

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

PRINTED: 01/30/2015
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 01/15/2015
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
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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 01/13/15 and concluded on 01/15/15. Deficiencies were cited with the highest Scope and Severity of an "F".

F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
SS=D

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

F 000 I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies dated 1/15/2015. 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.

F 157 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.

It is the policy of Richmond Rehabilitation and Health Center to inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a).

01-13-2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Benita Johnson, RNHA TITLE Administrator (X6) DATE 2/9/15

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

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F 157. Continued From page 1	<p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Physician was notified of a clinical change of status, change in skin condition, for two (2) of eighteen (18) sampled residents. Resident #6 was assessed by staff to have denuded areas to his/her buttocks and treatment provided; however, review of documentation and interview with staff revealed there was no evidence the Physician had been notified. Resident #3 had a skin assessment, on 01/07/15, and documented findings revealed a newly identified "hard knot area" was assessed on the right side of his/her buttock; however, documentation and interview revealed the Physician had not been made aware.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Clinical Status Change", revised 04/01/11, revealed when a resident was assessed and had a clinical status change, the licensed nurse was to document notification was made to the family/responsible party, other licensed nurses and the Physician to facility an appropriate plan of care. The policy revealed a significant clinical status change included a change in skin condition, color, and/or integrity. Further policy review revealed when a clinical status change was identified the licensed nurse was to call the physician, document the call in the nurse notes, obtain orders, and document the change on the facility's clinical status change/24 hour log.</p>	F 157	<p>The physician and responsible party was notified of resident #6 on 1/14/15 by Unit Manager #3, Registered Nurse, regarding the resident's skin condition with new orders noted. On 1/14/15, the care plan for resident #6 was revised by the MDS Coordinator, RN, to reflect the patient's skin assessment. The physician and responsible party was notified regarding Resident #3 on 1/16/15 by Unit #1, Licensed Practical Nurse of the resident's skin condition with no new orders noted.</p> <p>Skin assessments for all residents will be audited by 3 Unit Coordinator (1 RN, 2 LPN's) for notification of physician/family of any newly identified skin areas by 2/28/15.</p> <p>On 2/11/15, the Director of Nursing will re-inservice the 3 Unit Coordinators and the Assistant Director of Nursing regarding the community's policies relating to change of condition including changes in skin condition and proper notification of physician /family.</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 Quality Assurance ("QA") Nurse (LPN) regarding the community's policies relating to change of condition including changes in skin condition and proper notification of physician /family by 2/28/15.</p>	

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F 157 Continued From page 2

Resident #6 was identified to have denuded (excoriated) areas on the left and right buttocks by the nurse who performed the skin assessment for the surveyor on 01/14/15. Although staff interview, revealed these denuded areas to the buttocks were present during the last skin assessment on 01/12/15, there was no documented evidence the physician had been notified in order to obtain a treatment order for the areas.

1. Review of the clinical record revealed the facility admitted Resident #6 on 11/28/14 with diagnoses which included a Stage IV Pressure Ulcer to the Coccyx, and an Unstageable Pressure Ulcer to the Right Heel. Review of the Admission Minimum Data Set (MDS) Assessment dated 12/05/14, revealed the facility assessed Resident #6 as having a Brief Interview for Mental Status (BIMS) of a ten (10) out of fifteen (15) indicating moderate cognitive impairment.

Observation of a skin assessment for Resident #6 on 01/14/15 from 12:05 PM till 1:20 PM and 5:00 PM until 5:30 PM performed by Licensed Practical Nurse (LPN) #5 and LPN #6, revealed the resident had a red flat area with defined margins to the left buttocks measuring 1.3 centimeters (cm) L x 1.6 cm's W and a red flat area with defined margins to the right buttock measuring 2.1 cm L x 1.3 cm W which LPN #6 described as denuded. LPN #6 was observed to treat the denuded areas by cleansing the areas with Normal Saline and placing Aquacel over the areas.

Review of the "Non Pressure Skin Condition

F 157

The 3 Unit Coordinators (1 RN, 2LPN) will audit 6 skin assessments weekly for 6 weeks including physician and family notification of any newly identified skin areas.

The audits of skin assessments relating to physician/family notifications 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

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F 157 Continued From page 3

Record" revealed there was no documented evidence the resident had denuded areas to the left and right buttocks.

Review of the Physician's Orders dated January 2015 revealed there was no documented evidence of a treatment order for the denuded areas to the left and right buttocks.

Review of the Comprehensive Plan of Care dated 12/16/14, revealed the resident had impaired skin integrity related to the Stage IV area to the coccyx, an unstageable Pressure Ulcer to the right heel, and a venous ulcer to the right great toe with a goal that the ulcers would decrease with evidence of healing. However, there was no documented evidence the Care Plan was revised to indicate the resident had denuded areas to the buttocks with interventions to attempt to heal the areas and prevent other denuded areas from developing.

Interview, on 01/15/15 at 5:00 PM with Licensed Practical Nurse (LPN) #6, who performed the skin assessment on 01/14/15, revealed she had noted the denuded areas on the resident's buttocks just prior to the skin assessment observed by the surveyor and realized there was no treatment order in place for the areas. She further stated, she talked with the Unit Coordinator (UC) and was told to use Aquacel to the areas. LPN #6 confirmed there was no treatment order in place for the denuded areas to the buttocks at the time she was performing the treatment on 01/14/15.

Interview on 01/15/15 at 5:30 PM with the UC for the Rehabilitation Unit where Resident #6 resided, revealed if an area of skin breakdown was identified, the nurse was to report the area to

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F 157	<p>Continued From page 4</p> <p>the Physician in order to obtain a treatment. Continued interview revealed she had observed the denuded areas to the residents buttocks on 01/12/15 when she was completing the resident's skin assessment and felt it was irritation from the drape used for the wound vac on the coccyx wound. She stated at the time she did the skin assessment and dressing change on 01/12/14 she thought the Physician had already been notified and thought there was a treatment in place for Aquacel to the denuded areas. She stated she had not realized there was no treatment order in place for the denuded areas until yesterday.</p> <p>Interview, on 01/15/15 at 7:45 PM with the Director of Nursing (DON), revealed if a non pressure area of skin breakdown including denuded skin was noted, the nurse who found the area was to notify the Physician for treatment. She stated, there was room for education.</p> <p>Interview with the Attending Physician on 01/15/15 at 7:20 PM, revealed the Physician would need to be notified for denuded areas when they were found and if he had been notified he would have ordered Aquacel to the areas.</p> <p>Interview with the Administrator on 01/15/15 at 8:20 AM, revealed the physician was to be notified for any new areas of skin breakdown to obtain a treatment order.</p> <p>2. Review of Resident #3's medical record revealed the resident was admitted by the facility on 08/08/13 with diagnoses which included Hypertension, Non-Alzheimer's Dementia, Episodic Mood Disorder, and Depression. Review of the Quarterly Minimum Data Set, dated</p>	F 157	

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F 157	<p>Continued From page 5</p> <p>10/17/14, revealed the resident was assessed by the facility as severely cognitively impaired.</p> <p>Review of Resident #3's impaired skin integrity Care Plan revealed the resident was at risk due to decreased mobility and incontinence of bowel and bladder. Further review of the Care Plan revealed the interventions included assessing the skin for redness, skin tears, swelling and report any signs of skin breakdown.</p> <p>Observation, on 01/13/15 at 3:31 PM, of a skin assessment performed on Resident #3 revealed the resident had a newly identified open area to the right buttock, which was measured as 1.0 cm L by 0.6 cm W by 0.1 cm D.</p> <p>Interview, on 01/13/15 at 3:48 PM and on 01/14/15 at 10:49 AM, with LPN # 2/UC, who performed the observed skin assessment, revealed she was unaware of any open area/skin problems to the resident's right buttock prior to the skin assessment. LPN #2/UC revealed after the assessment she contacted the DON, Physician and Responsible Party regarding the area. LPN #2/UC revealed the area around the wound was hard and the DON, who assessed the site after being notified by the nurse, thought the open wound resulted from a cyst or ingrown hair at the site.</p> <p>Continued review of Resident #3's medical record revealed a weekly skin assessments done December 2014 had no skin problems identified to the right buttock; however, the 01/07/15 skin assessment described a "knot area trying to come out" to the resident's right buttock. Continued review of the medical record revealed no documentation the Physician was notified of</p>	F 157		
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F 157	<p>Continued From page 6 the skin condition change on 01/07/15.</p> <p>Telephone interview, on 01/14/15 at 7:01 AM, with Registered Nurse (RN) #1 revealed she had performed the skin assessment on 01/07/15 to Resident #3 and documented the findings on the Weekly Skin Integrity Review sheet. The RN revealed she had felt a slightly raised area on the resident's right buttock which was not open or red/pink in color and did not know what was meant by her documented description "trying to come out". RN #1 revealed because the area was not red or open and was unsure a treatment would have been ordered, she had not notified the Physician or completed a Situation Background Assessment Recommendation (SBAR) Communication document. In addition, the RN stated she had not documented the change on the facility's in-house written communication report, but had passed the change in status in verbal report.</p> <p>Continued interview with LPN #2/UC, on 01/14/15 at 10:49 AM, revealed the nurse who performed the skin assessment on 01/07/15 was supposed to communicate the skin change finding to the Physician/family even if it was not open and also documented the finding on the facility's 24/72 hour communication reports so the change was monitored.</p> <p>Interview with Resident #3's Physician, on 01/14/15 at 5:20 PM, revealed he had assessed the right buttock area and it appeared like a boil that had opened up and not a pressure area. The Physician revealed he was not made aware of the skin change, on 01/07/15, but based on the condition no treatment was needed just observation only.</p>	F 157		

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F 157	Continued From page 7 Interview with the DON, on 01/14/15 at 10:19 AM, revealed she observed Resident #3's open area on the right buttocks and the peri-wound surface had hard/indurated areas like a cyst or fistula had pushed through the skin surface. The DON revealed when the change of condition was identified, on 01/07/15, the nurse had not followed the facility's communication process which included the completion of the facility's SBAR form, used to document the change was communicated to the Physician/family and any recommendations. Interview, on 01/15/15 at 9:23 PM, with the Administrator revealed when the change of condition was identified, the nurse was expected to follow the facility's notification process. Further interview with the Administrator revealed the nurse should have followed procedure and contacted the Physician and communicated the finding to staff via written report.	F 157		
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	F 279	It is the policy of Richmond Place Rehabilitation and Health Center to use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care. Also, to 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. On 1/16/15, the care plan for resident #6 was developed related to falls by the MDS Coordinator, RN. On 1/15/15, the care plan was updated by the MDS Coordinator, RN, to reflect a regular diet for resident #10.	

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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 observation, interview, record review, and facility policy, it was determined the facility failed to ensure a comprehensive care plan was developed for each resident that included measurable objectives and timetables to meet a resident's medical and nursing needs that are identified in the comprehensive assessment for two (2) of eighteen (18) sampled residents (Resident #6 and #10).

Resident #6 was assessed to be at risk for falls; however, there was no documented evidence of a Care Plan to prevent falls.

Resident #10 was ordered a regular diet; however, the Care Plan specified the resident was to have a mechanically altered diet related to dysphagia.

The findings include:

Review of the facility "Care Plans-Comprehensive" Policy revised October 2010, revealed the Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the

F 279 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 falls, skin, and diets by 2/28/15.

On 2/11/15, the Interim Director of Nursing will re-inservice 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 relating to changes in condition including falls, skin and diets.

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 change of condition as well as the Care Plans Comprehensive Policy including timely updating and development of care plans relating to changes in condition including falls, skin and diets.

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 care plans relating to falls, skin and diets.

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resident may be expected to attain. The comprehensive care plan was based on a thorough assessment that included but was not limited to the Minimum Data Set (MDS) Assessment. Each resident's comprehensive care plan was designed to incorporate identified problem area, incorporate risk factors associated with identified problems, reflect treatment goals, timetables and objectives in measurable outcomes, aid in preventing or reducing declines in the resident's functional status and /or functional levels, and reflect current recognized standards of practice for problem areas and conditions.

1. Review of Resident #6's medical record revealed the facility admitted the resident on 11/18/14 with diagnoses which included Difficulty Walking, Muscle Weakness, a Stage IV Pressure Ulcer to the coccyx, and an unstageable Pressure Ulcer to the Right Heel. Review of the Admission MDS Assessment dated 12/05/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status of a ten (10) out of fifteen (15) indicating moderate cognitive impairment. Further review of the MDS, revealed the facility assessed the resident as requiring extensive assist of two (2) for transfers and extensive assist of one (1) for ambulation.

Review of the Care Area Assessment Summary dated 12/16/14 revealed falls triggered and the indicators included; orthopedic, cognitive, pain, electrolyte imbalance, hemoglobin and hematocrit concerns and the customized interventions related to falls could be found on the Plan of Care under potential for injury.

Review of the "Aims and Fall Risk Evaluation"

F 279 The audits of care plans relating to changes in condition including falls, skin, and diets 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.

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(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(K5) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETION DATE
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dated 11/28/14, revealed the resident was at risk for falls related to requiring assistance with elimination, was confined to chair, was not able to attempt to balance without physical help, was eighty-five (85) years or older, had a history of a hip fracture, joint pain, hearing impairment, and received medications including antidepressants and antihypertensives. According to the Evaluation a score of ten (10) or higher indicated a risk for falls and this resident's score was a sixteen (16).

Review of the Comprehensive Plan of Care, revealed there was no documented evidence of a Plan of Care to address this resident's fall risk with intervention to prevent falls.

Interview on 01/15/15 at 7:30 PM with the Resident Assessment Instrument (RAI) Coordinator, revealed there were three (3) RAI Coordinators who developed the care plans. After reviewing Resident #6's record, she stated the resident should have had a care plan developed related to falls and it must have been missed.

Interview on 01/15/15 at 7:45 PM with the Director of Nursing (DON), revealed the RAI Coordinators should have developed a Care Plan for Resident #6 related to falls and this should have been caught in the Quality of Care (QOC) Meeting when new admission care plans were reviewed.

Interview on 01/15/15 at 8:20 AM with the Administrator, revealed the care plans were reviewed on admission, annually, quarterly and with a significant change during the QOC Meetings. She stated a care plan should have

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been developed for Resident #6 related to falls by the RAI Coordinators and the QOC Meeting should have reviewed the care plan for accuracy after the resident was admitted.

2. Review of Resident #10's medical record revealed the facility admitted the resident on 12/05/14 with diagnoses which included Coronary Artery Disease, Gastroesophageal Reflux Disease, Diabetes Mellitus, Hypothyroidism, Anxiety Disorder, Depression, Asthma, Rehabilitation, Dysphagia, History of Solid/Liquid Pneumonitis, Laryngitis without Obstruction, General Muscle Weakness, and Difficulty Walking. Review of the Admission MDS Assessment, dated 12/18/14, revealed the facility assessed the resident as having a BIMS of a fifteen (15) indicating no cognitive impairment. Further review of the MDS revealed the facility assessed the resident as requiring limited assist with one (1) person physical assist with eating. Review of the Care Area Assessment Summary, dated 12/15/14, revealed nutritional status triggered due to resident Body Mass Index(BMI). Resident #10 was reportedly able to feed herself after tray set up.

Review of Resident #10's Physician orders on admission on 12/05/15 revealed orders for a regular consistency diet. Further review of Resident #10's Physician orders on 12/31/14 revealed orders for a regular consistency diet. Review of Resident #10's Comprehensive Care Plan revealed an Alteration in nutrition/hydration problem related to a low BMI and further stated Resident #10 received a mechanically altered diet related to a Dysphagia diagnosis and had a recent history of mild aspiration.

Further record review revealed Resident #10 had been ordered a mechanically altered diet on a

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F 279 Continued From page 12
previous admission in November 2014 related to a Dysphagia diagnosis and a history of mild aspiration; however, documentation from Speech Therapy from 11/03/14 through 11/19/14 revealed Resident #10 was able to tolerate a regular diet without signs and symptoms of aspiration or choking, was able to use compensatory strategies, and followed safety precautions to decrease risk of aspiration. Review of the Physician order on 11/11/14 revealed the diet was changed to regular texture.

F 279

Interview, on 01/15/15 at 7:45 PM, with the Resident Assessment Instrument (RAI) Coordinator, revealed there were three (3) RAI Coordinators who developed the care plans. After reviewing Resident #10's record, she stated if the resident's current Physician orders had a regular consistency diet ordered then the care plan should not state he/she is receiving a mechanically altered diet. Further interview revealed care plan accuracy for ordered diet consistency is important for the safety of the residents.

Interview, on 01/15/15 at 8:15 PM, with the DON revealed the care plan was followed for the resident's care and it could have been a potential risk had the resident needed a mechanically altered diet but was receiving a regular diet. Further interview revealed care plans should accurately reflect physicians orders.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO
SS=D PARTICIPATE PLANNING CARE-REVISE CP

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to

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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 observation, interview, record review and review of the facility's policy, it was determined the facility failed to review and revise the Comprehensive Plan of Care for two (2) of eighteen (18) sampled residents (Resident #6 and Resident #8).

Resident #6 was assessed to have an abrasion on the top of the right foot on 01/02/15, and a Physician's Order was obtained for a treatment that day; however, there was no documented evidence the Care Plan was reviewed and revised related to the abrasion.

In addition, Resident #6 was assessed to have a denuded (excoriated) area on the left and right buttocks by the nurse who performed the skin

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 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 1/14/15, the care plan for resident # 6 was revised by Unit Coordinator #3, RN, to reflect the patient's skin assessment.
On 1/14/16, the care plan for resident #8 was reviewed and revised by the Dietary Manager, DM, to reflect the resident's sustained actual weight loss.

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 falls, skin, and diets by 2/28/15.

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F 280	<p>Continued From page 14</p> <p>assessment on 01/14/15. Although staff interview revealed these denuded areas to the buttocks were present during the last skin assessment on 01/12/15, there was no documented evidence the Care Plan was reviewed and revised related to the denuded areas.</p> <p>Also, Resident #8's sustained significant weight loss; however, there was no documented evidence the Care Plan was reviewed and revised to indicate the resident sustained actual weight loss.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans-Comprehensive", revised October 2010, revealed assessments of residents were ongoing and care plans were revised as information about the resident and the resident's condition change. Further review revealed, the Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans.</p> <p>1. Review of Resident #6's medical record revealed the facility admitted the resident on 11/28/14, with diagnoses which included a Stage IV Pressure Ulcer to the Coccyx, and an Unstageable Pressure Ulcer to the Right Heel. Review of Resident #6's Admission Minimum Data Set (MDS) Assessment dated 12/05/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Observation of a skin assessment for Resident #6 on 01/14/15 from 12:05 PM till 1:20 PM and 5:00 PM until 5:30 PM performed by Licensed</p>	F 280	<p>On 2/11/15, the Interim Director of Nursing will re-inservice 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 relating to changes in condition including falls, skin and diets.</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 Policy including timely updating and development of care plans relating to changes in condition including falls, skin and diets by 2/28/15.</p> <p>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 falls, skin and diets.</p>	
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Practical Nurse (LPN) #5 and LPN #6, revealed the resident had an area to the top of the right foot measuring 2.6 centimeters (cm) in length (L) by (x) 0.5 cm in width (W) which LPN #6 described as an abrasion. Observation revealed there was also a red flat area with defined margins to the left buttocks measuring 1.3 cm L x 1.6 cm W and a red flat area with defined margins to the right buttock measuring 2.1 cm L x 1.3 cm W which LPN #6 described as denuded. Continued observation revealed LPN #6 cleansed the area to the top of the right foot with Normal Saline (NS) and applied a Mepilex Border dressing (all in one foam dressing designed for a wide range of wounds). Further observation revealed LPN #6 cleansed the denuded areas on the left and right buttocks with NS and placed Aquacel (an absorbent dressing) over the areas.

Review of the Physician's Orders dated 01/02/15 revealed an order obtained on 01/02/15, for Mepilex Border to the top of the right foot every other day. However, there was no documented evidence of a treatment order for the denuded areas to the left and right buttocks.

Review of Resident #6's Comprehensive Plan of Care dated 12/16/14, revealed the resident had a care plan for impaired skin integrity related to the Stage IV area to the coccyx, unstageable Pressure Ulcer to the right heel, and the venous ulcer to the right great toe. Review of the impaired skin integrity care plan revealed a goal stating the ulcers would decrease with evidence of healing. However, there was no documented evidence the care plan was revised to include information regarding the abrasion to the top of Resident #6's the right foot or the denuded areas to his/her buttocks and interventions to heal the

F 280

The audits of care plans relating to changes in condition including falls, skin, and diets 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

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F 280	<p>Continued From page 16</p> <p>areas and prevent further skin breakdown.</p> <p>Interview with LPN #4, on 01/15/15 at 4:45 PM, revealed she had notified the Physician of the abrasion to the top of Resident #6's right foot and obtained a treatment order. She stated if an area of skin breakdown was found and if a new order was obtained, the nurse should update the care plan to include this information. Continued interview revealed although she had notified the Physician of the skin breakdown, she did not think about updating the care plan.</p> <p>Interview, on 01/15/15 at 5:30 PM, with the Unit Coordinator (UC), for the Rehabilitation Unit where Resident #6 resided, revealed if a new area of skin breakdown was identified, the nurse was to report the area to the Physician in order to obtain a treatment and update the care plan as well. Per interview, the nurse who obtained the treatment related to the top of the Resident #6's right foot should have updated the care plan. She stated she had observed the denuded areas to the residents buttocks on 01/12/15, when she was completing the resident's skin assessment and felt it was irritation from the drape used for the wound vac on the coccyx wound. The UC stated she should have ensured there was a treatment in place related to the denuded areas and ensured the care plan was revised also.</p> <p>Interview, on 01/16/15 at 7:45 PM, with the Director of Nursing (DON), revealed if a non pressure area of skin breakdown was identified, the care plan would also need to be updated by the nurse who discovered the area and notified the Physician of the area. Per interview, walking rounds were done each morning, Monday through Friday, on each unit by herself, the MDS</p>	F 280		

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F 280 Continued From page 17
Nurse and other administrative nurses. She stated the new Physician's orders and incident reports were reviewed at that time of the rounds, and residents charts were pulled and the care plans were checked to ensure they were updated related to the orders and incidents which occurred. The DON stated Resident #6's care plan should have been updated related to the non pressure areas identified by staff.

F 280

2. Review of Resident #8's medical record revealed the facility admitted the resident on 03/22/14, with diagnoses which included Dementia with Psychotic Behaviors, Esophageal Reflex and Osteoporosis. Review of the Quarterly MDS Assessment dated 12/08/14, revealed the facility assessed Resident #8 to have a BIMS score of three (3), indicating the resident was severely cognitively impaired and not interviewable.

Review of the monthly weight log for Resident #8 revealed: on 08/22/14 the resident's weight was 151.4 pounds (lbs); on 09/07/14, 10/10/14, and 11/10/14, the resident's weight remained between 153.8 lbs to 152.4 lbs; on 12/08/14 the resident's weight was 156.6 lbs; however, on 01/07/15 his/her weight was documented as 146.4 lbs, a loss of 10.2 lbs.

Review of the Nutritional Quarterly Progress Note assessment dated 12/08/14, revealed the Dietary Manager (DM) noted Resident #8's weight as stable. Continued review of the Progress Notes revealed on 01/07/15, the Registered Dietician (RD) recommended two (2) ounces (oz) of Med Pass (a nutritional supplement) related to Resident #8's weight loss.

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F 280	<p>Continued From page 18</p> <p>Review of the Medication Administration Record (MAR) revealed Resident #8 received Ensure with each meal tray. Continued review revealed the resident also received ice cream on each meal tray, and a bed time snack.</p> <p>Review of Resident #8's Comprehensive Plan of Care revealed a care plan of nutrition with a goal for the resident's weight to remain stable. Continued review of the care plan revealed on 11/24/14, nursing staff updated the care plan to include offer encourage fluids at medication (med) pass and with snacks. However, further review of the care plan revealed no documented evidence the care plan was revised to address Resident #8's weight loss and with interventions to prevent further weight loss.</p> <p>Interview, on 01/15/15 at 5:40 PM, with the MDS nurse revealed the nurses were responsible for updating the care plan that pertained to nursing. She stated the Interdisciplinary Team (ID) jointly updated the care plan, and the nutrition care plan was the responsibility of the Dietary Manager (DM). She further revealed the care plan should have been updated to reflect Resident #8's weight loss.</p> <p>Interview, on 01/15/15 at 5:55 PM, with the DM revealed she reviewed the monthly weights and discussed the changes with the RD. Continued interview revealed Resident #8 experienced a five (5) percent weight loss from the dates of 12/08/14 to 01/07/15. She stated she should have updated/revised the care plan to reflect the resident's weight loss.</p> <p>Interview on 01/15/15 at 6:50 PM, with the DON revealed it was the responsibility of the DM to</p>	F 280		
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F 280 Continued From page 19
update residents' care plans to reflect weight decline.

Interview, on 01/15/15 at 6:55 PM, with the Administrator revealed Resident #8's significant weight change should have been addressed on the care plan to ensure proper care.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=0

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 observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide the necessary care and services to maintain the highest physical well-being for one (1) of four (4) sampled residents (Resident #6), who had skin breakdown or were at risk for skin breakdown out of a total of eighteen (18) sampled residents.

Resident #6 was assessed to have an abrasion on the top of the right foot on 01/02/15, and the nurse notified the Physician and obtained an order for treatment that day. However, there was no documented evidence of a description of the abrasion on the skin assessments or the Nurse's Notes and no documented evidence the care plan

F 280

F 309

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 comprehensive assessment and plan of care.

On 1/14/15, the care plan for resident # 6 was revised by Unit Coordinator #3, RN, to reflect the patient's skin assessment. On 1/14/15, Unit Coordinator #3, RN, updated the clinical record to reflect the skin assessments including the abrasion and denuded areas and treatment orders for resident #6.

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 falls, skin, and diets by 2/28/15

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F 309	<p>Continued From page 20</p> <p>was updated and revised regarding the abrasion.</p> <p>In addition, on 01/14/15, Resident #6 was identified to have a denuded (excoriated) area on the left and right buttocks by the nurse who performed the skin assessment that day. Although staff interview, revealed these denuded areas to the buttocks were present during the last skin assessment on 01/12/15, there was no documented evidence of a description and measurement of the denuded areas on the skin assessments or in the Nurse's Notes. In addition, there was no documented evidence of a treatment for the denuded areas or of updating and revision of the care plan related to the areas.</p> <p>The findings include:</p> <p>Review of the facility's protocol titled, "Skin Assessment and Wound Prevention Protocol", revised April 2011, revealed the purpose of the skin assessment was to observe the condition of a resident's skin on admission and on a routine basis. The Protocol revealed this process provided a system for Licensed Nurses to regularly assess each resident's skin condition. Further review revealed the Protocol stated the Licensed Nurse would complete the Weekly Skin Assessment by incorporating the assessment, initiate treatment intervention, and update the care plan.</p> <p>Review of Resident #6 medical record revealed the facility admitted him/her on 11/28/14, with diagnoses which included a Stage IV Pressure Ulcer to the Coccyx, and an Unstageable Pressure Ulcer to the Right Heel. Review of the Admission Minimum Data Set (MDS) Assessment dated 12/05/14, revealed the facility</p>	F 309	<p>On 2/11/15, the Interim Director of Nursing will re-inservice 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 relating to changes in condition including falls, skin and diets and the clinical record to reflect the skin assessments including the abrasion and denuded areas and treatment orders.</p> <p>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 change of condition as well as the Care Plans Comprehensive Policy including timely updating and development of care plans relating to changes in condition including falls, skin and diets, and that the clinical record is to reflect the skin assessments including the abrasion and denuded areas and treatment orders by 2/28/15.</p>		

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F 309	<p>Continued From page 21</p> <p>assessed Resident #6 as having a Brief Interview for Mental Status (BIMS) score of ten (10) which indicated moderate cognitive impairment.</p> <p>Observation, on 01/14/15 from 12:05 PM till 1:20 PM, and 5:00 PM until 5:30 PM, of the skin assessment for Resident #6, performed by Licensed Practical Nurse (LPN) #5 and LPN #6, revealed the resident was observed to have: a Stage IV Pressure Ulcer (PU) to the coccyx measuring 6.4 centimeters (cms) in length (L) by (x) 8.1 cms in width (W) x 1.1 cms in depth (D); an unstageable area to the right heel measuring 4 cms L x 3 cms W, a Venous Ulcer to the right great toe measuring 0.9 cms L x 0.6 cms W; an area to the top of the right foot measuring 2.6 cms L x 0.5 cm W, which LPN #6 described as an abrasion; red flat areas with defined margins to the left buttocks measuring 1.3 cms L x 1.6 cms W and to the right buttock measuring 2.1 cm L x 1.3 cm W, which LPN #6 described as denuded. Further observation revealed LPN #6 was observed to treat the denuded areas by cleansing the areas with Normal Saline (NS) and placing Aquacel dressings over the areas.</p> <p>Review of the "Wound Evaluation Flow Sheets" revealed the PU to Resident #6's right heel and the coccyx were being measured and described weekly. Review of the "Non Pressure Skin Condition Record" revealed Resident #6's right great toe Venous Ulcer was being described and measured weekly. However, continued review revealed was no documented evidence on the "Non Pressure Skin Condition Record" Resident #6 had an abrasion to the top of the right foot or denuded areas to the left and right buttocks. In addition, review of the Nurse's Notes revealed there was no documented evidence Resident #6</p>	F 309	<p>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 relating to falls, skin and diets and appropriate documentation of assessments and physician orders.</p> <p>The audits of care plans and the clinical record relating to changes in condition including falls, skin, and diets and appropriate documentation of assessments and physician 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.</p> <p>Completed date: February 28, 2015</p>

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had an abrasion to the top of the right foot or denuded areas to the left and right buttocks.

Review of the Physician's Orders dated 01/02/15, revealed orders for a change in treatment to the PU to the coccyx and right heel, and treatment orders to the Venous Ulcer to the right great toe. Continued review of the Physician's Orders revealed there was also an order obtained on 01/02/15 for Mepilex Border (a specialized dressing) to the top of Resident #6's right foot every other day. However, there was no documented evidence of a Physician's Order for treatment for the denuded areas to Resident #6's left and right buttocks.

Review of Resident #6's Comprehensive Plan of Care dated 12/16/14, revealed the facility had care planned resident for impaired skin integrity related to the Stage IV PU on the coccyx, unstageable PU to the right heel, and the Venous Ulcer to the right great toe. Review of the care plan revealed the goal was for the ulcers to decrease with evidence of healing. Continued review of the care plan revealed several interventions including to complete skin assessments and record. However, there was no documented evidence the care plan was updated and revised indicating the abrasion on top of Resident #6's right foot or of the denuded areas to his/her buttocks with interventions in place to heal the areas.

Interview with LPN #4 on 01/15/15 at 4:45 PM, revealed she notified the Physician on 01/02/15, and obtained the order related to the abrasion to the top of the resident's right foot. Per interview, if an area of skin breakdown was found, a Nurse's Note should be documented related to

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the area with a description and a measurement, and the area also documented on the "Non Pressure Skin Condition Record". She stated the care plan should also be updated and revised related to any new area of skin breakdown. LPN #4 revealed she had not followed through with documenting a description or measurement of the abrasion on Resident #6's foot in the medical record after obtaining the Physician's Order for treatment, and had not updated the care plan to indicate this information.

F 309

Interview, on 01/15/15 at 5:00 PM, with LPN #6, who performed the skin assessment for the Surveyor on 01/14/15, revealed she had noted the denuded areas on Resident #6's buttocks just prior to the skin assessment observed by the Surveyor. She stated she realized then there was no treatment order in place for the areas. Per interview, she had talked with the Unit Coordinator (UC) and was told to use Aquacel to the areas. However, she confirmed there was no treatment order in place for the denuded areas to the buttocks at the time she was performing the assessment and treatment on 01/14/15.

Interview, on 01/15/15 at 5:30 PM, with the UC for the Rehabilitation Unit, where Resident #6 resided, revealed if a new area of skin breakdown was identified which was a PU or non pressure area, the nurse was to report the area to the Physician in order to obtain a treatment. Per interview, an area of skin breakdown which was non pressure was to be described in the Nurse's Notes or the "S-BAR" Notes and the nurse should follow through with completing the "Non Pressure Skin Condition Record" and revising the care plan. Continued interview revealed the nurse was also to document the new area of skin breakdown

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F 309	Continued From page 24 on the "72 Hour Report" which was handed to the nurses on the next shifts to ensure they were aware of the new areas. She stated the "72 Hour Report" was also kept for the UC to use as an audit tool to ensure the appropriate documentation had been completed related to the skin breakdown, including a description and measurement of the area, and revision of the care plan. The UC revealed she had observed the denuded areas to Resident #6's buttocks on 01/12/15, when she was completing the resident's skin assessment. She reported at that time she felt the denuded areas were irritation from the drape used for the wound vac on the coccyx wound. Per the UC, she had not measured or described them on the Non Pressure Wound Sheet, but should have. She stated at the time she did the skin assessment and dressing change on 01/12/14, she thought there was already a treatment in place for Aquacel to the denuded areas. Further interview revealed she had not realized there was no treatment order in place for the denuded areas to Resident #6's buttocks until yesterday. Interview, on 01/15/15 at 7:45 PM, with the Director of Nursing (DON), revealed if a non pressure area of skin breakdown including denuded skin was noted, the nurses were to pass the information on in report so the area could continue to be monitored. She stated the nurse who found the area was to notify the Physician for treatment and document the area on the Non Pressure Wound Sheet with a measurement of the area if there was defined edges and a description of the area. She stated the care plan would also need to be updated and revised by the nurse who discovered the area. Per the DON, there was room for education regarding this.	F 309		
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Interview with the Administrator, on 01/15/15 at 8:20 AM, revealed the Physician was to be notified for areas of skin breakdown to obtain a treatment order and there should be documentation related to the skin breakdown in the resident's chart. Continued interview revealed the nurse who obtained the order or identified the skin breakdown was to update the resident's care plan.

F 325
SS=D 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE

Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

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 ensure residents maintained acceptable parameters of nutritional status for two (2) of eighteen (18) sampled residents (Residents #2 and #3).

Resident #3 had a prior order to receive a Magic cup supplement once a day and the Registered Dietician (RD) had requested the supplement be

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F 325

It is the policy of Richmond Rehabilitation & Health Center to maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates

that this is not possible; and receives a therapeutic diet when there is a nutritional problem.

On 1/14/15, the Dietary Manager updated the plan of care and audited the tray card related to new dietary recommendations and new physician orders received on 1/14/15 indicating the patient receive a Magic cup supplement four (4) time a day for resident #3.

On 1/15/15, the Registered Dietician reviewed the nutritional status of Resident #2 with no new recommendations noted and the MD was notified by the Unit Coordinator #2 with no new orders noted.

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F 325	<p>Continued From page 26</p> <p>increased to twice a day due to continued weight loss. However, Resident #3 was actually getting a Magic cup supplement four (4) times a day, at each meal and for a snack.</p> <p>Resident #2 had a dietary recommendation and order dated 12/11/14, for two (2) ounces (oz) of med pass supplement twice a day; however, record review revealed the resident was not started on med pass until 01/01/15, twenty-one (21) days later.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "House Supplements", updated September, 2011, revealed the house supplement was a two (2) calorie per milliliters (mls) med pass product and Magic cups were also an accepted supplement. The Policy revealed the amount of supplements provided varied based on the resident's nutritional needs and preferences. Per the Policy, if a Physician's Order was required for supplements, the frequency and amounts were to be specified in the order. Further Policy review revealed residents who got supplements were to be reviewed routinely to assess effectiveness and supplemental amounts might be changed or discontinued.</p> <p>1. Review of Resident #3's medical record revealed the facility admitted the resident on 08/08/13, with diagnoses which included Hypertension, Non-Alzheimer's Dementia, Episodic Mood Disorder and Depression. Review of the January 2015 Monthly Physician's Orders revealed the resident had an order for one (1) Magic cup by mouth once daily (QD).</p>	F 325	<p>The Registered Dietician and the Dietary Manager will audit all resident tray cards for accuracy in reflecting the current diet order by 2/28/15.</p> <p>On 1/15/15, the Registered Dietician re-inserviced the Dietary Manager and the Kitchen Manager regarding matching the tray card to the diet order and tray card entry procedures.</p> <p>On 2/11/15, the Interim Director of Nursing will educate the Assistant Director of Nursing and 3 Unit Managers (2 LPN/1 RN), the Quality Assurance Nurse, LPN and the Assistant Director of Nursing, RN, regarding the procedures for changeover and the 24 Hour Physician's order auditing process.</p> <p>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 procedures for changeover and the 24 Hours Physician's order auditing process by 2/28/15.</p> <p>The Dietary Manager will audit 6 diet orders per week for 6 weeks for accuracy compared to tray card.</p> <p>The Unit Manager (1 RN and 2 LPN, Quality Assurance Nurse, or Assistant Director of Nursing will audit a minimum of 6 charts for each unit following changeover for the next 3 months for accuracy of dietary orders on the MAR.</p>	

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Review of an 01/12/15, Nutritional Progress Note, completed by the RD, revealed Resident #3 had an 11.37% weight loss in six (6) months and the RD recommended the Magic cup supplement be increased to twice daily (BID). Review of the January Physician's Orders revealed no documented evidence Physician was notified of the recommendation and the Magic cup had been ordered.

Observation, on 01/13/15 at 12:47 PM, of Resident #3's meal and meal ticket revealed the resident received a Magic cup with his/her meal. Additional observation at 2:56 PM revealed staff providing a Magic cup snack to the resident.

Review of Resident #3's meal tickets, dated 01/14/15, revealed the resident was getting a Magic cup at each meal.

Interview, on 01/15/15 at 7:14 PM, with State Registered Nursing Assistant (SRNA) #2 revealed she took care of Resident #3 and assisted the resident with meals. The SRNA revealed the resident had been getting Magic cups with meals and snacks on the evening shift and enjoyed the Magic cup.

Interview, on 01/14/15 at 1:37 PM, with the Dietary Manager (DM) revealed Resident #3 had been getting Magic cups with each meal and afternoon snack; however, the Physician order, 11/18/14, was for the resident to receive a Magic cup "QD". The DM revealed she thought staff might have misinterpreted the abbreviation QD on the order as "QID" (four times a day). Per interview, the DM was unable to determine when Resident #3 had begun getting Magic cups four (4) times a day. The DM stated because of the

F 325 The audits of physician orders relating to diets and tray cards 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.

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Resident #3's current weight loss the RD recommended Magic cup supplement be given twice daily.

Interview, on 01/14/15 at 1:54 PM, with the RD revealed Resident #3 was ordered Magic cup daily as a supplement because he/she had triggered for weight loss and skin. Per interview, Resident #3 had also recently triggered for weight loss over a six (6) month period. The RD stated the Magic cups were recommended to be increased to twice daily based on the assumption he/she was getting the supplement daily. The RD revealed he was unaware the resident was getting Magic cup four (4) times a day. According to the RD, his recommendation for the Magic cup twice a day and the subsequent order was not followed. Per the RD, when the new BID order was communicated to dietary, the problem should have been caught at that time.

Interview, on 01/14/15 at 5:20 PM with the resident's Physician revealed the Magic cup was ordered daily, and the RD had requested an order for Magic cup twice daily. The Physician revealed he was unaware Resident #3 was actually getting Magic cup four (4) times a day and wanted to know why the resident got that amount. The Physician further revealed decreasing magic cup to twice daily if he/she was getting four (4) times a day wasn't effective and thought some other intervention was needed to increase his/her weight.

Follow-up interview, on 01/15/15 at 8:15 PM, with the RD revealed he had consulted with the Physician, since the last interview with the Surveyor, regarding Resident #3's supplement. The RD stated he had changed his

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F 325	<p>Continued From page 29</p> <p>recommendation to Magic cup to be given with meals and as an evening snack. The RD revealed they also increased the supplement med pass to four (4) ounces four (4) times a day.</p> <p>Interview, on 01/15/15 at 8:55 PM, with the Director of Nursing (DON) revealed the Magic cup was ordered once a day, but the resident was actually getting it four (4) times a day. The DON revealed there was a break down between the Physician Order and the dietary ticket which had Magic cup being given with meals in addition to the snack. The DON further revealed there was the possibility of unexpected weight gain as a result of the potential additional unplanned 870 caloric intake, as a Magic cup was 290 calories apiece. Per the DON however, Resident #3 had experienced weight loss.</p> <p>Interview, on 01/15/15 at 9:23 PM, with the Administrator revealed it was a nutritional problem because Resident #3 got extra calories that weren't planned or ordered and there was a risk of unplanned weight gain. However, in spite of the extra calories Resident #3 continued to lose weight.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident on 11/25/14, with diagnoses which included Cellulitis of the Leg, General Sepsis, History of Urinary Tract Infections (UTI) and Hypertension.</p> <p>Review of the Physician's Orders revealed an order on 12/18/14 for Resident #2 to have fortified food with meals, and to have two (2) oz of med pass by mouth twice daily related to weight loss and a decreased albumin. However, review of Resident #2's Medication Administration Record</p>	F 325	

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F 325 Continued From page 30

(MAR) revealed the med pass was not started until 01/01/15, twenty-one (21) days later.

Interview, on 01/15/15 at 8:15 PM, with the RD revealed because Resident #2 had some weight loss and a low albumin level which may have resulted from the Cellulitis inflammation, the RD had recommend med pass supplement for better nutrition, as it helped with wound healing and was good for weight loss. The RD revealed the Physician's Order was written on 12/18/14; however, was not started until 01/01/15 which the RD felt was a communication issue. Per the RD, Resident #2's med pass supplement should have been started soon after the order was received.

Interview, on 01/15/15 at 8:43 PM, with Licensed Practical Nurse (LPN) #2/Unit Coordinator (UC) revealed Resident #2 had an order for two (2) oz of med pass twice daily which was written on 12/18/14, and the med pass was started the next day. LPN #2/UC stated however, the nurse who took the order off on 12/18/14 had failed to place the order on the December MAR per the facility's process. Per interview, the nurse should have placed it on the MAR at the time it was received. LPN #2/UC stated the facility had a 24 Hour Physician's Orders auditing process in place, however, the error involving Resident 2's med pass was not identified on audit. LPN #2/UC revealed there must have been a breakdown in the process, but when the changeover of Physician's Orders from December to January was completed it was identified, and the order was placed on the January MAR. Per LPN #2/UC, however since the order was not followed through with when it was received the supplement was not started until 01/01/15. She further stated the concern was the potential for weight loss and

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F 325	Continued From page 31 overall nutritional status. Continued review of the medical record revealed Resident #2 was weighed at least weekly since his/her admission to the facility, and on 12/08/14 his/her weight was 121 pounds (lbs) and on 12/31/14 the resident's weight was 127.2 lbs. Continued interview, on 01/15/15 at 8:55 PM, with the DON revealed the med pass for Resident #2 was ordered on 12/18/14, but not put on the MAR until January. The DON revealed the facility's process was for the nurse who took the order to put it on the MAR, and the night nurse was supposed to audit orders daily to make sure the orders were put on the MAR. Per interview, however Resident #2's order for med pass had been missed. The DON further revealed the problem was identified in January when the nurses compared orders to the MAR, and the med pass was placed on the MAR at that time. Interview revealed the order was written on 12/18/14, and the med pass should have been started and given by 12/19/14 at the latest. The DON further stated it was a nutrition issue for Resident #2 to not get the med pass, and the resident had the potential of further weight loss and skin breakdown. Continued interview, on 01/15/15 at 9:23 PM, with the Administrator revealed her expectation was for the med pass to be given when ordered. The Administrator revealed the med pass was ordered as a nutritional supplement and should have been given more timely by staff.	F 325		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	F 367		

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F 367

Continued From page 32
Therapeutic diets must be prescribed by the attending physician.

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 the therapeutic diet in accordance with the Physician's Orders for one (1) of eighteen (18) sampled residents (Resident #15).

Observation of Resident #15's evening meal tray and meal ticket, on 01/15/15, revealed the resident was served a texture modified diet; however, staff interview and review of the Physician's Diet Orders revealed the resident was ordered to have a pureed diet on 01/15/15.

The findings include:

Review of the facility's policy titled, "Approved Diets/Menu", revised December, 2013, revealed residents were to be offered only approved diets. The Policy revealed pureed diets were to be the consistency of mashed potatoes or pudding. Further review of the Policy revealed it was the responsibility of the Dining Services management to implement compliance.

Review of Resident #15's medical record revealed the facility admitted the resident on 10/13/14, with diagnoses which included Dementia, Diabetes, Stage III Chronic Kidney Disease and Functional Decline. Review of the Initial Minimum Data Set (MDS) Assessment, dated 10/20/14, revealed Resident #15 was assessed as being severely cognitively impaired

F 367

It is the policy of Richmond Place Rehabilitation & Health Center that therapeutic diets must be prescribed by the attending physician.

On 1/15/15, the Dietary Manager provided the corrected tray card and discarded any incorrect cards for resident #15.

The Registered Dietician and Dietary Manager will audit all resident tray cards for accuracy in reflecting the current diet order by 2/28/15.

On 1/15/15, the Registered Dietician re-inserviced the Dietary Manager and the Kitchen Manager regarding matching the tray card to the diet order and tray card entry procedures as well as proper filing of new tray cards and disposal of any tray cards that do not reflect the current order.

The Registered Dietician and Kitchen Manager will re-educate dietary associates including cooks and aides regarding tray cards and checking to ensure accuracy by 2/28/15.

The Dietary Manager will audit 6 diet orders per week for 6 weeks for accuracy compared to tray card and then audit 6 tray cards monthly for 12 months with guidance from the Quality Assurance Committee, (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant).

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and required assistance with meals. Review of the Physician's Orders revealed an order dated 11/27/14, for Resident #15 to have a mechanical soft diet, (texture modified diet). Review of a verbal Physician's Order dated 01/15/15 at 0900, revealed Resident #15's diet was changed to pureed.

Observation, on 01/15/15 at 6:42 PM, revealed Resident #15 had a meal tray at bedside with a meal ticket which included documentation for a texture modified diet. Further observation revealed the meal served was texture modified in form.

Interview, on 01/15/15 at 6:53 PM, with Licensed Practical Nurse (LPN) #4, revealed she didn't work on the unit where Resident #15 resident, but came to assist the resident with his/her evening meal. LPN #4 revealed the meal ticket indicated Resident #15 was to have a modified texture diet and the meal served looked to be modified texture in appearance. LPN #4 stated if Resident #15 was ordered a pureed diet he/she was supposed to be served pureed food. Per interview, LPN #4 had not observed any signs of choking or aspiration by Resident #15.

Interview, on 01/15/15 at 3:15 PM and 7:02 PM, with LPN #3/Unit Coordinator (UC) revealed after observing Resident #15's meal ticket and food, the meal ticket indicated a texture modified diet. Per LPN #3/UC the meal served to Resident #15 was texture modified in appearance; however, the resident had been evaluated by Speech Therapy (ST) with a recommendation for a pureed diet. LPN #3/UC stated an order was written that morning to change Resident #15's diet to pureed which was then communicated to the dietary

The audits of physician orders relating to diets and tray cards 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.

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F 367	Continued From page 34 department via the Physician Diet Order. Continued interview revealed the diet texture served was incorrect, and was a potential risk for aspiration for Resident #15, as he/she had assessed swallowing difficulties and was diagnosed with Dysphagia. LPN #3/UC stated Resident #15 receiving the wrong diet was a dietary issue, because nursing had notified dietary; however, the new diet was not implemented. Further interview revealed the facility's process was for dietary to compare the food served to the meal ticket which in this situation matched. Interview, on 01/15/15 at 7:40 PM, with the Dietary Manager (DM) revealed Resident #15 was served a modified texture diet for dinner on 01/15/15; however, because the resident was assessed as "pocketing" food the diet was changed to pureed. The DM revealed her department had received the dietary communication form that morning, and Resident #15's meal ticket was changed to pureed. However, she stated the new ticket was not included with the dinner tray meal cards. Per interview, tray servers in the kitchen were responsible for putting the meal tickets in the tray line card packet, and the DM assumed the updated tray card had not replaced the previous diet card, therefore, Resident #15 was given a modified diet meal instead of the ordered pureed diet. Interview, on 01/15/15 at 8:15 PM, with the Registered Dietician (RD) revealed he was not involved in determining Resident #15's diet texture because it was a ST recommendation after their evaluation. The RD revealed if the Physician's Diet Order indicated a pureed texture	F 367			

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F 367. Continued From page 35

Resident #15 was to receive a pureed diet, and not a modified texture diet as per the Physician's Order which was supposed to be followed.

Interview, on 01/15/15 at 8:55 PM, with the Director of Nursing (DON) revealed the pureed ordered diet was not followed by staff because the tray ticket indicated Resident #15 was to receive a modified texture diet and staff compared the meal ticket to the food. Per interview, this was a kitchen problem because the aide care plan was updated to include a pureed diet for Resident #15. The DON stated however, staff could come from any unit to assist with feeding and if the diet was not correct those staff would not know as they looked at the meal ticket to identify residents diet needs.

Interview, on 01/15/15 at 9:23 PM, with the Administrator revealed her expectation was residents received the right therapeutic diet; however Resident #15 was not served the right therapeutic diet. Per interview, Resident #15 should have received the pureed diet ordered. The Administrator revealed ST did the evaluation and recommended a pureed diet because during the evaluation process Resident #15 was pocketing and expelling food, not because of aspiration. The Administrator further revealed the meal ticket incorrectly indicated modified texture diet and the meal served was modified texture so it was not caught by the person who was assisting with the meal.

F 367

F 371

It is the policy of Richmond Rehabilitation and Heath Center to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions.

F 371 483.35(i) FOOD PROCURE.
SS=F STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or

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F 371	Continued From page 36 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to store and serve food under sanitary conditions. Observation during the initial kitchen tour on 01/13/14, revealed non-perishable foods were not labeled and not dated. Observation revealed two (2) clear food containers with white powder substances not labeled and not dated. Further observation on 01/13/15, revealed an ingredient bin with a rice-like food product in it which was not labeled or dated that had a scoop stored in it. The findings include: Review of the facility's policy titled, "Storage of Non Perishable Food", revised May 2010, revealed all non-perishable foods were stored to maximize nutrient retention, quality and food safety. Non-perishable foods were dated upon delivery with the month, day and year it was received. Non-perishable foods were to be stored with other non-perishable foods on a first in, first out (FIFO) rotation. Observation, on 01/13/15 at 5:45 AM, during the initial kitchen tour revealed the bottles of spices	F 371	On 1/13/15, the 2 food containers not labeled/dated and the rice-like food not dated and with scoop stored in container was removed from the kitchen; as were the spices that were not dated or with illegible dates and identified as sticky were also disposed by the Kitchen Manager. On 1/16/15, the Kitchen Manager completed an audit of all items in the kitchen for proper labeling, dating, and storage. On 1/16/15, the Kitchen Manager and the Dietary Manager was educated by the Registered Dietician regarding dating and labeling of food items, proper storage of scoops and the Sanitation Quality and Review Audit Tool. The registered Dietician and the Kitchen Manager will educate dietary associates including cooks and aides regarding proper labeling, dating, and storage by 2/28/15. The lead chefs will be educated regarding use of the Sanitation Quality and Review Audit by 2/28/15. The Kitchen Manager and/or Lead Chef will audit all food items for proper storage including labeling, dating and storage of scoops 2 times a day for 6 weeks. The results of the Sanitation Quality and Review audits will be forwarded to the Quality Assurance Committee, (Medical Director, Director of Nursing, Administrator, Quality Assurance	
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F 371	<p>Continued From page 37</p> <p>and seasonings stored on the cook's shelf, with four (4) of the eleven (11) spices not dated. Continued observation of the spices and seasoning containers revealed a dust-like appearance on the tops of the containers. Further observation during the initial tour revealed two (2) of the eleven (11) containers had dates which were not legible.</p> <p>Observation, on 01/13/15 at 6:00 PM, revealed one (1) of the eleven (11) spice/seasoning containers was sticky to the touch. Observation revealed two (2) clear containers with lids stored on the cook's shelf which contained unidentified white powdered substances that were not labeled or dated. Further observation revealed an ingredient bin with a white grain that was rice-like in appearance which was not labeled or dated. In addition, observation revealed the ingredient bin had a scoop lying on top of the food product.</p> <p>Interview, on 01/15/15 at 5:10 PM, Cook Supervisor #1 revealed all foods should be labeled and dated with the expiration date. Per interview, foods should be dated once they were opened, and the expiration date would be dependent on the type of food, as perishable and non-perishable foods had a different shelf life. Cook Supervisor #1 stated all foods should be dated to prevent contamination by bacteria because if foods were not dated it could cause harm to residents' through possible food poisoning. Further interview revealed the food items which were not labeled and dated should be thrown away.</p> <p>Interview, 01/15/15 at 5:20 PM, with the Certified Dietary Manager (CDM) revealed food should be dated once it was opened and staff should be</p>	F 371	<p>Coordinator, and Pharmacy Consultant) for review to maintain compliance.</p> <p>Completion Date: February 28, 2015</p>

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F 431

Continued From page 39
permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure all drugs and biologicals used in the facility were not expired and all drugs and biologicals were stored in locked compartments. Observation revealed expired lubricating jelly in all three (3) unit crash carts, expired latex sterile gloves in one (1) unit crash cart, and one (1) vial of Lorazepam 2 mg/1 ml injection medication lying in the unlocked medication room refrigerator.

The findings include:

Review of the facility's policy titled, "Storage of Medications", revised April, 2007, revealed the facility should store all drugs and biologicals in a safe, secure, and orderly manner and all compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals should be locked when not in use. Further review of the Policy revealed the facility should not use discontinued, outdated, or deteriorated drugs or biologicals.

F 431

On 1/15/15, the Director of Nursing re-educated the Central Supply Coordinator regarding expired item on crash carts. On 2/11/15, the Interim Director of Nursing will re-inservice the 3 Unit Coordinators and the Assistant Director of Nursing regarding proper storage of medications.

Direct care staff (Registered Nurses, Licensed Practical Nurses, and Medication 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 medication storage by 2/28/15.

The 3 Unit Coordinators (1 RN, 2LPN) will audit the medication refrigerator during daily rounds to ensure proper storage of narcotics 5 days a week for 4 weeks. The Central Supply Coordinator will audit the crash carts monthly for expired items.

The audits of narcotic storage and crash carts relating to expired items 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.

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1. Observation, on 01/13/15 at 6:55 AM, revealed a Lorazepam 2 mg/1 ml injectable medication vial in the unlocked and unsecured South Hall Unit medication room refrigerator.

Interview with Kentucky Medication Aide (KMA) #3, on 01/13/15 at 6:55 AM, revealed she was not sure who placed the Lorazepam 2 mg/1 ml injectable vial in the unlocked South Hall medication room refrigerator. Per interview, all controlled drugs should be kept under double lock, and in a locked drawer for controlled drugs in the South Hall medication room refrigerator.

Interview with Licensed Practical Nurse (LPN) #7, on 01/13/15 at 6:55 AM, revealed she got the Lorazepam 2 mg/1 ml injectable medication vial out of the facility's emergency box during the night shift on 01/13/15. LPN #7 stated she did not lock the medication in the locked refrigerator drawer because her key would not work in the drawer for the controlled drugs. Further interview revealed LPN #7 was aware the medication should have been locked in the refrigerator drawer to ensure it was under double lock as this was how controlled drugs should be stored.

Interview with the South Unit Manager, on 01/14/15 at 5:15 PM, revealed the Lorazepam 2 mg/1 ml medication vial and all other narcotics were expected to be stored under double lock.

Interview with the facility's Pharmacist, on 01/15/15 at 9:55 AM revealed controlled substances needed to be stored under double lock, and the Lorazepam 2 mg/1 ml medication vial should have been locked in the South Hall medication room refrigerator.

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Interview with the Director of Nursing (DON), on 01/15/15 at 5:45 PM, revealed narcotics/controlled drugs should always be under double lock, and LPN #7 should have locked the Lorazepam 2 mg/1 ml medication vial in the South Unit medication room refrigerator drawer immediately since it was not being used.

Interview with the Administrator, on 01/15/15 at 7:20 PM, revealed all narcotics/controlled drugs should be stored under double lock.

2. Observation of the South Hall Unit crash cart on 01/13/15 at 7:05 AM, revealed fifteen (15) lubricating jelly packets with an expiration date of May, 2013 and four (4) lubricating jelly packets with an expiration date of October, 2014. Further observation of the South Hall Unit crash cart revealed five (5) pairs of sterile latex gloves with an expiration date of April, 2014.

Observation of the Rehabilitation (Rehab) Unit crash cart on 01/13/15 at 8:35 AM, revealed twelve (12) lubricating jelly packets with an expiration date of May, 2013.

Observation of the North Hall Unit crash cart, on 01/14/15 at 8:55 AM, revealed one (1) lubricating jelly packet with an expiration date of May, 2013 and twenty-one (21) lubricating jelly packets with an expiration date of October, 2014.

Continued interview with Kentucky Medication Aide (KMA) #3, on 01/13/15 at 6:50 AM, revealed the crash carts on each unit were checked by the night shift nurses who were supposed to check the contents and expiration of materials located in the crash carts.

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F 431	Continued From page 42 Interview with the Central Supply Director (CSD), on 01/14/15 at 9:20 AM, revealed night shift nurses were supposed to check the crash carts every night and notify her if any item needed to be re-stocked. Further interview revealed the night shift nurses should have been checking for expired items in the crash carts. Interview with the North Unit Manager, on 01/14/15 at 5:10 PM, revealed night shift nurses checked the crash carts for the contents on the log sheet and should also be checking to make sure the supplies were not expired. Interview with the South Unit Manager, on 01/14/15 at 5:15 PM, revealed night shift nurses on the 7:00 PM to 7:00 AM shift, were supposed to check the crash carts for the contents on a check off sheet, and for expiration dates on the contents/supplies. Interview with the Rehab Unit Manager, on 01/15/15 at 5:10 PM, revealed the 7:00 PM to 7:00 AM night shift nurses checked the crash carts and they checked the contents on the check list. Per interview, the night shift nurses should be checking the expiration dates on the supplies because they should not be using supplies past the expiration date. Interview with the Director of Nursing (DON), on 01/15/15 at 5:45 PM, revealed the crash carts contents were monitored nightly by the night shift nurses, and there was a checklist. The DON stated however, the checklist did not specify to check for expiration dates of the products located in the crash cart. Per interview, someone should have been checking for expiration dates of the contents in the crash carts.	F 431			

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F 431 Continued From page 43

F 431

Interview with the Administrator, on 01/15/15 at 7:20 PM, revealed the night shift nurses checked the crash carts contents; however, was not sure if the check list notified them to check for expirations. Further interview revealed someone should have been checking for expiration dates on the supplies.

F 441 483.65 INFECTION CONTROL, PREVENT
SS=D SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
- (3) The facility must require staff to wash their hands after each direct resident contact for which

It is the policy of Richmond Place Rehabilitation and Health Center to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

On 1/15/15, a flu vaccination was given to resident #6 per the physician order by a Registered Nurse.

LPN #8 and Unit Manager LPN #2 will be re-inserviced by the Director of Nursing on 2/11/15 regarding the infection control policy including skin assessments and hand washings.

Physician orders for all residents related to vaccinations will be audited to ensure flu vaccinations ordered have been given by 2/28/15 by the 3 Unit Managers (2 LPN and 1 RN).

On 2/11/15, the Director of Nursing will re-inservice the 3 Unit Coordinators, Assistant Director of Nursing and the QA nurse regarding Infection Control Procedures including hand washing and flu vaccinations.

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hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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 establish and maintain an infection control program designed to help prevent the development and transmission of disease and infection for one (1) of eleven (11) sampled residents who were reviewed for immunizations out of a total sample of eighteen (18) residents (Resident #6).

Although Resident #6 was admitted by the facility on 11/28/14; there was no documented evidence the resident received the influenza vaccine until surveyor intervention.

In addition, poor infection control technique was observed during skin assessments for Resident #2 and Resident #3.

The findings include:

Review of the the facility "Influenza Vaccine" Policy, effective 10/06, revealed all residents would be offered the influenza vaccine annually, in the fall, to encourage and promote the benefits associated with immunizations against influenza. Further review revealed between October 1st and

F 441 Direct care staff (Registered Nurses, Licensed Practical Nurses, and Medication 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 Infection control including hand washing and flu vaccinations by 2/28/15.

The Director of Nursing and the Assistant Director of Nursing and Quality Assurance nurse will observe a total of 3 skin assessments a week for 6 weeks to ensure proper infection control techniques are utilized. The 3 Unit Managers (2 LPN and 1 RN) will audit 6 flu orders per week for six weeks to ensure the vaccination is administered.

The audits for infection control including skin assessments and flu vaccinations 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

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F 441	<p>Continued From page 45</p> <p>March 31st each year, annual influenza vaccinations would be administered to residents, unless the vaccination was medically contraindicated or the resident refused the vaccine due to personal or religious reasons.</p> <p>1. Review of Resident #6's medical record revealed the facility admitted the resident on 11/18/14 with diagnoses which included Aftercare Fracture of the Right Wrist, Osteoarthritis, and Pressure Ulcers. Review of the Admission Minimum Data Set (MDS) Assessment dated 12/05/14, revealed the facility assessed Resident #6 as having a Brief Interview for Mental Status (BIMS) of a ten (10) out of fifteen (15) indicating moderate cognitive impairment. Further review of the MDS, revealed the facility assessed the resident as not receiving the influenza vaccine at this facility for this years influenza vaccination season.</p> <p>Review of the "Rehabilitation/Skilled Nursing Center Admission Consent Information", signed and dated by the Responsible Party on 11/28/14 revealed consent was given for the facility to administer the influenza vaccine on admission and annually.</p> <p>Review of the Physician's Orders written 11/28/14 revealed the resident may have the annual flu vaccine 0.5 milliliters intramuscular if not allergic to eggs.</p> <p>Review of the Immunization Record on 01/13/14 revealed there was no documented evidence the resident had received the Influenza vaccine since admission. Further review revealed the resident was allergic to penicillin (antibiotic medication) and non steroidal anti-inflammatory drugs. There</p>	F 441		
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F 441	<p>Continued From page 46</p> <p>was no indication the resident was allergic to eggs.</p> <p>Interview, on 01/15/15 at 5:30 PM with the Unit Coordinator of the Rehabilitation Unit where Resident #6 resided, revealed once the consent for the vaccine was signed by the responsible party, the vaccine was to be administered. She further stated after each resident was admitted, she completed an admit audit and she had discovered during the admit audit she completed for Resident #6, the resident had not received the vaccine. She further stated, after the audit was completed, she reminded a staff nurse to administer the vaccine; however, had not followed up to ensure the resident had actually received the vaccine by checking the Medication Administration Record. Continued interview, revealed she realized the nurse had not followed through with administering the vaccine when the surveyor asked for documentation related to the vaccine being given during the survey.</p> <p>Interview, on 01/15/15 at 7:45 PM with the Director of Nursing (DON), revealed on admission, the residents and/or responsible parties sign a form stating if they want the influenza vaccine. She stated there was no set timeframe in which the vaccine was to be administered after admission; however, the vaccine should have been given prior to the survey. She stated this should have been caught by the Quality of Care Meeting which reviewed the chart for all new admissions.</p> <p>Interview with the Administrator on 01/15/14 at 8:20 AM, revealed the Unit Coordinator was responsible for tracking the vaccines and the vaccine should have been given shortly after the</p>	F 441		
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consent form was signed.

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2. Review of the facility's Handwashing/Hand Hygiene Policy, from the facility's Infection Control Policy and Procedure Manual Revised June 2010, revealed hand hygiene was considered the primary means to prevent the spread of infection. Further policy review revealed staff was supposed to wash hands after removing gloves and were to use alcohol based hand rub if moving from a contaminated body site to a clean body site during resident care.

Review of Resident #2's medical record revealed the resident was admitted by the facility on 11/25/14 with diagnoses which included Cellulitis of the Leg, General Sepsis, History of UTI, Coronary Artery Disease, and Hypertension. Review of the Admission MDS Assessment, dated 12/02/14, revealed the resident was always incontinent of bowel and bladder. Review of the Comprehensive Care Plan, dated 12/02/14 revealed the resident was care planned for alteration in elimination related to incontinence of the bowel and bladder.

Observation, on 01/13/15 at 4:27 PM, of a skin assessment performed on Resident #2 by Licensed Practical Nurse (LPN) #8 revealed after the nurse assessed the vaginal/perineal/anal areas she failed to remove her gloves and wash her hands before continuing. After touching the perineal/vaginal area LPN #8 assessed Resident #2's upper legs, back, and perineal/anal area. After completing the skin assessment the nurse touched Resident #2's clothing, bed linens, and Prevalon boots (off load heel boots) prior to removing gloves and washing hands.

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Interview, on 01/13/15 at 4:50 PM, with LPN #8 revealed the groin and bottom areas were considered dirty/contaminated body sites. LPN #8 revealed after assessing those areas, on Resident #2, she was supposed to clean her hands and re-glove before continuing because of the potential of cross contamination/spread of organisms. The LPN further revealed she was nervous and didn't clean her hands.

3. Observation, on 01/13/15 at 3:31 PM, of a skin assessment, on Resident #3, by LPN #2/Unit Coordinator (UC) revealed after assessing the perineal/vaginal area the LPN continued to assess the resident's legs and back, before assessing the perineal/anal area and then removing her gloves and washing hands.

Interview, on 01/13/15 at 3:48 PM and on 01/14/15 at 10:49 AM, with LPN #2/UC revealed after assessing the vaginal area she was supposed to wash hands and change gloves before continuing the skin assessment because of potential contamination and infection control. LPN #2 revealed she was nervous during the assessment and knew better.

Interview, on 01/15/15 at 7:17 PM, with LPN #1/Infection Control (IC) Coordinator revealed the perineal/vaginal area and perineal/anal areas were considered contaminated areas even if not visibly soiled. LPN #1/IC revealed the infection control procedure after assessing those areas was for the nurse to change gloves and wash hands prior to doing anything else. LPN #1/IC further revealed the risk to the residents was cross contamination and possible infection.

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Interview, on 01/15/15 at 8:55 PM, with the

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Director of Nursing (DON) revealed during the skin assessment the nurses should assess from dirty to clean areas. The DON revealed after completing assessments of the perineal area (vaginal/anal areas) she expected staff to change gloves and wash hands after completion of the assessment to those areas. The DON further revealed the risk was potential cross contamination of organisms and related infection.

Interview on 01/15/15 at 9:23 PM with the Administrator revealed she only had a basic knowledge of infection control but expected staff to follow infection control procedures. The Administrator further revealed she understood the infection control guideline of not putting clean and dirty together.

2. Review of the facility's Handwashing/Hand Hygiene Policy, from the facility's Infection Control Policy and Procedure Manual Revised June 2010, revealed hand hygiene was considered the primary means to prevent the spread of infection. Further policy review revealed staff was supposed to wash hands after removing gloves and were to use alcohol based hand rub if moving from a contaminated body site to a clean body site during resident care.

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Review of Resident #2's medical record revealed the resident was admitted by the facility on 11/25/14 with diagnoses which included Cellulitis of the Leg, General Sepsis, History of UTI, Coronary Artery Disease, and Hypertension. Review of the Admission MDS Assessment, dated 12/02/14, revealed the resident was always incontinent of bowel and bladder. Review of the Comprehensive Care Plan, dated 12/02/14 revealed the resident was care planned for alteration in elimination related to incontinence of the bowel and bladder.

Observation, on 01/13/15 at 4:27 PM, of a skin assessment performed on Resident #2 by Licensed Practical Nurse (LPN) #8 revealed after the nurse assessed the vaginal/perineal/anal areas she failed to remove her gloves and wash her hands before continuing. After touching the perineal/vaginal area LPN #8 assessed Resident #2's upper legs, back, and perineal/anal area. After completing the skin assessment the nurse touched Resident #2's clothing, bed linens, and Prevaion boots (off load heel boots) prior to removing gloves and washing hands.

Interview, on 01/13/15 at 4:50 PM, with LPN #8 revealed the groin and bottom areas were considered dirty/contaminated body sites. LPN #8 revealed after assessing those areas, on Resident #2, she was supposed to clean her hands and re-glove before continuing because of the potential of cross contamination/spread of organisms. The LPN further revealed she was nervous and didn't clean her hands.

3. Observation, on 01/13/15 at 3:31 PM, of a skin assessment, on Resident #3, by LPN #2/Unit

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F 441	Continued From page 51 Coordinator (UC) revealed after assessing the perineal/vaginal area the LPN continued to assess the resident's legs and back, before assessing the perineal/anal area and then removing her gloves and washing hands. Interview, on 01/13/15 at 3:48 PM and on 01/14/15 at 10:49 AM, with LPN #2/UC revealed after assessing the vaginal area she was supposed to wash hands and change gloves before continuing the skin assessment because of potential contamination and infection control. LPN #2 revealed she was nervous during the assessment and knew better. Interview, on 01/15/15 at 7:17 PM, with LPN #1/Infection Control (IC) Coordinator revealed the perineal/vaginal area and perineal/anal areas were considered contaminated areas even if not visibly soiled. LPN #1/IC revealed the infection control procedure after assessing those areas was for the nurse to change gloves and wash hands prior to doing anything else. LPN #1/IC further revealed the risk to the residents was cross contamination and possible infection. Interview, on 01/15/15 at 8:55 PM, with the Director of Nursing (DON) revealed during the skin assessment the nurses should assess from dirty to clean areas. The DON revealed after completing assessments of the perineal area (vaginal/anal areas) she expected staff to change gloves and wash hands after completion of the assessment to those areas. The DON further revealed the risk was potential cross contamination of organisms and related infection. Interview, on 01/15/15 at 9:23 PM with the Administrator revealed she only had a basic	F 441			

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F 441	Continued From page 52 knowledge of infection control but expected staff to follow infection control procedures. The Administrator further revealed she understood the infection control guideline of not putting clean and dirty together.	F 441			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 520	It is the policy of Richmond Place Rehabilitation and Health Center to maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. It is our policy that the quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. On 1/15/15, the Dietary Manager provided the corrected tray card and discarded any incorrect cards for resident #15. The Quality Assurance Plan for F367 Therapeutic Diet prescribed by physician, will be reviewed by the Quality Assurance Committee and updated to reflect specific concerns identified during survey with new actions and audits by 2/28/15. The Registered Dietician and Dietary Manager will audit all resident tray cards for accuracy in reflecting the current diet order by 2/28/15.		

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 01/15/2015
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 520	Continued From page 53 and review of the facility's policies and Plan of Correction (POC) for the Standard Survey completed on 01/30/14, it was determined the facility failed to maintain an effective Quality Assessment and Assurance (QA) Program to ensure the facility's POC was implemented, monitored, evaluated and revised to ensure ongoing compliance was maintained. This was evidenced by a repeat deficiency related to the facility's failure to ensure residents received and consumed foods in the appropriate form as prescribed by the Physician for one (1) of eighteen (18) sampled residents (Resident #15). Resident #15 had a Physician's Order dated 01/15/15, for him/her to receive a pureed diet; however, observation of the meal ticket and food revealed a modified texture diet was served to the resident on 01/15/15. (see F367) The findings include: Review of the facility's policy titled, "Quality Assurance Overview", revised 12/01/11, revealed one (1) of the primary goals of the Quality Assurance and Performance Improvement (QAPI) Committee was to provide systematic analysis/actions whereby opportunities for improvement relative to resident care were identified and resolved through an interdisciplinary approach and positive outcomes were reinforced through education and monitoring. Further review of the Policy revealed the QAPI team reviewed action plans to identify the root cause of areas recognized as opportunities of improvement, and implemented systems intended to prevent reoccurrence and sustain improvement. Review of the facility's POC, with a compliance	F 520	The Regional Director of Clinical Services, RN re-educated the Administrator regarding the Quality Assurance ("QA") policies and procedures on 2/09/15. The Administrator will re-educate the Quality Assurance Committee, (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) regarding the QA policies and procedures by 2/28/15. On 1/15/15, the Registered Dietician re-inserviced the Dietary Manager and the Kitchen Manager regarding matching the tray card to the diet order and tray card entry procedures as well as proper filing of new tray cards and disposal of any tray cards that do not reflect the current order. The Registered Dietician and Kitchen Manager will re-educate dietary associates regarding tray cards and checking to ensure accuracy by 2/28/15. The Dietary Manager will audit 6 diet orders per week for 6 weeks for accuracy compared to tray card and then audit 6 tray card monthly for 12 months monthly with guidance from the Quality Assurance Committee, (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant).		

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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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F 520 Continued From page 54
date of 03/14/14, revealed the Dietary Manager (DM) and the Kitchen Manager were educated on therapeutic diet policies, on 02/21/14, by the Registered Dietician (RD). Per the POC, re-inservicing was performed by the Assistant Director of Nursing (ADON) and the Quality Assurance (QA) Nurse, for all Unit Managers (UM) and all nurses on the therapeutic diet policies, including proper notification of diet changes by 03/14/14. Review of the POC revealed audits of therapeutic diet orders were performed by the DM of six (6) residents for compliance with orders for six (6) weeks and then monthly for six (6) months. Further review of the POC revealed audit results were reviewed by the QA/PI Committee for compliance.

Review of the facility's policy titled, "Approved Diets/Menu", revised December, 2013, revealed residents were to be offered only approved diets, and it was the responsibility of Dining Services management to implement compliance.

Observation, on 01/15/15 at 6:42 PM, of Resident #15's meal tray revealed the resident received a texture modified diet. Review of the Resident #15's meal ticket at the time of observation revealed the resident was to receive a texture modified diet. However, review of Resident 15's medical record revealed a Physician's Order, dated 01/15/15, to change the resident's diet to a pureed diet.

Interview, on 01/15/15 at 3:15 PM and 7:02 PM with LPN #3/Unit Coordinator (UC) revealed, Resident #15 had been served a texture modified diet and the meal ticket indicated that was what the resident was to receive. However, LPN #3/UC revealed an order was written that

F 520 The audits of physician orders relating to diets and tray cards will be forwarded and reviewed by the Quality Assurance Committee, (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review to maintain compliance. In addition, the Action Plan for Therapeutic Diets will be reviewed monthly by the QA Committee for a minimum of 12 months with new interventions changed or added as needed.

Completion Date: February 28, 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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F 520: Continued From page 55

morning to change Resident #15's food texture to pureed. Per interview, this was communicated to the dietary department via the "Physician Diet Order" form.

Interview, on 01/15/15 at 7:40 PM, with the DM revealed Resident #15 was served a modified texture diet for dinner that day; however, the resident should have received a pureed diet as his/her diet had been changed that morning. Per interview, the dietary department had received a dietary communication form that morning to change Resident #15's diet to pureed and the meal ticket was updated. However, the new ticket was not included with the dinner tray meal ticket cards, therefore Resident #15 received the wrong diet.

Interview, on 01/14/15 at 1:54 PM, with the RD revealed he did quarterly random audits of five (5) residents and compared the meal tickets to the order.

Interview, on 01/15/15 at 8:55 PM, with the DON revealed the pureed ordered diet was not followed by staff because the tray ticket indicated a modified texture diet. The DON revealed she was not aware if dietary had a process to audit the orders residents meal tickets.

Interview, on 01/15/15 at 9:23 PM, with the Administrator revealed the meal ticket incorrectly indicated a modified texture diet and the meal served was modified texture. However, the Administrator revealed a pureed diet was ordered and the resident should have received that.

Interview with the QA Nurse on 01/15/15 at 10:15 PM, revealed an inservice was done after the last

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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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F 520 Continued From page 56
annual survey by the RD for the DM and the Kitchen Manager related to facility's therapeutic diet policies. She stated the ADON and she inserviced all the nurses and Unit Managers regarding the therapeutic diet policies. Per interview, the DM was still auditing the trays to ensure the tray tickets, and the meal was correct and comparing it with his reference sheet. Continued interview revealed all the tray cards were still being audited and updated by the DM daily to ensure they were correct. The QA Nurse stated this audit was not being taken to the QA Committee at this time, and the audits were being analyzed and discussed between the RD and the DM.

F 520

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/13/2015
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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K 000 INITIAL COMMENTS

Building: 01

Plan Approval: 1991

Survey under: NFPA 101 (2000 Edition)

Facility type: SNF/NF

Type of structure: Type V (000) Unprotected

Smoke Compartment: Two (2)

Fire Alarm: Complete Fire alarm System

Sprinkler System: Complete Sprinkler System (Wet and Dry)

Generator: Type II Diesel and Type II Natural Gas

A Life Safety Code Survey was initiated and concluded on 01/13/15. The facility was found to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid, Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility is licensed for one hundred and twenty (120) beds and the census was eighty-eight (88) on the day of the survey.

K 000

01-13-2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Berita Dickerson Administrator
TITLE
DATE
2/9/15

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