

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

PRINTED: 03/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/18/2014
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 03/14/14.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 02/25/2014
FORM APPROVED
OMB NO. 0938-0301

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 01/30/2014
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F 000	INITIAL COMMENTS AMENDED A Recertification Survey was initiated on 01/28/14 and concluded on 01/30/14. Deficiencies were cited with the highest Scope and Severity of a "F".	F 000	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies dated 2/13/2014. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 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 promote care for residents in a manner and environment that maintained or enhanced each resident's dignity and respect in full recognition of their individuality by failure to interact with residents prior to and during meal service. The findings include: Review of the facility policy titled, "Quality of Life-Dignity", revised October 2009, revealed each resident was to be treated with dignity and respect at all times. Review of the facility job description for Resident Care Associate, State Registered Nurse Aide (SRNA), dated April 2009, revealed the SRNA was to treat the resident with dignity and respect.	F 241	It is the policy of Richmond Rehabilitation and Health Center to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	

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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Benita Dickerson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3-14-14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>Review of the facility job description for Nurses, dated March 2010, revealed nurses were to assist in maintaining a social and psychological environment in the best interest of the resident.</p> <p>1. Observation of lunch meal service in the ice cream parlor on 01/28/14 revealed Unsampled Resident D received a lunch tray at at 12:25 PM; however, Resident #16 who was at the same table did not receive a lunch tray until 12:40 PM, fifteen (15) minutes later.</p> <p>Interview on 01/28/14 at 12:45 PM with Licensed Practical Nurse (LPN) #2 who was assisting in the ice cream parlor with meal service, revealed the main dining room had been unavailable since "last Thursday" due to a problem with frozen pipes, so the usual dining routine had changed. She stated Resident #16 did not usually eat lunch in the ice cream parlor; and, therefore his/her meal tray did not come up with the other residents who were eating in the ice cream parlor. Further interview, revealed it was a dignity issue for residents not to receive meal trays at the same time if they were sitting at the same table.</p> <p>Interview on 01/28/14 at 2:00 PM with Resident #16, revealed he/she usually ate in his/her room. Resident #16 stated "today" at lunch was the second time he had eaten out of his/her room due to being embarrassed because he/she was a messy eater. He/She stated it bothered him/her when he/she did not get the meal tray at the same time as a tablemate. Further interview revealed he/she was usually pretty easy to get along with, but sometimes he/she could be impatient.</p> <p>2. Observation of the dinner meal service in the</p>	F 241	<p>Dining service for Resident #2 and Resident #16 and unsampled Resident A was reviewed by the Director of Nursing on 1/31/14. The Dining location for Resident #2 and Resident #16 and unsampled Resident A was communicated to the Dietary Manager prior to each meal service so that the trays could be served at the same time as their tablemates on 1/31/14.</p> <p>Dining service to the main Dining Room resumed on 2/7/14. Dining Service including seating arrangements and meal delivery times for all residents, including those residents dining in the dining room, receiving room service, and/or dining throughout the facility, will be reviewed by the Assistant Director of Nursing and the Dietary Manager. Dining arrangements for all residents throughout the facility will be updated including seating arrangements, location where the resident will dine each meal and timeliness of tray delivery in order to facilitate an environment that maintains or enhances each resident's dignity and respect by March 14, 2014.</p>	

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F 241	<p>Continued From page 2</p> <p>North Kitchen area, on 01/28/14 at 5:51 PM, revealed Resident #2 sitting at the dining table, with his/her dinner served and no one to cue or assist the resident with the meal. Continued observation revealed at 6:10 PM, Registered Nurse (RN) #3 came to the table and started to assist the resident. Further observation revealed the resident took bites when assisted by staff.</p> <p>Review of Resident #2's medical record revealed the resident was admitted by the facility on 05/10/12, with diagnoses which included Alzheimer's Disease, Oropharyngeal Dysphagia, and Diabetes Type II. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 12/31/13, revealed the facility assessed Resident #6 to be severely cognitively impaired and to require extensive assistance of one (1) staff with eating. Review of Resident #2's care plan for Alteration in Nutrition/Hydration revealed an intervention to assist the resident with meals as allowed by the resident for maximum intake and to provide cues and prompts as indicated.</p> <p>Interview, on 01/28/14 at 7:02 PM, with Registered Nurse (RN) #3 revealed Resident #2 ate one hundred percent of his/her meal after she assisted him/her. RN #3 stated staff were not to sit down and assist residents with meals until everyone's trays were delivered. She stated unfortunately there had been a delay in getting resident trays and this delayed providing assistance. The RN further stated she was unsure how long the meal was in front of the resident prior to her assisting the resident with eating.</p> <p>Interview, on 01/30/14 at 5:08 PM, with LPN #2/South Unit Coordinator regarding the dinner</p>	F 241	<p>The Assistant Director of Nursing and/or the Quality Assurance Nurse will re-in-service facility staff involved in the dining process regarding the community's dining policy and procedure and related documents including service time, resident rights, resident interaction, and dignity by March 14, 2014.</p> <p>The Quality Assurance Nurse and/or the Unit Coordinator will audit meal service three (3) times weekly for six (6) weeks for compliance with facility policy and procedure including observation of staff interaction and service time. The Quality Assurance nurse, Director of Nursing and/or the Assistant Director of Nursing will monitor and observe via daily rounds at least five (5) times a week for six (6) weeks that all residents are treated in a manner and environment that maintains/enhances each resident's dignity and individuality.</p>	

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F 241	<p>Continued From page 3</p> <p>meal observation of Resident #2 on 01/28/14, revealed if Resident #2 was making no attempt to feed himself/herself, someone should have intervened and assisted the resident. The LPN stated the resident's wait for assistance could have effected the temperature of his/her food; and it did not make sense for staff to wait until all trays were delivered before assisting residents.</p> <p>Interview, on 01/30/14 at 6:07 PM, with the Director of Nursing (DON) regarding observation of the delay in assisting Resident #2 with his/her meal, revealed she would have preferred for staff to have intervened sooner. The DON stated dining had been an issue related to the main dining area being closed because of frozen water pipes and damage to that area, therefore there had been confusion in arranging residents at the tables. According to the DON, there had been delays in getting residents their meals because more residents were coming out of their rooms to eat. She stated the facility needed to make changes due to this and put together a plan to resolve the issue.</p> <p>3. Observation on 01/28/14 at 12:15 PM, in the South Living Room revealed ten (10) residents waiting for lunch. Observation revealed Unsampld Resident B and Unsampld Resident A were sitting at the same table. Continued observation revealed Unsampld Resident B received a lunch tray; however, Unsampld Resident A did not receive a lunch tray. Unsampld Resident A was observed to reach out toward the lunch tray of Unsampld Resident B. Unsampld Resident B tray kept moving his/her lunch tray saying, "no, no, it's not yours." Further observation revealed staff did not intervene during this exchange.</p>	F 241	<p>The audits of meal service and results of daily rounds will be forwarded to the Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for continued monitoring to maintain compliance.</p> <p>Completion Date: March 14, 2014</p>	

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F 241	Continued From page 4 Interview with the South Unit Coordinator on 01/28/14 at 12:25 PM, revealed Unsampled Resident B received an early tray and there was two (2) early trays served for that Unit. Continued interview revealed it would bother her if her tablemates received a tray and she did not. Continued observation on 01/28/14 at 12:30 PM, after the interview with the South Unit Coordinator, revealed residents that were not served an early tray were moved to the South Kitchenette dining area. 4. Observations, during the dinner meal service on 01/28/14, revealed residents sat in the South Kitchenette dining area from approximately 5:15 PM to 6:35 PM, when trays arrived, without staff engaging residents in conversation or offering the residents a drink. Observations included State Registered Nurse Aide (SRNA) #1 who was observed to be leaning against the kitchen island at times before trays arrived and sitting at a table with (4) residents with her arms crossed and not interacting with them at other times. Interview with SRNA #1 on 01/28/14 at 6:05 PM revealed staff should interact with residents prior to and during meal service. Interview with SRNA #2 on 01/28/14 at 6:10 PM who was also in the dining area indicated she was unaware of the need to interact with the residents while waiting for meal service. Interview with the Director of Nursing (DON) on 01/30/14 at 4:15 PM revealed her expectation was for staff was to interact with residents during meal service. She indicated this was to ensure	F 241			

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F 241	Continued From page 5 residents were treated with dignity and respect. An additional interview, on 01/30/14 at 6:07 PM, with the Director of Nursing (DON) revealed dining in the facility had been an issue related to the main dining area being closed because of frozen water pipes and damage to that area, therefore there had been confusion in arranging residents at the tables available. According to the DON, there had been delays in getting residents their meals because more residents were coming out of their rooms to eat. She stated the facility needed to make changes due to this and put together a plan to resolve the issue.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	It is the policy of Richmond Rehabilitation and Health Center 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. Resident #13 was reassessed and the care plan was updated as indicated by the Minimum Data Set (MDS) Coordinator #2 on 1/29/14.	

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F 279	Continued From page 6 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 the Comprehensive Plan of Care was developed with specific interventions to meet the resident's medical and nursing needs that were identified in the Comprehensive Assessment for one (1) of twenty-two (22) sampled residents (Resident #13). Resident #13's Comprehensive Plan of Care revealed Interventions for a sensor alarm to the bed and wheelchair; however, interviews revealed the resident was not to have sensor alarms. The findings include: Review of the facility's policy titled, "Care Planning/Interdisciplinary Team", revised December 2008, revealed the facility's Care Planning/Interdisciplinary Team was responsible for the development of an individualized Comprehensive Plan of Care. Further review revealed areas of concern which were triggered during the resident assessment were evaluated using specific assessment tools before interventions were added to the care plan. Care plan interventions were designed after careful consideration of the relationship between the resident's problem areas and their causes. Review of the medical record for Resident #13 revealed the facility admitted the resident on 01/06/14, with diagnoses which included Rheumatoid Arthritis, Degenerative Joint Disease (DJD) and Joint Pain of the left leg. Review of	F 279	The facility's three (3) MDS Coordinators will audit all resident care plans for accuracy and will update as indicated by March 14, 2014. All of facility's three (3) MDS Coordinators will be re-inserviced by the Regional Minimum Data Set (MDS) Coordinator regarding the community's policy and procedures relating to the care planning process by March 14, 2014. MDS Coordinator #1 will educate the Interdisciplinary Care Plan Team (Dietary Manager, Activities Director, three (3) Unit Managers, and two (2) Social Service Coordinators) by March 14, 2014. The Comprehensive Care Plans for all residents will be audited for accuracy by the Director of Nursing or Assistant Director of Nursing quarterly for one (1) year to verify they include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs.		

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F 279	<p>Continued From page 7</p> <p>the Admission Minimum Data Set (MDS) Assessment dated 01/13/14, revealed the facility assessed Resident #13 as having a Brief Interview for Mental Status (BIMS) of a fifteen (15) which indicated the resident was cognitively intact. Further review revealed the facility had assessed Resident #13 as having had no falls since admission. Review of the Care Area Assessment Summary (CAAS) dated 01/17/14 revealed falls triggered and was to be care planned.</p> <p>Review of the Comprehensive Plan of Care dated 01/17/14 revealed the resident had a care plan for the potential for injury and falls related to decreased mobility due to diagnoses of DJD and Rheumatoid Arthritis. Further review of this care plan revealed interventions which included a sensor alarm to the bed and wheelchair.</p> <p>Observation of Resident #13 on 01/29/14 at 8:30 AM and 9:00 AM, revealed Resident #13 was lying on the bed with the call bell and phone in reach. Further observation revealed no sensor alarm was on the bed or on the wheelchair at bedside.</p> <p>Interview, on 01/29/14 at 9:15 AM, with State Registered Nurse Aide (SRNA) #7, revealed she was assigned to the resident and was very familiar with the resident. She stated she was unaware of the resident having alarms to the bed or wheelchair. She checked the Certified Nursing Aide Care Plan Record and stated the alarms were not on the Care Plan. Further interview revealed the nurses were to tell the CNA's if a resident was to have alarms and the CNA's were responsible for placing them on the bed or chair.</p>	F 279	<p>The Quarterly audits will be forwarded to the Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for continued monitoring to maintain compliance.</p> <p>Completion Date: March 14, 2014</p>	

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F 279	<p>Continued From page 8</p> <p>Interview, on 01/29/14 at 10:30 AM, with Licensed Practical Nurse (LPN) #5, revealed she was assigned to Resident #13, and she was unaware of the resident having any alarms on the bed or wheelchair.</p> <p>Interview on 01/29/14 at 10:35 AM with Registered Nurse (RN) #4/Director of the Rehabilitation Unit, revealed none of the residents on the Rehabilitation Unit had alarms, and she was unsure why the intervention for the sensor alarms to the bed and wheelchair was on the care plan. She stated the MDS nurses generated the care plans and she would ensure it was corrected.</p> <p>Interview on 01/29/14 at 6:45 PM with Licensed Practical Nurse (LPN) #6/MDS Coordinator on 01/29/14 at 6:45 PM, revealed the Comprehensive Plan of Care was developed within twenty-one (21) days for new admissions by the interdisciplinary team which included social services, nursing, dietary, and activities staff. She stated Resident #13 had been at the facility once before this admission and when the resident was admitted this last time, she pulled the care plan over from the last admission. She stated she then tweaked the care plan to ensure it was correct for this admission. Continued interview revealed the intervention for sensor alarms might have been on the care plan from the previous admission when she pulled it over; however the sensor alarms should not have been on the current care plan as Resident #13 did not require them.</p> <p>Interview on 01/30/14 at 7:00 PM with the Director of Nursing (DON), revealed her expectation was for Care Plans be correct as far</p>	F 279		

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F 279	Continued From page 9 as interventions including alarms. She indicated care plans were to accurately reflect residents needs.	F 279			
F 282 SS=0	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide care in accordance with each resident's written Comprehensive Care Plan related to Oxygen administration for two (2) of twenty two (22) sampled residents (Resident #6 and Resident #15) and as related to bowel management for one (1) of (22) sampled residents (Resident #11). The findings include: Review of the facility's policy titled, "Care Planning-Comprehensive Policy", revised 2010, revealed an individualized care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was to be developed for each resident and identify the professional services responsible for each element of care. 1. Review of Resident #15's medical record revealed diagnoses which included Oxygen (O2) Dependent, Stage IV Kidney Disease,	F 282	It is the policy of Richmond Rehabilitation and Health Center that the services provided or arranged by the facility are in accordance with each resident's written plan of care. Resident #15 oxygen tank was replaced at 12:47 PM on 01/28/14 by the Assistant Director of Nursing. Resident #6 was reassessed and physician orders were clarified, O2 was set according to the clarified order, MAR updated to reflect the clarified order and care plan updated as indicated on 1/29/2014 by the Unit Coordinator. The physician was notified on 1/30/14 by the Unit Coordinator regarding Bowel Management for resident #11 with new orders noted and care plans updated as indicated.		

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F 282	<p>Continued From page 10</p> <p>Thrombocytopenia and Anxiety. Review of Resident #15's Comprehensive Care Plan, dated 12/20/13, revealed an intervention for Resident #15 to receive oxygen (O2) per Physician's Orders. Review of the monthly Physician's Orders for January 2014 revealed an order for O2 administration at four (4) liters per minute (LPM) per nasal cannula (NC).</p> <p>Observation on 01/28/14 at 12:40 PM, in the ice cream parlor revealed Resident #15's portable O2 tank on the back of the wheelchair was empty. Continued observation revealed the empty tank was not changed until 12:47 PM, by the Assistant Director of Nursing (ADON).</p> <p>Interview, with State Registered Nurse Aide (SRNA) #1 on 01/28/14 at 12:42 PM, revealed direct care staff were only to observe the volume of the O2 tanks and alert the nurse as to the amount. SRNA #1 stated she had returned Resident #15 to the ice cream parlor from toileting at approximately 11:40 AM and had not checked the volume of the O2 tank during the time she was with the resident.</p> <p>Interview with the ADON on 01/28/14 at 12:47 PM, revealed her expectation was for staff to check the O2 volume on the tank when residents initially were attached to the portable O2 tanks and all through the day. Continued interview revealed all staff who come in contact with residents on O2 have the responsibility to observe the volume and alert the nurse if the volume was low. She further stated staff had at least two (2) opportunities to observe the volume of the tank prior to time it was changed. The ADON stated Resident #15 usually required replacement of his/her O2 tank about every two</p>	F 282	<p>The Assistant Director of Nursing, Quality Assurance Nurse, and Unit Managers will audit all physicians' orders including all oxygen orders and orders relating to bowel care to ensure they are followed per the physicians order by March 14, 2014. The MDS Coordinator will review all care plans including those related to oxygen and bowel care and update as indicated by March 14, 2014.</p> <p>All care staff (Unit Managers, Registered Nurses, Licensed Practical Nurses, and Nurse Aides) will be re-inserviced on the community's policies relating to care and services including following physicians orders, protocols for monitoring oxygen, and protocols for monitoring bowel care, and associated care plans by the Assistant Director of Nursing and the Quality Assurance nurse and the Unit Manager by March 14, 2014. The MDS Coordinators will be re-inserviced by the Regional MDS Coordinator regarding the community's policy and procedures relating to the care planning process by March 14, 2014.</p>	

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F 282	<p>Continued From page 11</p> <p>hours to every two and a half hours because of the ordered flow rate of four (4) LPM per NC.</p> <p>Interview, with SRNA #3 (assigned to Resident #15 on 01/28/14), on 01/29/14 at 2:50 PM, revealed Resident #15 was already up by the time she started working that morning. She stated she had looked at the volume at approximately 8:00 AM and the O2 tank was half full. She further stated it was everyone's responsibility to be aware of the volume in the O2 tanks.</p> <p>Interview, on 01/29/14 at 3:00 PM, with Licensed Practical Nurse (LPN) #3, who was the nurse assigned to Resident #15 on 01/28/14, revealed Resident #15 had not needed his/her O2 tank replaced when she performed her initial assessment the morning of 01/28/14. The LPN stated it was everyone's responsibility to "keep an eye" on the volume in the portable O2 tanks.</p> <p>Interview, on 01/29/14 at 3:20 PM, with the Physical Therapy Aide (PTA), who had assisted with Resident #15 therapy on 01/28/14, revealed she had changed the resident's portable O2 tank at approximately 9:30 AM on 01/28/14, before she took Resident #15 to therapy.</p> <p>2. Observations on 01/28/14 at 2:26 PM, and on 01/29/14: at 8:32 AM and 12:20 PM revealed Resident #6 had a nasal cannula in place and his/her O2 was observed to be set for four (4) LPM.</p> <p>Review of Resident #6's medical record revealed the resident was admitted by the facility on 12/13/11 and had diagnoses which included Heart Failure, Chronic Kidney Disease and Pneumonia</p>	F 282	<p>Physician orders and the associated protocol, including orders/protocols relating to oxygen and bowel care, will be (six (6) charts per week) audited weekly for six (6) weeks and then monthly for three (3) months for compliance by the Quality Assurance Nurse and the Assistant Director of Nursing. In addition, all Comprehensive Care Plans will be audited by the Director of Nursing or the Assistant Director of Nursing quarterly for one (1) year to ensure the services provided or arranged by the facility are in accordance with each resident's written plan of care</p> <p>The audits of physician orders, associated protocols, and Comprehensive Care Plans will be forwarded to the Quality Assurance Committee, (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review to maintain compliance.</p> <p>Completion Date: March 14, 2014</p>	

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F 282	<p>Continued From page 12</p> <p>on 01/01/14. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 01/14/14, revealed the facility assessed the resident as cognitively impaired with short/long term memory problems. Review of Resident #6's Comprehensive Care Plan revealed a care plan for impaired gas exchange, dated 01/24/14 with interventions which included to administer oxygen as ordered.</p> <p>Review of Resident #6's Physician Orders revealed an order dated 01/01/14 timed 3:00 PM, to administer two (2) LPM of O2 via NC to maintain Resident #6's oxygen saturation (O2 sats) greater than ninety (90) percent. In addition, there was a Physician's Order, dated 01/02/14, to have staff monitor the resident's O2 saturation each shift related to the use of O2 and shortness of air.</p> <p>Review of Resident #6's Medication Record dated 01/14 included staff were to monitor the resident's O2 sats each shift and could administer two (2) liters O2 via NC to maintain O2 sats greater than ninety (90) percent. Continued review of the Medication Record revealed staff were recording the resident's O2 sats each shift until 01/14/14 when the Medication Record indicated the monitoring was discontinued. However, review of the Physician's Orders revealed no order to discontinue the O2 sats monitoring.</p> <p>Interview, on 01/29/14 at 12:26 PM, with Licensed Practical Nurse (LPN) #4 who was assigned to the resident, revealed she observed the resident was currently receiving O2 at four (4) LPM; however the order was for Resident #6 to receive O2 as needed at two (2) LPM via NC to maintain O2 sat levels above ninety (90) percent. The</p>	F 282		
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F 282	<p>Continued From page 13</p> <p>LPN further stated it was the nurses responsibility to check the O2 administration level.</p> <p>Interview, on 01/30/14 at 5:03 PM, with LPN #2/South Unit Coordinator revealed there were no orders to discontinue monitoring the resident O2 sat level, and she thought it had been mistakenly discontinued by staff when the resident was admitted to Hospice. The LPN stated the O2 sats were to have been monitored to see if Resident #6's saturation level was above ninety (90) percent to determine the need for O2 administration. In addition, she stated staff could do a better job of monitoring O2.</p> <p>Interview, on 01/30/14 at 5:40 PM, with the Director of Nursing (DON) revealed Resident #6 had been treated for Pneumonia and had an order to monitor O2 sats and an order for O2 to be administered at two (2) LPM as needed. The DON stated staff should have continued to monitor the O2 need and the order should not have been discontinued. She stated staff should have clarified if the O2 was to have been continuous or as needed.</p> <p>3. Review of Resident #11's medical record revealed diagnoses which included Paralysis Agitans, Alzheimer's disease, and Difficulty in Walking. Review of the Annual Minimum Data Set (MDS) Assessment dated 11/26/13, revealed the facility assessed Resident #11 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of a possible fifteen (15), indicating the resident was cognitively intact. Review of Resident #11's Comprehensive Care Plan, dated 12/04/13, revealed a care plan regarding the resident's potential for constipation related to the use of pain medications. Continued</p>	F 282		

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F 282	<p>Continued From page 14</p> <p>review of this care plan revealed the goal stated the resident was to have a bowel movement (BM) at least every three (3) days. Further review revealed the interventions included monitoring the bowel record every day and administering laxatives as needed if no BM for three (3) days.</p> <p>Review of Resident #11's Bowel and Bladder Chart Detail Report revealed the resident had a BM on 12/08/13, and the next BM was noted to be on 12/16/13, eight (8) days later. Review of the Medication Record dated December 2013 revealed Resident #11 received Milk of Magnesia (a laxative medication) thirty (30) milliliters (ml's) prn (as needed) on 12/13/14, and 12/14/13 for constipation. Further review of the Medication Record revealed no documented evidence of the results of the Milk of Magnesia (MOM) recorded on it.</p> <p>Continued review of the Bowel and Bladder Chart Detail Report revealed the resident had a BM on 01/15/14, with the next BM noted to be on 01/21/14, six (6) days later. Review of the Medication Record dated January 2014 revealed Resident #11 received MOM thirty (30) ml's prn as a laxative on 01/19/14, 01/20/14, and on 01/21/14. Further review of the Medication Record revealed no documented evidence of results recorded on it</p> <p>Interview, on 01/30/14 at 4:30 PM, with Licensed Practical Nurse (LPN) #7/Unit Coordinator (UC) on Resident #11's unit, revealed the night shift nurse ran the seventy-two (72) hour report for residents who had not had a BM for the past three (3) days. LPN #7/UC stated morning shift received the seventy-two (72) hour report and asked night shift staff if the resident had received</p>	F 282		

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F 282	<p>Continued From page 15</p> <p>a laxative. According to LPN #7/UC if the resident had not received a laxative on night shift, day shift administered the laxative. She stated if the laxative was ineffective, the nurse were to call the Physician to inquire if another medication could be prescribed for the resident. LPN #7/UC reviewed Resident #11's bowel history for the dates of 12/09/13 through 12/15/13. After reviewing the bowel history, she stated Resident #11 should have been noted on the seventy-two (72) hour report. She indicated Resident #11 had received MOM prn during that time period. LPN #7/UC stated the resident had possibly had a BM during that time period; however if so, it was not documented. LPN #7/UC reviewed Resident #11's bowel history for January 2014 and stated the resident had a BM on 01/15/14, and did not have another BM until 01/21/14, six days later. Further interview with LPN #7/ UC revealed Resident #11 had received a laxative on 01/19/14, 01/20/14, and 01/21/14. She reviewed Resident #11's record and reported there was no documented evidence the resident had a BM during that time period.</p> <p>Interview with the DON on 01/30/14 at 9:00 AM and 7:36 PM, revealed Resident #11's Physician should have been notified of the lack of BMs to see if there had been a decline in the resident's condition and to what advice the Physician had after the laxatives were administered and Resident #11 had no documented BM. She indicated this would have ensured Resident #11 had BMs on a regular basis. She stated the nurses and the Unit Coordinators were responsible to ensure care plans were followed.</p>	F 282	
F 309 SS=0	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	

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F 309	<p>Continued From page 16</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for one of twenty-two (22) sampled residents (Residents #11). The facility failed to ensure their bowel protocol was followed for Resident #11 who had no documented evidence of a bowel movement from 12/9/13 until 12/16/13 (eight days) and from 1/16/14 until 1/21/14 (six days).</p> <p>The findings include: Review of the the facility's policy titled, "Bowel Management", revised 04/01/11, revealed the policy was to ensure all residents who had not had a bowel movement (BM) in three (3) days, were given safe, effective and timely care for the management of their constipation to prevent fecal impaction. Continued review revealed the nurse would complete an assessment on the resident to include the following: a visual exam of the abdomen and rectum; auscultation of bowel sounds; and note signs and symptoms of constipation. Further review revealed if a resident had not had any prn (as needed) bowel</p>	F 309	<p>It is the policy of Richmond Place Rehabilitation and Health Center to provide the necessary care to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>The physician was notified on 1/30/14 regarding Bowel Management for resident #11 with new orders noted and the care plan updated as indicated by the Unit Coordinator.</p> <p>The Assistant Director of Nursing, Quality Assurance Nurse, and Unit Managers will audit all current physicians' orders including those relating to bowel care to ensure they are followed per the physicians order by March 14, 2014. The Assistant Director of Nursing and the Quality Assurance Nurse will review the</p>	

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F 309	<p>Continued From page 17</p> <p>medication or product ordered by the Physician, and was in acute distress, the Physician was to be contacted. If a resident was not in acute distress and had a prn bowel medication or product, these were to be administered according to Physician instructions. If no results were observed or noted within eight (8) hours or per Physician instruction, the Physician was to be contacted for further instructions.</p> <p>Review of Resident #11's medical record revealed diagnoses which included Alzheimer's Disease, Paralysis Agitans and Difficulty Walking. Review of the Annual Minimum Data Set (MDS) Assessment dated 11/26/13, revealed the facility assessed Resident #11 as having a Brief Interview for Mental Status (BIMS) score of a thirteen (13) out of a possible fifteen (15), indicating the resident was cognitively intact.</p> <p>Review of Resident #11's Bowel and Bladder Chart Detail Report revealed bowel movements (BMs) documented on 12/08/13 and 12/16/13; however no documented evidence of a BM during the eight (8) days between those dates. Review of the December 2013 Medication Record revealed Milk of Magnesia (laxative medication) thirty (30) milliliters (ml's) prn was administered to Resident #11 on 12/13/14 and 12/14/13 for constipation. Further review of the Medication Record revealed no documented evidence Resident #11 had results from the Milk of Magnesia (MOM) recorded on it.</p> <p>Additional review of Resident #11's Bowel and Bladder Chart Detail Report revealed the resident had documented BMs documented on 01/15/14 and 01/21/14; however no documented evidence of a BM during the six (6) days between those</p>	F 309	<p>bowel report to verify that all residents currently on the report are in compliance with all community policies and procedures and protocols by March 14, 2014. The MDS Coordinators will review all care plans including those related to bowel care and update as indicated by March 14, 2014.</p> <p>The Unit Coordinators will be re-inserviced regarding the community's policies relating to care and services including following physicians orders, protocols for monitoring bowel care, and associated care plans by the Assistant Director of Nursing and the Quality Assurance nurse by March 14, 2014. All remaining care staff (Registered Nurses, Licensed Practical Nurses, and Nurse Aides) will be re-inserviced on the community's policies relating to care and services including following physicians orders, protocols for monitoring bowel care, and associated care plans by the Assistant Director of Nursing and/or the Quality Assurance nurse and/or the Unit Manager by March 10, 2014. The three (3) MDS</p>	

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F 309	<p>Continued From page 18</p> <p>dates. Review of the January 2014 Medication Record revealed the resident received the laxative, MOM thirty (30) ml's prn on 01/19/14, 01/20/14, and on 01/21/14. Further review of the Medication Record revealed no documented evidence Resident #11 had results from the laxative recorded on it.</p> <p>Interview, on 01/30/14 at 4:30 PM, with Licensed Practical Nurse (LPN) #7/Unit Coordinator (UC), on Resident #11's unit, revealed the process for monitoring BM was a seventy-two (72) hour report would be obtained by night shift nurse to note residents who had not had a BM for three (3) days. LPN #7/UC stated when day shift came on and received the report they inquired if night shift had administered a laxative. The LPN/UC stated if night shift had not administered a laxative day shift would give the resident one. She stated the Physician was to be notified if the laxative was not effective to see if the Physician wanted to prescribe an additional laxative. LPN #7/UC reviewed Resident #11's BMs for the time period of 12/09/13 through 12/15/13, and stated Resident #11's lack of BMs should have been noted by the nurses on the seventy-two (72) hour report and a laxative should have been administered to the resident. She stated MOM had been administered during the time period; and Resident #11 had possibly had a BM which had not been documented. LPN #7/UC reviewed the resident's BM history for the time period of 01/15/14 through 01/21/14, which indicated the resident had a BM on 01/15/14 and 01/21/14 noting the six (6) days between. She stated a laxative was administered to Resident #11 on 01/19/14, 01/20/14, and 01/21/14. According to LPN #7/UC if a laxative had been administered with no results after a three (3) day period of no</p>	F 309	<p>Coordinators will be re-inserviced by the Regional MDS Coordinator regarding the community's policy and procedures relating to the care planning process by March 14, 2014.</p> <p>Physician orders and the associated protocol for bowel care including the bowel report, will be audited (six (6) charts per week) weekly for 6 weeks and then monthly for 3 months for compliance by the Quality Assurance Nurse and the Assistant Director of Nursing. These audits will be forwarded to the Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review.</p> <p>Completion Date: March 14, 2014</p>	

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F 309	<p>Continued From page 19</p> <p>BM the Physician should have been notified. After review of Resident #11's record, she indicated there was no documented evidence the Physician had been notified for further instructions as per policy.</p> <p>Interview with the Director of Nursing (DON) on 01/30/14 at 9:00 AM, revealed the BM monitoring process was for night shift nurses to obtain the bowel report from the computer; and a list was printed of residents who had no BM or only a small BM for the past seventy-two (72) hours. She stated the night shift nurse was to report this information to the day shift nurse; and the day shift nurse could contact the Physician if needed. The DON stated night shift or day shift could administer a prn laxative if the resident had orders for one. She stated the UC was to follow up and interview residents on the list to see if they had a BM and were to document their findings in the Nurse's Notes. According to the DON, the documentation was to include an abdominal assessment to check for distention and for bowel sounds. Continued interview revealed residents would stay on the list until a BM was observed or noted. She stated she obtained the list on Monday through Friday and the Weekend Supervisor followed up from the list other nurses had. The DON stated she checked with the UC to ensure they had looked at the bowel list and checked to see if residents on the list from the day before had a BM or if a laxative was given. She stated she did not document the UC's answers; however, had recognized some residents stayed on the list longer than they should have. She further stated, she needed to check the residents records to ensure the nurses documented BM's after a laxative was given or after the resident was interviewed.</p>	F 309		

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F 309	Continued From page 20 An additional interview with the DON on 01/30/14 at 7:36 PM, revealed Resident #11's Physicians should have been consulted to see if the resident had experienced a "clinical" decline; and for advice regarding the resident going long periods without a BM, even though a prn laxative had been administered.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. 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 have an effective system in place to ensure residents received the necessary care and monitoring to ensure Oxygen (O2) was provided as ordered for two(2) of twenty-two (22) sampled residents (Resident #6 and Resident #15). Resident #6 was observed to have O2 administered at four (4) liters per minute (LPM); however, the Physician's Order was for O2 at two	F 328	It is the policy of Richmond Place Rehabilitation and Health Care Center to ensure that residents receive proper treatment and care for special services. Resident #15 oxygen tank was replaced at 12:47 PM on 01/28/14 by the Assistant Director of Nursing. Resident #6 was reassessed and physician orders were clarified, O2 was set according to the clarified order, MAR updated to reflect the clarified order and care plan updated as indicated on 1/29/2014 by the Unit Coordinator.	

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F 328	<p>Continued From page 21</p> <p>(2) LPM to maintain O2 saturation (sats) levels greater than ninety (90) percent. Additionally, Resident #6 had a Physician's Order to monitor the resident's O2 sats level each shift; however, review of the Medication Record revealed the facility had discontinued monitoring the resident's O2 sats level on 01/14/14 without a Physician's Order.</p> <p>In addition, Resident #15 had a nasal cannula (NC) connected to a portable O2 tank; however, observation revealed the tank was empty.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Oxygen Administration", revised October 0210, revealed the purpose of the procedure was to provide safe O2 administration. Continued review of the policy revealed staff were to review the Physician's Order for O2 administration and while the resident was receiving O2 therapy, the resident's O2 sats were to be assessed, if applicable.</p> <p>1. Review of Resident #6's medical record revealed diagnoses which included Heart Failure, Alzheimer's Disease, Heart Failure and Pneumonia on 01/01/14. Further record review revealed the resident was admitted to Hospice on 01/07/14 due to a diagnosis of Failure to Thrive. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 01/14/14, revealed the facility assessed Resident #6 to as cognitively impaired with short/long term memory problems.</p> <p>Review of a Physician's Order, dated 01/01/14 timed 3:00 PM, revealed orders for a chest x-ray related to decreased O2 sats, Shortness of Air, Wheezing Congestion, and Diminished Lung</p>	F 328	<p>The Assistant Director of Nursing, Quality Assurance Nurse, and Unit Managers will audit all current physicians' orders including all oxygen orders and orders relating to bowel care to ensure they are followed per the physicians order by March 14, 2014. The MDS Coordinators will review all care plans including those related to oxygen and bowel care and update as indicated by March 14, 2014.</p> <p>All care staff (Unit Managers, Registered Nurses, Licensed Practical Nurses, and Nurse Aides) will be re-inserviced on the community's policies relating to care and services including following physicians orders, protocols for monitoring oxygen and associated care plans by the Assistant Director of Nursing and the Quality Assurance nurse and the Unit Manager by March 10, 2014. The MDS Coordinators will be re-inserviced by the Regional MDS Coordinator regarding the community's policy and procedures relating to the care planning process by March 14, 2014.</p>	

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F 328	<p>Continued From page 22</p> <p>Sounds; and an order to administer two (2) LPM of O2 via a NC to maintain Resident #6's O2 sats greater than ninety (90) percent. Further review, revealed a Physician's Order dated 01/02/14, for staff to monitor the resident's O2 sats each shift related to O2 use and shortness of air.</p> <p>Review of the Medication Record dated 01/14 Resident #6's O2 sats were to be monitored each shift. Further review revealed staff recorded the resident's O2 sats each shift until 01/14/14. Continued review of the Medication Record revealed the O2 sats monitoring was discontinued on 01/14/14. However, review of the Physician's Orders revealed no documented evidence of an order to discontinue Resident #6's O2 sats monitoring.</p> <p>Observations of Resident #6 on 01/28/14 at 2:26 PM, and on 01/29/14: at 8:32 AM and 12:20 PM revealed a NC in place to his/her nares (nostrils) and O2 administered at four (4) LPM.</p> <p>Interview, on 01/29/14 at 12:26 PM, with Licensed Practical Nurse (LPN) #4 revealed she had observed the resident currently receiving O2 administered at four (4) LPM; however the O2 was ordered prn (as needed) at two (2) LPM; and the Medication Record indicated staff was to administer O2 at two (2) LPM via NC to maintain O2 sats above ninety (90) percent. Further interview revealed it was the nurse's responsibility to check the O2 administration level.</p> <p>Interview, on 01/30/14 at 5:03 PM, with LPN #2/South Unit Coordinator revealed there were no Physician's Orders to discontinue monitoring the resident's O2 sats level; and she thought staff had mistakenly discontinued the O2 sats levels</p>	F 328	<p>Physician orders and the associated protocol, including orders/protocols relating to oxygen will be audited (six (6) charts per week) weekly for six (6) weeks and then monthly for three (3) months for compliance by the Quality Assurance Nurse and the Assistant Director of Nursing. These audits will be forwarded to the Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review to maintain compliance.</p> <p>Completion Date: March 14, 2014</p>

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F 328	<p>Continued From page 23</p> <p>when Resident #6 was admitted to Hospice. LPN #2 stated the O2 sats should have been monitored to see if Resident #6's O2 sats level stayed above ninety (90) percent to determine O2 administration. In addition, she stated thought staff could do a better job monitoring O2.</p> <p>Interview, on 01/30/14 at 5:40 PM, with the Director of Nursing (DON) revealed Resident #6 had been treated for Pneumonia recently. She stated the resident had an order to monitor O2 sats levels and for O2 to be administered at two (2) LPM prn. The DON confirmed staff should have continued to monitor Resident #6's O2 need because the order had not been discontinued. She further stated staff should have clarified the O2 order to determined whether the O2 was to have been continuous or prn.</p> <p>2. Review of Resident #15's medical record revealed diagnoses which included O2 Dependency, Stage IV Kidney Disease and Anxiety. Review of the January 2014 monthly Physician's orders, revealed an order for O2 administration at four (4) LPM per NC.</p> <p>Observation of Resident #15 on 01/28/14 at 12:40 PM, in the ice cream parlor, revealed the resident's portable O2 tank on the back of the wheelchair was empty. Further observation at 12:47 PM, seven (7) minutes after the initial observation, revealed the Assistant Director of Nursing (ADON) changed Resident #15's empty O2 tank.</p> <p>Interview, with the ADON on 01/28/14 at 12:47 PM, at the time she was changing Resident #15's empty O2 tank, revealed she expected staff to check the volume on the O2 tanks when</p>	F 328		

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F 328	<p>Continued From page 24</p> <p>residents initially were placed on the portable O2 tanks. She stated staff should then check the O2 volume status periodically while the resident was on the portable O2 tank. Continued interview revealed all staff who came in contact with residents on O2 had the responsibility to observe the volume level of O2 and alert the nurse if the volume was low. She stated staff had at least two (2) opportunities to check the volume level of Resident #15's portable O2 tank prior to her changing the tank at that time. The ADON stated Resident #15 usually required a full tank approximately every two hours to every two and a half hours because of his/her ordered flow rate of four (4) LPM per NC.</p> <p>Interview, with State Registered Nurse Aide (SRNA) #1, on 01/28/14 at 12:42 PM, revealed SRNA's were to check the O2 volume level on residents' O2 tanks and notify the nurse of the amount. Further interview revealed she had assisted Resident #15 to the bathroom and returned him/her to the ice cream parlor at approximately 11:40 AM. She stated she had not checked the O2 volume level of the resident's O2 tank.</p> <p>Interview, with SRNA #7, on 01/28/14 at 12:45 PM, revealed direct care staff were to check the O2 volume levels on residents' portable O2 tanks when they assisted residents from their rooms and throughout the day.</p> <p>Interview, with SRNA #3 on 01/29/14 at 2:50 PM, who had been assigned to Resident #15 on 01/28/14, revealed the resident was already up in the wheelchair receiving his/her O2 from the O2 tank on the wheelchair. She stated she had looked at the O2 volume level at approximately</p>	F 328		

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F 328 Continued From page 25
 8:00 AM and the O2 tank was half full at that time. She further stated it was everyone's responsibility to be aware of the volume of O2 in the O2 tanks.

Interview, on 01/29/14 at 3:00 PM, with LPN #3, who was the nurse assigned to Resident #15 on 01/28/14, revealed the resident had not needed replacement of his/her O2 tank when she performed her initial assessment that morning. Further interview revealed it was everyone's responsibility to monitor the O2 volume level in the portable O2 tanks.

Interview, on 01/29/14 at 3:20 PM, with the Physical Therapy Aide (PTA), who had transported Resident #15 to the therapy department on 01/28/14, revealed she had changed the resident's O2 tank at approximately 9:30 AM on 01/28/14 before transporting the resident to the therapy department.

F 367 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN
 SS=D

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 ensure residents received and consumed foods in the appropriate form as prescribed by the Physician for one (1) of twenty-two (22) sampled residents (Resident #6). Resident #6 was ordered a mechanical soft diet related to a decline and inability to chew his/her

F 328

F 367

It is the policy of Richmond Place Health and Rehabilitation Center that therapeutic diets are prescribed by the attending physician.

Resident # 6 was reassessed and the physician notified regarding therapeutic diet with new orders noted and care plan updated as indicated on 1/29/14 by the Unit Coordinator.

All therapeutic diet orders and tray cards will be audited for all residents

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F 367 Continued From page 26
 food well; however, observation of the resident's meal ticket and meals served revealed the resident was receiving regular texture meals.

The findings include:

Review of the facility's policy title, "Interdepartmental Notification of Diet (Including Changes and Reports)", revised December 2008, revealed Nursing Services was to notify the Food Services Department of a resident's diet orders, including any changes in the resident's diet. Further review of the policy revealed when a diet had been changed, the Nurse Supervisor was to ensure the Food Services Department received a written notice of the diet order.

Review of Resident #6's medical record revealed the resident was admitted by the facility on 12/13/11, with diagnoses which included Alzheimer's Disease, Heart Failure, Hypertension, Chronic Kidney Disease, Gastroesophageal Reflux Disease. Record review revealed Resident #6 had been admitted to Hospice on 01/07/14 due to a diagnosis of Failure to Thrive. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 01/14/14, revealed the facility had assessed Resident #6 to have cognitive impairments with short and long term memory problems.

Review of the Physician's Orders for Resident #6 revealed an order dated 01/17/14, for a diet change to mechanical soft texture due to a physical decline and the resident's inability to chew his/her foods well.

Observation, on 01/28/14 at 6:42 PM, of Resident #6's meal ticket revealed it indicated the resident

F 367
 and updated as indicated by the Dietary Manager by March 14, 2014.

The Dietician has re-inserviced the Dietary Manager and the Kitchen Manager on the community's therapeutic diet policies on February 21, 2014. The Assistant Director of Nursing and the Quality Assurance Nurse will re-inservice all Unit Managers and all nurses regarding the community's therapeutic diet policies including proper notification of Diet Changes by March 14, 2014.

The Dietary Manager will audit the therapeutic diet orders for six (6) residents weekly for six (6) weeks for compliance with the order and then monthly for six (6) months. The results of the audits 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: March 14, 2014

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was to received a regular texture diet. Observation of the meal revealed it included spaghetti. In addition, observation of Resident #6's meal ticket and meal, on 01/29/14 at 8:32 AM, revealed the meal ticket noted regular texture; and the resident received a sandwich with strips of bacon.

Interview, on 01/29/14 at 9:30 AM, with Licensed Practical Nurse (LPN) #2/South Unit Manager (UM) revealed Resident #6 had an order dated 01/17/14 to change the resident's diet to mechanical soft related to his/her decline and inability to chew food well. She stated Resident #6 had mouth sores which made chewing difficult at that time. LPN #2/South UM stated the resident's meal ticket showed a regular diet texture and not mechanical soft diet ordered. The LPN reported if there was an order for a diet change nursing staff were to notify dietary by completing the Dietary Order and Communication Notice form, which was the nurse's responsibility to complete. The LPN further stated they must have "overlooked" the order for Resident #6's diet to be changed to mechanical soft. She indicated the order "got missed".

Interview, on 01/29/14 at 9:34 AM, with the Dietary Manager (DM) revealed she had not seen an order to change Resident #6's diet to mechanical soft. The DM stated she should have been made aware of any dietary change.

Interview, on 01/30/14 at 5:40 PM, with the Director of Nursing (DON) revealed the person who had taken the order for Resident #6's diet change to mechanical soft, should have sent a communication slip to dietary due to the resident's inability to chew his/her foods well. In

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F 367 Continued From page 28
 addition, she stated the UM should have brought the order to the Quality of Care meeting to discuss the dietary change for Resident #6. The DON stated in Resident #6's case the diet change was due to the resident having a sore mouth, but staff had not followed the facility's process to ensure dietary changes were made as ordered. The DON further stated it was important to ensure changes were made as ordered with the diet textures because in some situations it could have led to a choking risk for a resident.

F 367

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

F 371

The facility must -
 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
 (2) Store, prepare, distribute and serve food under sanitary conditions

It is the policy of Richmond Rehabilitation and Health Center to store, prepare, distribute and serve food under sanitary conditions.

The Rehabilitation Kitchen, Main Kitchen, and Nourishment rooms were thoroughly cleaned and any out of date food items removed on 1/28/14 by the Kitchen Manager and/or Dietary Manager. The facility's inservice titled "Labeling & Dating of Safe Storage of Food" will be reviewed by the

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, prepare and distribute food under sanitary conditions as evidenced by dietary staff failing to wash their hands between glove changes, and using improper handwashing technique in the kitchen. In addition, the nourishment rooms on the units contained foods which were unlabeled, undated and expired; and the steam table on the Rehabilitation Unit had soiled wells. Additionally, there were bowls filled

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F 371	<p>Continued From page 29</p> <p>with water sitting in the hand sink, and a brown dried substance underneath the coffee maker and coffee pot.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled, "Cleaning Schedules Policy" undated revealed dietary staff were to maintain the sanitation of the Dietary Department through compliance with written, comprehensive cleaning schedules developed for the facility by the Dietary Manager. The Dietary Manager was to record all cleaning and sanitation tasks for the Dietary Department. Continued review revealed all tasks were to be addressed as to frequency of cleaning; and under the dates of the week or the weeks the Dietary Manager or designee could check off assignments completed or the employee could initial. <p>Review of the facility's inservice titled, "Labeling and Dating for Safe Storage of Food" undated, revealed objective participants were to learn that labeling and dating were critical in order to promote food safety. The use of use-by-dates was to be reviewed. All products were to be dated upon receipt, and products were to be used by "use-by-dates" on all food. Continued review of the inservice revealed expiration dates superceded storage guide. The inservice indicated if commercially processed foods came marked with an expiration or "use-by-date", there would be no need to mark a "use-by-date" on the products. Further review revealed when food was taken out of an original container, staff were to note the name of the food being stored on the container and note the "use-by-date".</p> <p>Review of the facility's, "Food from Outside</p>	F 371	<p>Dietician and updated to reflect necessary changes in the education by March 14, 2014. The updated education will be used for all future staff educational sessions.</p> <p>Cook#1 was re-inserviced on 1/28/14 by the Kitchen Manager regarding hand washing per community's policy related to hand washing.</p> <p>An audit was performed throughout the facility including the rehabilitation kitchen and nourishment rooms on dietary sanitation, safe storage of foods, and proper dating and labeling of food and any issues were immediately corrected as needed by the Dietary Manager and Kitchen Manager on 1/28/14.</p> <p>All Dietary associates (cooks and aides) will be re-inserviced by the Kitchen Manager and/or the Quality Assurance Nurse on the community's policies on dietary sanitation, safe storage of foods, and proper dating and labeling of food including the facility's in-service titled "Labeling & Dating of Safe Storage of Food" by March 14, 2014.</p>	

DEPARTMENT OF HEALTH AND HUMAN 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 01/30/2014
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 30</p> <p>Sources Policy", dated 2012, revealed perishable foods were to be sealed and dated with a "use-by-date" and placed in the refrigerator.</p> <p>Observation, on 01/28/14 at 10:00 AM, revealed the Rehabilitation kitchen steam table had four (4) wells which were soiled. In addition, there were two (2) soiled cranberry bowls filled with water sitting in the hand sink; and a brown dried substance underneath the coffee maker and coffee pot. Continued observation revealed the side by side refrigerator/freezer contained two (2) sherbet containers which were undated and had no resident identification on them. Observation of the stand alone freezer revealed it contained "Sysco Cobbler" tops one (1) case dated 08/06/13; fresh frozen red raspberries dated September 2011 with a "use-by-date" of 09/14/11; and three (3) frozen unbaked pie shells in plastic wrap dated 06/20/13.</p> <p>Observation, on 01/28/14 at 10:10 AM, revealed the Rehabilitation Nourishment refrigerators contained five (5) Magic Cups (nutritional supplement) which were undated; a four (4) ounce orange liquid undated and unlabeled; and one (1) styrofoam bowl with contents which were unlabeled, undated and had no resident identification on it.</p> <p>Further observation, on 01/29/14 at 8:45 AM, revealed the Rehabilitation kitchen had two (2) soiled trays, and a soiled spoon and fork on the tray in the clean area located beside the coffee machine.</p> <p>Observation, on 01/28/14 at 12:15 PM, of the 200 Unit nourishment refrigerator revealed it contained four (4) sandwiches dated 01/27/14.</p>	F 371	<p>A Sanitation Quality Assurance Review (copy attached) was initiated on 2/17/14 and will be completed in the Main Kitchen and the Rehabilitation Kitchen five (5) times a week for six (6) months by the Kitchen Manager, Dietary Manager or Lead Cook. The Sanitation Quality Assurance Review audits sanitation in all areas of the kitchen including: General Work Areas, Food Preparation Areas, Dry Storage, Cold Storage, Utility Room, Personnel, Dishwashing Area, Pot and Pan Washing Area, and Equipment to ensure that we store, prepare, distribute and serve food under sanitary conditions. A weekly audit for six (6) months will be completed for all Nourishment rooms by the Kitchen Manager. Results of the audits 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>Completion Date: March 14, 2014</p>	

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PRINTED: 02/25/2014
FORM APPROVED
OMB NO. 0938-0391

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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 371	<p>Continued From page 31</p> <p>Additionally, observation revealed there was also a brown dried substance on the left cabinet door under the sink and inside the cabinet's lower shelf.</p> <p>Observation, on 01/28/14 at 12:32 PM, of the 100 Unit nourishment room refrigerator revealed It contained six (6) sugar free cookies with undated; Fieldstone Bakery Homestyle Crispy Rice Bars dated 12/09/13 unopened; five (5) Fieldstone fig bars undated; a Fieldstone Oatmeal Creame Pie box with a date of 01/23/14; and one (1) container of blended non-fat vanilla yogurt undated.</p> <p>Interview, on 01/28/14 at 12:25 PM, with the Certified Dietary Manager (CDM) revealed labor hours had been cut and staff had not been able to use the Rehabilitation Unit kitchen for months, since last October. An additional interview, on 01/29/14 3:40 PM, with the CDM revealed if any food was outdated, the food would need to be discarded immediately. The CDM stated the Rehabilitation kitchen had not been used since October; however, there was a Christmas meal for the staff in December which was catered by an outside company and the the steam table wells were not cleaned afterwards. Further interview revealed the nourishment refrigerators were the responsibility of dietary for stocking and rotating nourishments, as well as nursing responsibility with the occasional assistance of housekeeping for the floor.</p> <p>2. Review of the facility's policy titled, "Personal Hygiene" updated October 2008, revealed personal hygiene was to be followed in order to promote a safe and sanitary department. Further review revealed hands were always to be washed prior to beginning work, after smoking, using the</p>	F 371		
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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 371	Continued From page 32 restroom, or handling any unsanitary items. Observation, on 01/28/14 at 5:15 PM, of the kitchen resident tray line, revealed Cook #1 changed gloves and used improper hand washing technique by washing his/her hands for only five (5) seconds. Further observation revealed Cook #2 changed gloves between tasks, from the soiled pot and pan sink, to clean areas of the kitchen; however, did not wash his hands between glove changes. Further observation, on 01/28/14 at 5:20 PM, revealed Cook #2 re-entered the kitchen and used improper handwashing technique by washing his hands for only five (5) seconds. Interview, on 01/29/14 3:40 PM, with the CDM revealed hand washing was a Quality Indicator the Dietary Supervisor followed and Cook #2 was corrected for not washing his hands between glove changes during the resident tray line. The CDM stated, in-services had been conducted on hand washing in the past and the staff demonstrated how to correctly wash their hands. The CDM further revealed she monitored for hand washing technique in the kitchen.	F 371	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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 -	F 441	It is the policy of Richmond Place Nursing & Rehabilitation Center to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

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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 441	<p>Continued From page 33</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed 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 for one (1) Unsampld Resident (Unsampld Resident C).</p>	F 441	<p>LPN #5 was re-inserviced by the Quality Assurance Nurse on 1/30/14 the community's infection control policy relating to cleaning of glucometers.</p> <p>The Quality Assurance Nurse will re-inservice all nurses including Unit Managers on the community's Infection Control Policies and Procedures including those relating to cleaning of glucometers by March 14, 2014. All associates (RN's, LPN's, Nurse Aides, Housekeeping Aides, Cooks, Dietary Aides, Housekeeping and Laundry Aides) will be re-inserviced by the Quality Assurance Nurse and/or Unit Managers, regarding the facility's infection control policies and procedures to ensure a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection by March 14, 2014 and annually.</p>	

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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 441	<p>Continued From page 34</p> <p>Observation of a fingerstick blood sugar for Unsampled Resident C, revealed the nurse failed to clean the glucometer after use.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Blood Sampling-Capillary (Finger Sticks)" Policy, revised August 2011, revealed the purpose of the procedure was to guide the safe handling of capillary blood sampling devices to prevent transmission of bloodborne disease to residents and employees. Further review revealed the procedure included the following; staff were to wash their hands, don gloves, place blood glucose monitoring device on a clean field, place a new lancet and disposable platform on the spring loaded finger stick device; wipe the area to be lanced with an alcohol pledget; obtain the blood sample; discard the lancet and platform in the sharps container; wipe any visible blood from the spring loaded device with alcohol pledgets or manufacturer's instructed method, following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use; remove gloves, and discard into appropriate receptacle, wash hands, replace blood glucose monitoring device in storage area after cleaning.</p> <p>Review of the Trueresult Quality Assurance/Quality Control manual for the facility's Trueresult Blood Glucose Monitoring System, undated, revealed all parts of the Trueresult blood glucose monitoring system was considered potentially infectious and capable of transmitting blood borne pathogens. Continued review revealed to clean the blood glucose monitoring system to remove blood or soil from surface of</p>	F 441	<p>The Quality Assurance Nurse and/or the Pharmacy Consultant will audit one (1) med pass a month for three (3) months. The Quality Assurance nurse, Director Of Nursing and/or the Assistant Director of Nursing will monitor and observe via daily rounds at least five (5) times a week for six (6) weeks that an Infection Control Program is established and maintained to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.</p> <p>The results of the med-pass audit and daily rounds will be forwarded to the Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review to maintain compliance.</p> <p>Completion Date: March 14, 2014</p>	

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PRINTED: 02/25/2014
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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 441	<p>Continued From page 35</p> <p>the meter and disinfect to destroy infectious agents on the surface of meter after each use. Further review revealed to clean and disinfect meter, use "PDI Super Sani-Cloth Germicidal Disposable Wipes", let the blood glucose monitoring meter air dry thoroughly before testing.</p> <p>Observation on 01/28/14 at 12:45 PM, revealed Licensed Practical Nurse (LPN) #5 performed a fingerstick blood glucose on Unsampled Resident C and failed to clean and disinfect the blood glucose meter prior to placing the device in a plastic box labeled with the resident's name which contained test strips, lancets, and alcohol pads. Further observation revealed the LPN then cleaned the outside of the plastic box containing the meter with a "PDI Super Sani-cloth Germicidal Disposable Wipe".</p> <p>Interview, on 01/29/14 at 12:50 PM, with LPN #5, revealed she had a recent inservice on how to clean and disinfect the blood glucose monitoring meter. LPN #5 indicated the meter should have been cleaned and disinfected with a "Super Sanicloth" wipe; however stated she just cleaned the box the blood glucose meter went in.</p> <p>Interview, on 01/29/14 at 1:30 PM, with Registered Nurse (RN) #4/Director of the Rehabilitation Unit, revealed she would need to pull the policy; however, thought nurses were to clean and disinfect the blood glucose meters with Dispatch with Bleach Wipes. She stated she did not recall any recent inservice in regards to blood glucose monitor cleaning and disinfecting; and she rarely watched medication pass or fingerstick blood glucoses being performed.</p>	F 441		

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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 441	Continued From page.36 Interview, with the Director of Nursing, on 01/30/14 at 7:00 PM, revealed her expectation was for the blood glucose monitoring meters to be cleaned and disinfected after each use with the "Super Sanicloth Wipes" as per manufacturer's recommendations.	F 441			

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PRINTED: 03/18/2014
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 03/18/2014
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 A desk review was completed on 03/18/14 of the Plan of Correction for Richmond Place Rehabilitation and Health Center and found to be acceptable. The facility was found to meet the requirements for participation in the Medicare and Medicaid program.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

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PRINTED: 02/13/2014
FORM APPROVED
OMB NO. 0938-0391

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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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K 000	INITIAL COMMENTS Building: 01 Plan Approval: 1891, Addition added in 2011. 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 conducted on 01/28/14. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "D".	K 000	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies dated 2/14/2014. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	It is the policy of Richmond Place Rehabilitation and Health Center to continuously maintain automatic sprinkler systems in a reliable operating condition and inspected and tested periodically.	

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

TITLE

(X6) DATE

Berita Bagg-Dickson

Healthcare Administrator

2-20-14

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

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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 062	<p>Continued From page 1</p> <p>Based on observation and interview, it was determined the facility failed to ensure the sprinkler system was inspected and maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) smoke compartment. The facility is licensed for one hundred twenty (120) beds and the census the day of survey was one hundred eight (108).</p> <p>The findings include:</p> <p>Observation on 1/28/14 at 10:50 AM, revealed the sprinkler piping in attic space above the Central Storage area was being used to support various wiring. Sprinkler piping cannot be used to support building wiring.</p> <p>Interview, on 1/28/14 at 10:55 AM, with the Maintenance Director, revealed he had lifted all wiring off the sprinkler piping via hangers in previous months, but had not realized that some still existed.</p> <p>Interview, on 1/28/14 at 1:30 PM, with the Administrator revealed she was unaware of the wiring but would make the correction at once.</p> <p>Reference: NFPA 25 (1998 edition)</p> <p>2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be</p>	K 062	<p>The wiring was removed from the sprinkler piping in the attic space above the Central Storage area by the Maintenance Director on 1/28/14.</p> <p>The entire sprinkler system was inspected by the Maintenance Director on 2/5/14 to ensure that all sprinkler piping is free of any wiring.</p> <p>The Maintenance Director will inspect the sprinkler system one (1) time a week for six (6) weeks and quarterly thereafter.</p> <p>The inspections will be forwarded monthly to Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review.</p> <p>Completion Date: March 10, 2014</p>	
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2014
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NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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K 062 Continued From page 2
subjected to external loads by materials either resting on the pipe or hung from the pipe.

Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection.

Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.

K 062

K 147 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

K 147

It is the policy of Richmond Place Rehabilitation and Health Center to maintain electrical wiring and equipment in accordance with NFPA 70.

The multi-outlet strips were removed by the Director of Rehabilitation on 1/28/14.

The Administrator educated the Director of Rehabilitation regarding the requirement that multi-outlet strips are not permitted on 1/28/14.

The Maintenance Director inspected the entire facility to ensure that no other multi-outlet strips or extension cords were in use on 1/28/14.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the facility had an adequate number of electrical receptacles to meet the needs of residents without the use of extension cords or multiple outlet adapters according to National Fire Protection Association (NFPA). The deficiency had the potential to affect one (1) smoke compartment, five (5) residents, staff and visitors.

The findings include:

Observation, on 01/28/14 at 11:15 AM, with the Maintenance Director revealed multi-outlet strip

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

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OMB NO. 0938-0301

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 01/28/2014
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 147	<p>Continued From page 3</p> <p>being used as permanent wiring. A Hydrocollator, Spa Bath, and Three (3) Exercise Bikes were observed plugged into power strips in the Physical Therapy Department. In addition, extension cords and multi-outlet strips cannot be used as a substitute for permanent wiring.</p> <p>Interview, on 01/28/14, at 11:25 AM, with the Maintenance Director revealed he was unaware of the power strips being used in Physical Therapy.</p> <p>Interview on 01/28/14 at 1:40 PM with the Administrator revealed she was unaware of the power strips and would remove them immediately. She also stated she would make the Supervisor over Physical Therapy aware of the requirement.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D</p> <p>2. Minimum number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 	K 147	<p>The Maintenance Director will inspect the entire facility for use of multi-use power strips and/or extension cords are not in use one (1) time a week for six (6) weeks and quarterly thereafter.</p> <p>The inspections will be forwarded monthly to Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review.</p> <p>Completion Date: March 10, 2014.</p>

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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2014
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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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K 147	Continued From page 4 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-B. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2014
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 03/18/2014
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 A desk review was completed on 03/18/14 of the Plan of Correction for Richmond Place Rehabilitation and Health Center and found to be acceptable. The facility was found to meet the requirements for participation in the Medicare and Medicaid program.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2014
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: 1891, Addition added in 2011. 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 conducted on 01/28/14. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "D".	K 000	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies dated 2/14/2014. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	It is the policy of Richmond Place Rehabilitation and Health Center to continuously maintain automatic sprinkler systems in a reliable operating condition and inspected and tested periodically.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Berita Bagg-Dickson TITLE
Healthcare Administrator (X6) DATE
2-20-14

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

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K 062	<p>Continued From page 1</p> <p>Based on observation and interview, it was determined the facility failed to ensure the sprinkler system was inspected and maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) smoke compartment. The facility is licensed for one hundred twenty (120) beds and the census the day of survey was one hundred eight (108).</p> <p>The findings include:</p> <p>Observation on 1/28/14 at 10:50 AM, revealed the sprinkler piping in attic space above the Central Storage area was being used to support various wiring. Sprinkler piping cannot be used to support building wiring.</p> <p>Interview, on 1/28/14 at 10:55 AM, with the Maintenance Director, revealed he had lifted all wiring off the sprinkler piping via hangers in previous months, but had not realized that some still existed.</p> <p>Interview, on 1/28/14 at 1:30 PM, with the Administrator revealed she was unaware of the wiring but would make the correction at once.</p> <p>Reference: NFPA 25 (1998 edition)</p> <p>2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be</p>	K 062	<p>The wiring was removed from the sprinkler piping in the attic space above the Central Storage area by the Maintenance Director on 1/28/14.</p> <p>The entire sprinkler system was inspected by the Maintenance Director on 2/5/14 to ensure that all sprinkler piping is free of any wiring.</p> <p>The Maintenance Director will inspect the sprinkler system one (1) time a week for six (6) weeks and quarterly thereafter.</p> <p>The inspections will be forwarded monthly to Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review.</p> <p>Completion Date: March 10, 2014</p>	
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K 062 Continued From page 2
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K 147

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The Administrator educated the Director of Rehabilitation regarding the requirement that multi-outlet strips are not permitted on 1/28/14.

The Maintenance Director inspected the entire facility to ensure that no other multi-outlet strips or extension cords were in use on 1/28/14.

This STANDARD is not met as evidenced by:
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The findings include:

Observation, on 01/28/14 at 11:15 AM, with the Maintenance Director revealed multi-outlet strip

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K 147	<p>Continued From page 3</p> <p>being used as permanent wiring. A Hydrocollator, Spa Bath, and Three (3) Exercise Bikes were observed plugged into power strips in the Physical Therapy Department. In addition, extension cords and multi-outlet strips cannot be used as a substitute for permanent wiring.</p> <p>Interview, on 01/28/14, at 11:25 AM, with the Maintenance Director revealed he was unaware of the power strips being used in Physical Therapy.</p> <p>Interview on 01/28/14 at 1:40 PM with the Administrator revealed she was unaware of the power strips and would remove them immediately. She also stated she would make the Supervisor over Physical Therapy aware of the requirement.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D</p> <p>2. Minimum number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 	K 147	<p>The Maintenance Director will inspect the entire facility for use of multi-use power strips and/or extension cords are not in use one (1) time a week for six (6) weeks and quarterly thereafter.</p> <p>The inspections will be forwarded monthly to Quality Assurance Committee (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review.</p> <p>Completion Date: March 10, 2014.</p>

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