's policies relating to change of condition as well as the Care Plans Comprehensive Policies including timely updating and development of care plans including physician orders by 2/28/15.</p> | |
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| F 309 SS=D | 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 the facility's policy, it was determined the facility failed to assure orders received for residents were reduced to writing for one (1) of four (4) sampled residents (Resident #1). On 01/20/15, Resident #1 had an order for Intravenous (IV) fluids to be started and staff failed to document order on the medical record. IV fluids were not started due to staff being unable to start the IV. The Advanced Registered Nurse Practitioner (ARNP) was notified on 1/20/15 with new A order written to encourage PO intake and to repeat Comprehensive Metabolic Panel (CMP) on 1/22/15 and discontinue Zaroxolyn 2.5 mg daily. The finding include: Review of the facility's policy titled, "Telephone Orders", dated 12/2008, revealed the order must be received by licensed personnel and must be reduced in writing by the person receiving the order, and recorded in the resident's medical record. The entry must contain the instructions | F 309 | The Interdisciplinary Care Plan Team including the Interim Director of Nursing, RN, Assistant Director of Nursing RN, 3 Unit Coordinators (1 RN, 2LPN), the Director Manger, and MDS Coordinators will audit a minimum of 6 charts for each unit weekly for 6 weeks for changes of condition including updating and revising care plans relating to new physician orders as appropriate. The audits of care plans relating to changes in condition including new physician orders as appropriate 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: February 28, 2015 It is the policy of Richmond Rehabilitation and Health Center that 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 | |

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| F 309 | <p>Continued From page 4</p> <p>from the physician, date, time, and the signature and title of the person transcribing the information. The policy also stated the order must be countersigned by the Physician during his or her next visit.</p> <p>Review of Resident #1's medical record revealed that facility admitted the resident on 10/19/12 with diagnoses which included Diabetes Mellitus Type II, Congestive Heart Failure, Dementia without behaviors, Dysphagia, Depression, and Alzheimer's. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/14/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) out of fifteen (15) which indicated severe cognitive impaired.</p> <p>Review of the Comprehensive Plan of Care with an onset date of 08/26/14, revealed Resident #1 was at risk for dehydration related to use of Diuretic and history of poor oral (PO) intake. The goal stated that diuresis would be achieved with no signs or symptoms of dehydration over the next 90 days. The revised goal was dated 03/02/15. Interventions include administering medication as ordered, looking for signs of dehydration and electrolyte imbalance (dry tongue/lips, dizziness upon standing, muscle cramping), encourage PO fluids, weigh resident as directed, and monitor labs as ordered.</p> <p>Interview with Registered Nurse (RN) #1 on 02/05/15 at 2:45 PM, revealed that she was aware of an order to start IV fluids on 01/20/15; however, she was not working the day the order was taken. She did however, remember the Licensed Practical Nurse (LPN), LPN #1, that was taking care of Resident #1 on 01/20/15.</p> | F 309 | <p>comprehensive assessment and plan of care.</p> <p>On 2/06/15, the care plan for resident # 1 was revised by Unit Coordinator (LPN #2), to reflect the resident's physician orders, interventions, and changes in condition. On 2/06/15, Unit Coordinator (LPN #2) updated the clinical record to reflect the resident's physician orders, interventions, and changes in condition for resident #1.</p> <p>Care Plans were audited for all residents by the 3 MDS Coordinators, RN's, and 3 Unit Coordinators (1 RN, 2 LPN's) for accuracy of care plans related to changes in condition including physician orders and interventions by 2/28/15.</p> <p>On 2/11/15, the Interim Director of Nursing re-inserviced the Interdisciplinary Care Plan Team including 3 Unit Coordinators, Assistant Director of Nursing, 3 MDS Coordinators and Dietary Manager regarding the community's policies relating to changes of condition and the Care Plan</p> | | |

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| F 309 | Continued From page 5 Interview with Licensed Practical Nurse (LPN) #1 on 02/05/15 at 3:18 PM, revealed that she did receive a verbal order on 01/20/15 to start IV fluids for Resident #1 on 01/20/15 from the Advanced Registered Nurse Practitioner (ARNP). She stated it was a "hectic day" and the LPN/ Unit Coordinator (LPN #2) was supposed to write the order for LPN #1. LPN #1 stated Resident #1 was "really dehydrated with elevated labs". LPN #1 stated she attempted to start the IV and was unable to get it started. LPN #1 stated the protocol for writing verbal or telephone orders was the order should have been written immediately. She stated LPN #2 called the ARNP to report the IV could not be started and a new order was obtained to encourage PO fluids. Interview with LPN #2/ Unit Coordinator on 02/05/15 at 3:05 PM revealed LPN #1 was unable to start the IV on 01/20/15 after attempting one time. LPN #2 also stated she should have made an entry that she was unsuccessful when attempting to start the IV. Review of the medical record revealed no order pertaining to IV fluids or that IV sticks were attempted and unsuccessful. LPN #1 stated there should have been an order and documentation that the IV was not started. Interview with RN #2/ADON on 02/05/15 at 3:55 PM, revealed the facility's procedure was the nurse should talk to the MD or ARNP, fax the order to pharmacy, and then notify the Power of Attorney (POA)/family. She stated whoever took the order should have written it. She further stated her expectation of the nursing staff in regard to writing orders was, they should be completed timely and filled out completely. She stated it was not standard procedure for someone | F 309 | Comprehensive Policy including timely updating and development of care plans and documentation of physician orders by 2/28/15. Direct care staff (Registered Nurse, Licensed Practical Nurses, and Nurse Aides) will be re-inserviced by the 3 Unit Managers (1 RN, 2 LPN), Assistant Director of Nursing (RN) and QA Nurse (LPN) regarding the community's policies relating to changes of condition and the Care Plan Comprehensive Policy including timely updating and development of care plans and documentation of physician orders by 2/28/15. The Interdisciplinary Care Plan Team including the Interim Director of Nursing, RN, Assistant Director of Nursing RN, 3 Unit Coordinators (1 RN, 2LPN), the Director Manger, and MDS Coordinators will audit a minimum of 6 clinical records for each unit weekly for 6 weeks for changes of condition including updating care plans and ensuring documentation including physician telephone orders and appropriate documentation of assessments and | | |

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| F 309 | Continued From page 6 to write an order who did not talk to the Physician or ARNP and she replied that she would not write an order that she didn't take. She stated the facility's procedure for monitoring, assessing, and documenting for a change of status, including a change of condition would be to follow up with Nurses Notes and with 72 hour follow up/charting. She continued by stating the nurses should have documented signs and symptoms of dehydration were assessed such as skin turgor; however, review of the Nurses Notes revealed no documented evidence of charting to reflect the monitoring of hydration. | F 309 | interventions. The audits of care plans and the clinical record relating to changes in condition and physician telephone orders an orders 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. | | |
| 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 interview, record review and review of the facility's policy, it was determined the facility failed to maintain accurate documentation in the | F 514 | Completed date: February 28, 2015 It is the policy of Richmond Place Rehabilitation and Healthcare 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 2/06/15, the care plan for resident # 1 was revised by Unit Coordinator (LPN #2), to reflect the resident's physician orders, interventions, and changes in condition. On 2/06/15, Unit Coordinator (LPN #2) updated the clinical record to reflect the resident's physician orders, | | |

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| F 514 | Continued From page 7 medical record for one (1) of four (4) sampled residents (Resident #1). Resident #1 had an order on 01/20/15 for intravenous (IV) fluids to be started which was not written in the medical record, documented in the nurses notes. The IV fluids were not started due to staff being unable to start an IV and the APRN was notified that IV was unable to be started and new orders were written to encourage oral (PO) intake and repeat the comprehensive Metabolic Panel (CMP) on 1/22/15 and to discontinue Zaroxolyn (diuretic) 2.5 mg daily; however, the facility failed to document this in the clinical record. The finding include: Review of the facility's policy titled, "Skilled Documentation", dated 02/2006 revealed all services provided to the resident, or any Clinical Status changes in the resident's condition should be documented in the resident's medical record. The policy further revealed documentation should occur every shift for a minimum of 72 hours for all clinical status changes including new Physician's orders. Review of Resident #1's medical record revealed that facility admitted resident 10/19/12 with diagnoses which included Diabetes Mellitus Type II, Congestive Heart Failure, Dementia without behaviors, Dysphagia, Depression, and Alzheimer's. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/14/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) out of fifteen (15) which indicated severe cognitive impairment. | F 514 | interventions, and changes in condition for resident #1. Care Plans will be audited for all residents by the 3 MDS Coordinators, RN's, Dietary Manager and 3 Unit Coordinators (1 RN, 2 LPN's) for accuracy of care plans related to changes in condition including physician orders and interventions by 2/28/15. On 2/11/15, the Interim Director of Nursing re-inserviced the Interdisciplinary Care Plan Team including 3 Unit Coordinators, Assistant Director of Nursing, 3 MDS Coordinators and Dietary Manager regarding the community's policies relating to changes of condition and the Care Plan Comprehensive Policy including timely updating and development of care plans and documentation of physician orders by 2/28/15. Direct care staff (Registered Nurse, Licensed Practical Nurses, and Nurse Aides) will be re-inserviced by the 3 Unit Managers (1 RN, 2 LPN), Assistant Director of Nursing (RN) and QA Nurse (LPN) regarding the | | |

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| NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER | 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 514 | Continued From page 8 Interview with Licensed Practical Nurse (LPN) #1 on 02/05/15 at 3:18 PM, revealed that she received a verbal order on 01/20/15 to start Intravenous (IV) fluids on 01/20/15 from the Advanced Registered Nurse Practitioner (ARNP) for Resident #1 related to dehydration. She stated it was a "hectic day" and the LPN/Unit Coordinator (LPN #2) was supposed to write the order for LPN #1. LPN #1 stated Resident #1 was really dehydrated with elevated labs. LPN #1 attempted to start the IV without success. Interviewed LPN #1 revealed, as to the protocol for writing verbal or telephone orders was the order should have been written immediately. She stated LPN #2 called the ARNP that IV could not be started and a new order was obtained to encourage PO fluids. She stated neither LPN #1 or LPN #2 wrote the order in the medical record. Review of the record revealed no documented evidence the first order for the IV nor the second order for encourage PO fluids were in the record. Interview with LPN #2/ Unit Coordinator at 3:05 PM, on 02/05/15 revealed that LPN #1 on 01/20/15 was unable to start the IV and she attempted one time and was unable to start the IV. Review of the medical record revealed no order pertaining to IV fluids being ordered or that IV sticks were attempted. LPN #2/Unit Coordinator stated there should have been documentation of the orders in the medical record. LPN #2 also stated she should have made an entry that she was unable to start the IV. Interview with Registered Nurse (RN) #2/ADON on 02/05/15 at 3:55 PM, revealed the facility's policies and procedures were to document the orders in the medical record. She further stated | F 514 | community's policies relating to changes of condition and the Care Plan Comprehensive Policy including timely updating and development of care plans and documentation of physician orders by 2/28/15. The Interdisciplinary Care Plan Team including the Interim Director of Nursing, RN, Assistant Director of Nursing RN, 3 Unit Coordinators (1 RN, 2LPN), the Director Manger, and MDS Coordinators will audit a minimum of 6 clinical records for each unit weekly for 6 weeks for changes of condition including updating care plans and ensuring documentation including physician telephone orders and appropriate documentation of assessments and interventions. The audits of care plans and the clinical record relating to changes in condition and physician telephone orders an orders will be forwarded to the Quality Assurance Committee, (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and | |
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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: 185463 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/05/2015 |
| NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509 | | |
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| F 514 | Continued From page 9 her expectation of the nursing staff in regard to writing orders was, that they should be documented timely and filled out completely. | F 514 | Pharmacy Consultant) for review to maintain compliance. Completed date: February 28, 2015 | | |