

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

PRINTED: 04/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/09/2015
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NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00023018 was initiated on 04/06/15 and concluded on 04/09/15 with deficient practice identified at the highest Scope and Servity of a "D."	F 000	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies dated 4/23/2015. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.	
F 156 SS-D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	F 156		

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged; and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during

It is the policy of Richmond Place Rehabilitation and Health Center to inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. It is also the policy to inform each resident before, or at the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Benita Oakerson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/1/15</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 156	Continued From page 1 the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;	F 156	time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. On 4/22/15, Resident #1 was seen by a Podiatrist. Resident charts will be audited for signed and dated "Financial Consent to Ancillary Services" forms by the (2) two Social Service Coordinators. Residents who do not have a signed and dated "Financial Consent for Ancillary Services" form will be informed of the availability of these services by the (2) two Social Service Coordinators and Podiatry Services will be notified of additional patients who have requested Podiatry Services by 5/7/15. On April 9 th , the Admission Coordinator and Admission Assistant were re-educated regarding the proper completion of the "Financial Consent to Ancillary		
	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.				

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F 156	Continued From page 2 The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156	Services" form by the Heathcare Administrator including the necessity of signing and dating each form to clearly indicate when the form was reviewed and the patient's choice.		
	This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to inform the legal representative, on or before the date of admission, of services available in the facility for one (1) of seven (7) sampled residents (Resident #1). Review of the documentation in Resident #1's medical record revealed no documented evidence the resident's family was made aware of the services available for him/her upon admission to the facility. Resident #1's family requested podiatric services for the resident after finding out the service was available periodically within the facility. However, the facility failed to provide the requested podiatric services for Resident #1. The findings include: Review of Resident #1's medical record revealed the facility admitted the resident on 11/14/14, with diagnoses which included Difficulty Walking, Cognitive Communication Deficit and Infection-Clostridium Difficile. Review of the Quarterly Minimum Data Set (MDS) Assessment,		The (2) two Social Service Coordinators will audit 10 completed "Financial Consent to Ancillary Services" forms monthly for the next 3 months for a signature and date and clear indication if the service was requested or refused. The results of the audit 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: May 7, 2015		

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F 156	Continued From page 3 dated 02/13/15, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status score of seven (7) out of fifteen (15), indicating severe cognitive impairment. Continued record review revealed no documented evidence facility staff had discussed with Resident #1's family the availability of podiatric services, at the time of the resident's admission. Record review revealed a "Financial Consent to Ancillary Services" form in Resident #1's medical record which was unsigned and undated. Interview with Resident #1's Power of Attorney (POA) #1 on 04/07/15 at 10:40 AM, revealed she was present during Resident #1's admission to the facility, and had never been informed of the availability of ancillary services within the facility which included podiatry services. Per interview, had she known services were available at the time of Resident #1's admission she would have ensured the resident was scheduled to be seen for podiatric services. The POA revealed Resident #1 had a bad toenail which needed to be cut. According to Resident #1's POA #1, after learning of the availability of podiatric services, her sister, who was also POA for Resident #1, spoke with the former Director of Nursing (DON), as well as, Social Worker (SW) #1 about having Resident #1 seen within the facility for podiatry. Per POA #1, her sister was informed Resident #1 would be seen by the Podiatrist; however, when the Podiatrist came to the facility the resident was not seen for services. POA #1 revealed Resident #1's family paid the facility hairstylist to give the resident a pedicure, as he/she was not seen by the Podiatrist to have his/her toenails cut. Interview with SRNA #1 on 04/07/15 at 5:28 PM,	F 156			

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F 156	Continued From page 4 revealed nail care was provided to residents on shower days on an as needed basis. SRNA #1 revealed a resident's care plan, which was posted on the inside of each resident's closet door, instructed staff on whether or not they could provide nail care for the resident. Per interview, nurse aides could provide nail care for residents, unless a resident was a Diabetic or on blood thinner, in which case nurses were responsible for providing nail care. SRNA #1 stated residents' appointments were documented in front of the nurse aide book, and nurses or Unit Coordinators (UCs) were responsible for making the residents' appointments.	F 156	
	Interview with the Admissions Coordinator on 04/08/15 at 2:13 PM, revealed she or her assistant were responsible for reviewing the "Financial Consent to Ancillary Services" form with residents' responsible parties upon admission. The Admissions Coordinator stated some families did not sign the form, as they might be expecting the resident to only have a short stay at the facility. Per interview, if families chose not to sign and date the form, there was no evidence it was reviewed with the responsible party. The Admissions Coordinator stated Social Services (SS) usually followed up with families regarding ancillary services, especially if residents were admitted for a long-term stay. Per the Admissions Coordinator SS could then ensure ancillary services were added for the residents. Interview with SW #1 on 04/08/15 at 2:29 PM, revealed a podiatrist was last at the facility on 02/06/15. SW #1 stated if residents were not added to the ancillary services list upon admission, nursing could let SS know and the residents could be added. Per interview, SW #1		

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F 156	Continued From page 5 was at a therapy meeting with the family on 02/03/15, where it was mentioned Resident #1 needed to be seen by a podiatrist. SW #1 revealed if she knew a resident wanted to be seen by podiatry ahead of time, she usually called the healthcare provider to see if they could see the resident. SW #1 stated the facility was unable to get Resident #1 on the podiatry list to be seen on 02/06/15, because the "list was full". According to SW #1, the facility did not contact the healthcare provider regarding the request for Resident #1 to be seen by podiatry as she didn't have time to add him/her to the list, even though she was aware on 02/03/15, the resident wanted to be seen. She stated instead, the podiatrist was told on 02/06/15, when the podiatrist was in the facility to provide services. Further interview revealed the "Financial Consent for Ancillary Services" form in Resident #1's medical record, which was not signed or dated, with a line struck through it, was not proper documentation to indicate services had been refused. Per SW #1, the "Financial Consent for Ancillary Services" form should have been checked as "I do not consent", and the form should have been signed and dated by the responsible party. Interview with the healthcare provider's Vision/Podiatry Coordinator (VPC) on 04/08/15 at 3:11 PM, revealed Resident #1 was not listed in their system for podiatric services until 04/08/15, when the facility called and requested the resident be added. The healthcare provider's VPC revealed they wanted long term care facilities to inform families about the available services the offered upon admission, although residents could be added later as well. Per interview, the healthcare provider tried to send a preliminary list of residents they would see to the	F 156			

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F 156	Continued From page 6 facility a week in advance to provide the facility an opportunity to add and delete residents from the list. The VPC revealed the preliminary list could be changed the day of the scheduled podiatry visit if necessary. Further interview revealed she had not received any paperwork regarding Resident #1 at the time of the last podiatry visit, and everyone on the list was seen for services.	F 156			
	<p>Interview with LPN #3 on 04/09/15 at 12:48 PM revealed she knew Resident #1's family wanted the resident to be seen by the podiatrist when he/she was first admitted to the facility. LPN #3 revealed she wasn't sure where she heard this information, whether it was through report or some other source, but knew the family wanted Resident #1 to be seen the podiatrist.</p> <p>Interview with LPN #2 revealed she knew Resident #1's family wanted the resident to be seen by the podiatrist. LPN #2 revealed however, on the day the podiatrist came to the facility, they didn't have time to see Resident #1. LPN #2 revealed when Resident #1 missed getting to see the podiatrist she wasn't sure if his/her toenails were ever clipped. Further interview revealed she wasn't sure why aides weren't providing toenail care for Resident #1, "unless they were too thick for the aides to cut". Per interview, she offered to have Resident #1 sent to a podiatrist outside the facility, but the family didn't want him/her to leave the facility for an appointment.</p> <p>Interview with the acting Director of Nursing (DON) on 04/09/15 at 6:07 PM, revealed she did not know anything about Resident #1 getting his/her toenails cut by the "stylist"; however, the "stylist" was qualified to do so. After reviewing the unsigned and undated "Financial Consent to</p>				

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F 156	Continued From page 7 Ancillary Services" form present in Resident #1's medical record, the acting DON agreed the documentation wasn't present to support the facility having offered ancillary services to Resident #1 upon admission. Interview with the Administrator on 04/09/15 at 8:00 PM, revealed she understood Resident #1's "Financial Consent to Ancillary Services" form was not signed and dated. The Administrator revealed however, it was the facility's practice at the time, if families were not interested in receiving the ancillary services, just to "strike through" the document. Per interview, the facility offered to send Resident #1 out of the facility for podiatric services, but the family did not want Resident #1 sent out of the facility. According to the Administrator, the podiatric services were "coming up again" and the facility was trying to get the resident on the list to be seen.	F 156			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157	It is the policy of Richmond Rehabilitation and Health Center that a facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial		

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F 157	Continued From page 8 the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2), or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Infectious Disease Consultant (IDC) Physician was informed of a positive Toxigenic Clostridium difficile (C. diff) lab result, and initiation of the related Vancomycin treatment ordered by the Primary Care Physician (PCP) for one (1) of seven (7) sampled residents (Resident #1). Resident #1 had a history of C. diff for which the resident had been followed by an IDC Physician. Resident #1's Power of Attorney (POA) wanted the facility to inform the IDC Physician of any changes to the resident's C. diff treatment. Resident #1 saw the IDC Physician on 02/11/15, and the IDC Physician's Report of Consultation revealed the facility could re-check the resident's stool for C. diff toxin in one (1) week. The laboratory (lab) test to re-check Resident #1's	F 157	status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility a specified in 483.12(a). The IDC Physician was notified of lab results for Resident #1 on 3/3/15 by Nurse #1 with orders noted per the IDC Physician recommendation. On 4/9/15, the Nurse Manager (LPN), contacted the IDC physician's office to review the patient's current condition and recommendations with no new orders or recommendations noted. Lab results received in the past 30 days will be audited by the (3) three Unit Managers (2 LPN, 1 RN) for notification of consultant physicians that have recommended or ordered labs by 5/07/15. On 4/10/15, the Administrator re-educated the Interdisciplinary Care Plan Team including 3 Unit Coordinators, Assistant Director of Nursing, 3 MDS Coordinators, Activities and (2) Social Service		

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F 157	Continued From page 9 stool for C. diff toxin was ordered by the facility. However, the facility failed to notify the IDC Physician of the positive lab test result, and resulting Vancomycin antibiotic treatment initiated on 02/14/15. The IDC Physician was not notified of this information until the POA inquired about Resident #1's C. diff treatment, and requested the facility notify the IDC Physician regarding the antibiotic orders.	F 157	Coordinators regarding the community's policy titled "Lab and Diagnostic Test Results – Clinical Protocol" policies relating to notification of physician to include both the PCP and the IDC physician or the consulting physician who recommended or wrote an order.		
	<p>The findings include:</p> <p>Review of the facility's policy titled, "Lab and Diagnostic Test Results -Clinical Protocol", revised April 2013, revealed the Physician ordered lab testing based on monitoring needs and staff arranged the test. Further policy review revealed all test results were reported to the Physician as soon as the results were obtained.</p> <p>Review of the facility's policy titled, "Clinical Status Change", revised 04/01/11, revealed when a resident was assessed with a change in clinical status the licensed nurse was to follow through in documenting notification of family/responsible party and the Physician to facilitate the appropriate plan of care. Further review of the policy revealed clinical status change included abnormal lab values.</p> <p>Interview, on 04/07/15 at 10:47 AM, with Resident #1's POA revealed the facility was informed the Infectious Disease Specialist was supposed to be involved in the resident's C. Diff treatment needs.</p> <p>Review of Resident #1's medical record revealed a bold lettered laminated document, untitled and undated, which noted "NO changes made to any orders regarding C. diff unless through" the IDC</p>		<p>Nurses (Registered Nurses and Licensed Practical Nurses) will be re-educated by the 3 Unit Managers (1 RN, 2 LPN), Assistant Director of Nursing (RN) and QA Nurse (LPN) regarding the community's policies relating to titled "Lab and Diagnostic Test Results – Clinical Protocol" policies relating to notification of physician to include both the PCP and the IDC physician or the consulting physician who recommended or wrote an order by 5/7/15.</p> <p>The (3) three unit coordinators (2 LPN, 1 RN) and the Quality Assurance Nurse will audit 6 lab results per week for 6 weeks for notification to both the PCP and any involved IDC or consulting physician who ordered or recommended a lab.</p>		

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F 157	Continued From page 10 Physician. Record review revealed the facility initially admitted Resident #1 on 11/14/14, with diagnoses which included C. diff Infection (a bacterial infection), Post-Code Encephalopathy and Depression. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/13/15, revealed the facility assessed Resident #1 to be severely cognitively impaired.	F 157	The results of the audit 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.	
	Continued record review revealed Resident #1 was seen by the IDC Physician on 02/11/15. Review of the IDC Physician's Report of Consultation document received, after the resident's visit, revealed the IDC Physician noted Resident #1's C. diff status was "clinically okay", with the recommendation the facility could re-check the C. diff toxin, the Probiotics times two (2) weeks, and the follow-up visit in three (3) weeks. Further review of the IDC Physician's Report of Consultation revealed no documented evidence of the Vancomycin antibiotic treatment recommendations if the C. diff re-occurred. Review of Resident #1's February Physician telephone orders revealed an order, dated 02/11/15, to draw the C. diff lab in one (1) week, and a telephone order, dated 02/14/15, to initiate Vancomycin 250 mgs three (3) times a day for fourteen (14) days for C. diff. Review of Resident #1's February 2015 Medication Administration Record (MAR) revealed Vancomycin was administered as ordered from 02/15/15 through 02/28/15. Review of Resident #1's C. diff lab result, dated 02/16/15, revealed an abnormal positive result. However, review of the Nurse's Notes revealed no documented evidence the IDC Physician had been notified of the 02/16/15 positive C. diff lab		Completion Date: May 7, 2015	

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F 157	Continued From page 11 result when the report was received, and no documented evidence the IDC Physician was notified of the initiation of Vancomycin antibiotic treatment. Continued review of the Nurse's Notes revealed a Note dated 03/03/15 at 9:30 AM, revealed facility staff received phone calls from Resident #1's POA regarding the resident's Vancomycin treatment course, and why the resident had not continued on Vancomycin, as per, the IDC Physician treatment plan. Continued review of the Note revealed Resident #1's POA requested the facility contact the IDC Physician regarding the antibiotic. Further review of the 03/03/15 Nurse's Note revealed the facility contacted the IDC Physician's office and requested/received the 02/11/15 IDC Physician's visit note, which included the IDC Physician's Vancomycin treatment recommendations. Further review of the Note revealed the nurse spoke to the IDC Physician's staff and reported the facility had not received the IDC Physician's visit note after Resident #1's visit on 02/11/15, and the office staff reported the visit note was sent with a family member. Review of the IDC Physician's visit note for the 02/11/15 visit revealed the IDC Physician's recommendations included to repeat C. diff (lab) next week, and if the C. diff re-occurred, then two (2) weeks of Vancomycin 250 milligrams (mgs) should be given orally four (4) times a day, followed by a two (2) month taper. Review of the March 2015 Physician's telephone orders revealed an order dated 03/03/15, for Vancomycin 250 mg twice a day times fifteen (15) days per the IDC Physician's recommendation.	F 157			

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F 157	Continued From page 12 Interview, on 04/09/15 at 4:26 PM, with the IDC Physician's office nurse, as the IDC Physician was on vacation at the time, revealed Resident #1's family wanted Resident #1 followed by the IDC Physician for treatment of C. diff. The office nurse stated if the IDC Physician recommended a C. diff lab in one (1) week, the IDC Physician office would have expected to be notified of the lab results. Per interview, the IDC Physician was not made aware of the C. diff lab result until the office was called by the facility on 03/03/15. She further stated the IDC Physician's office had faxed the 02/11/15 IDC Physician's visit note to the facility on 03/03/15. Interview, on 04/08/15 at 6:38 PM with the Advanced Practice Registered Nurse (APRN) revealed the IDC Physician consult note, 02/11/15, included the recommendation the facility could re-check C. diff next week and an order was obtained. Per interview, the APRN had not felt the IDC Physician had asked to be notified. Further interview revealed the facility "probably" sent the lab about the positive C. diff to the IDC Physician, but it was not mandatory for the facility to contact them. Interview, on 04/08/15 at 4:25 PM, with Licensed Practical Nurse (LPN) #2 revealed Resident #1 went to the IDC Physician on 02/11/15, and they sent the Report of Consultation form back which included the C. diff lab draw in one (1) week. Per interview, Vancomycin treatment was started on 02/15/15, and the stool culture obtained on 02/16/15, was positive. LPN #2 stated however, the IDC Physician's office was not notified of the lab results until 03/03/15, when the POA requested the facility contact the IDC Physician about the Vancomycin treatment. Further	F 157			

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F 157	Continued From page 13 interview revealed based on the laminated Note in the chart, the IDC Physician should have been contacted when Resident #1 was started back on Vancomycin. Interview, on 04/07/15 at 6:16 PM and 04/09/15 at 5:13 PM, with the LPN #1/Infection Control Coordinator (ICC) revealed it was Resident #1's and his/her POA's right to have other consultants involved in the resident's care. Per interview, Resident #1's family wanted the recommendations from the IDC Physician reported to the resident's PCP. LPN #1 revealed if the IDC Physician recommended to check the C. diff toxin in the stool next week and the PCP ordered the lab, then the facility should have called the IDC Physician with the lab result. Further interview with LPN #1/ICC revealed the IDC Physician's recommendations were given to Resident #1's PCP on 03/03/15, and orders were written based on the recommendations. Interview, on 04/09/15 at 6:39 PM, with the Director of Nursing (DON) revealed Resident #1's family wanted the resident to be seen by the IDC Physician; however, there was documentation in the resident's chart to notify the IDC Physician of any C. Diff treatments. The DON revealed Resident #1 was treated by the resident's Physician at the facility, but the facility should have notified the IDC Physician of the C. diff lab result more timely once the result was available. Interview, on 04/09/15 at 8:00 PM, with the Administrator revealed the facility did not have to notify the IDC Physician of the C. diff lab result and related treatment. The Administrator revealed she was unsure when the laminated note requesting the facility make no changes to any	F 157			

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F 157	Continued From page 14 orders regarding Resident #1's C. diff unless through the IDC Physician was put in the chart, because there was no date on the note.	F 157		
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 - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	It is the policy of Richmond Place Rehabilitation and Healthcare Center to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. On 4/9/15, the Housekeeping supervisor ordered a product that does have an Environmental Protection Agency (EPA) claim to be effective against c.diff. This product will be used to clean surfaces in rooms in precautions for c.diff by 4/30/15. SRNA # 9 and SRNA #10 were educated by the Quality Assurance nurse on 4/8/15 and SRNA #3 were re-educated by the Quality Assurance Nurse on 4/7/15 to wear a gown in addition to gloves when a patient is in contact precautions when providing care. Housekeeper # 1, #2, and #3 was educated by the	

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F 441	Continued From page 15 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, product information review, review of the Centers for Disease Control (CDC) Guidelines for Environmental Infection Control in Health-Care Facilities and review of the facility's policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary environment and help prevent the development and transmission of disease and infection for two (2) of seven (7) sampled residents (Residents #1 and #2). Residents #1 and #2 were diagnosed with Clostridium difficile (C. diff), a contagious bacteria which could remain on dry surfaces for extended periods of time, and placed on contact precautions. However, observations revealed staff failed to follow the facility's policies and guidelines regarding gown use when providing care or cleaning the environment of residents with contact precautions. In addition, review of the the facility's housecleaning product used to disinfect the rooms of Resident #1 and #2, who had been diagnosed with the C. diff, revealed the product information did not list the product as being effective against C. diff. Interview with a Customer Service Representative for the product company revealed the product used by the	F 441	Housekeeping Supervisor on 4/8/15 to wear a gown and gloves when cleaning a room in contact precautions. On 4/10/15, the Administrator re-educated the Interdisciplinary Team including the Quality Assurance Nurse, 3 Unit Coordinators, Assistant Director of Nursing, and Housekeeping Supervisor regarding the community's policy titled "Isolation Precautions" relating to using gowns and gloves in rooms of patients in contact precautions to prevent the transmission of infectious agents. Direct Care (Nurses and SRNA) and Housekeeping staff will be re-educated by the Quality Assurance Nurse (LPN), 3 Unit Managers (1 RN, 2 LPN), and Assistant Director of Nursing (RN) regarding the community's policies relating to titled "Isolation Precautions" relating to precautions for patients in contact precautions including wearing gowns and gloves to prevent transmission of infectious agents by 5/7/15.	

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F 441	Continued From page 16 facility, did not have an Environmental Protection Agency (EPA) claim for being effective against C. diff. The findings include: Review of the CDC Guidelines for Environmental Infection Control in Health Care Facilities, dated 2003, revealed C. diff. was a spore forming bacteria which could persist in the environment for extended periods of time. The Guidelines revealed environmental contamination by the organism was well known, especially in places where fecal contamination might occur. Continued review revealed direct exposure to high-touch environmental surfaces, such as, bathrooms have been implicated as sources of the infection. Per the Guidelines, studies regarding the use of sodium hypochlorite (bleach) were inconclusive but, limited data revealed meticulous cleaning followed by disinfection with sodium hypochlorite as appropriate, showed declines in healthcare associated C. diff infections. However, the Guidelines revealed because no Environmental Protection Agency (EPA) registered products for inactivating C. diff spores were available, the recommendation was based on the best available evidence from scientific literature. 1. Review of the facility's policy titled, "Isolation Precautions", revised 04/01/11, revealed Contact Precautions were utilized to prevent the transmission of infectious agents, such as, C. diff associated diarrhea, spread by direct or indirect contact with the resident or the resident's contaminated environment. The Policy revealed when a resident was on Contact Precautions staff were to wear a gown for all interactions that might	F 441	The (3) three unit coordinators (2 LPN, 1 RN) and the Quality Assurance Nurse will complete 6 observations of care for rooms in contact precautions per month to ensure gloves and gowns are in use for all interactions that might involve contact with the resident or potentially contaminated items. The Housekeeping Supervisor will complete 6 observations a month of cleaning in rooms in contact precautions per month to ensure gloves and gowns are in use for all interactions that might involve contact with the resident or potentially contaminated items. 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: May 7, 2015	

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F 441	Continued From page 17 involve contact with the resident or potentially contaminated items in the resident's environment. Observations, on 04/07/15 at 10:23 AM and at 10:28 AM, revealed Resident #1 and Resident #4 had signs on their respective room doors which stated, "Visitors Please Report to the Nurses Station Before Entering".	F 441			
	<p>Interview, on 04/09/15 at 6:39 PM and at 8:38 PM, with the Director of Nursing (DON) revealed when a resident was on isolation precautions the facility staff placed a sign on the door to make people/staff aware about the room. Per interview staff were to wear the proper Personal Protective Equipment (PPE), which was provided in the rooms on the back of the door.</p> <p>Review of Resident #1's medical record revealed the resident was initially admitted by the facility on 11/14/14, and had diagnoses which included C. diff Infection, Depression, Antiarrhythmia, and Post-Code Encephalopathy.</p> <p>Observation, on 04/08/15 at 7:42 AM, revealed State Registered Nursing Assistant (SRNA) #9 and SRNA #10 entered Resident #1's room putting gloves on and repositioned Resident #1 in the bed.</p> <p>Interview, on 04/08/15 at 7:59 AM, with SRNA #10 revealed she repositioned Resident #1 in the bed, to eat breakfast, and wore gloves but did not put on a gown. Further interview with the SRNA revealed they were only supposed to wear a gown if they provided incontinence care for the resident.</p> <p>Interview, on 04/08/15 at 8:56 AM, with SRNA #9</p>				

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F 441	<p>Continued From page 18</p> <p>revealed she normally did not work the hall where Resident #1 was located and had not seen the sign on Resident #1's door. Per interview, she had not seen the PPE supplies when she followed the other SRNA into Resident #1's room and helped reposition the resident in bed without wearing a gown. SRNA #9 revealed she observed the PPE supplies after repositioning Resident #1 in the bed and realized then the resident was on Contact Precautions. SRNA #9 stated when a resident was on Contact Precautions they were supposed to wear a gown when care was provided so they didn't spread the infection.</p> <p>Interview, on 04/09/15 at 1:19 PM, with Licensed Practical Nurse (LPN) #2 revealed if a resident was on Contact Precautions the aides, who repositioned Resident #1 in the bed were supposed to wear a gown. The LPN revealed there was the possibility of contamination if they had not worn gowns.</p> <p>Review of Resident #4's medical record revealed the resident was initially admitted by the facility on 03/06/15 with diagnoses which included C. diff., Anemia, Non-Alzheimer's Dementia and Re-occurring Pneumonia.</p> <p>Observation, on 04/07/15 at 10:23 AM, revealed SRNA #3 was in Resident #4's room standing next to the bed and was not observed wearing a gown.</p> <p>Interview, on 04/07/15 at 10:31 AM and at 3:24 PM, with SRNA #3 revealed he was from an agency and had just came into the facility at 9:30 AM that morning. He stated he did not get report on the residents and went into the room to help</p>	F 441			

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F 441	Continued From page 19 provide care to Resident #4. Per interview, he was not informed Resident #4 was on Contact Precautions and was used to seeing PPE supplies outside the door if a resident was on Contact Isolation. SRNA #3 revealed he had provided incontinence care for Resident #4, and had not worn a gown, but did have gloves on. SRNA #3 revealed if a resident was on Contact Precautions staff were supposed to wear a gown when providing care because of infection control reasons. Further interview revealed he had been educated by the Infection Control Nurse (ICN) on Contact Precautions, and wore a gown when he provided care to Resident #4 that afternoon. Review of a document, dated 04/07/15, revealed the ICN had educated SRNA #3 on "infection control and contact rooms". The document revealed SRNA #3 was educated he was supposed to wear a gown when in direct contact with a resident on Contact Precautions and the location of PPE. Observation and interview, on 04/08/15 at 1:37 PM, revealed Housekeeper #3 in Resident #4's bathroom cleaning without wearing a gown. Housekeeper #3 revealed when cleaning a room she cleaned the bathroom area, lights and the overbed table. Per interview, she was educated on infection control and if a room had a yellow sign on the door they were supposed to wear a gown, mask, and gloves when they cleaned because they didn't want to contaminate other residents. Housekeeper #3 revealed she had gotten in a hurry, and had not worn a gown to clean, but had not seen any blood or stool in the bathroom. Interview, on 04/07/15 at 2:18 PM, with	F 441			

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F 441	<p>Continued From page 20</p> <p>Housekeeper #1 revealed she had training on infection control and with certain residents, who were sick, there was supposed to be a sign put on the door for visitors to report to the nurse's station. Per interview, the facility tried to move a resident's roommate, who was not sick, to another room. Continued interview revealed when she cleaned rooms she would clean the bathrooms, the overbed table, the bed frame, and the head/footboard of the bed. Further interview with the Housekeeper revealed when cleaning rooms, which had signs on the door, she only used gloves.</p> <p>Interview, on 04/08/15 at 10:41 AM, with Housekeeper #2 revealed Resident #1's room was a precaution room and everything got sanitized in it. Per interview, she cleaned the door handles, remote control, bedside tables, bed rails, light over the bed and in the bathroom she cleaned the toilet, sink, and wall rails. Housekeeper #2 revealed she put on gloves and if the resident was in the rooms she would put on a mask. Further interview revealed however, she didn't wear a gown because she had no direct contact with the resident.</p> <p>Interview, on 04/09/15 at 5:13 PM and 8:33 PM, with the ICN revealed the facility followed the CDC Contact Precaution Guidelines for use of PPE and provided a private room until the infection was cleared. The ICN revealed if nursing staff provided direct care to resident on Contact Precautions, including incontinence care, they were supposed to wear a gown. She revealed when the resident on Contact Precautions room was cleaned by the Housekeepers, they were supposed to wear gowns because they could come in contact with</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 21 contaminated surfaces in the room environment. Per interview, housekeeping staff received the same infection control training as the nursing staff. The ICN further revealed if staff were not following the proper precautions there was a potential of cross contamination, but felt no actual cross contamination had occurred.	F 441			
	Continued interview, on 04/09/15 at 6:39 PM and 8:38 PM, with the DON revealed anytime someone was in isolation, if staff was going to come in contact with body fluids or any contamination, they were to wear a gown because of transmission concerns. The DON revealed it was best practice to wear a gown if incontinence care was provided for residents on Contact Precautions. Per interview, the resident on Contact Precautions bed was considered a high risk contamination area, so staff were supposed to wear a gown. In addition, the DON revealed housekeeping staff should have worn a gown when going into the room of residents on Contact Precautions to provide housekeeping services. Interview, on 04/09/15 at 8:00 PM, with the Administrator revealed she did not feel like the aides who repositioned the resident in bed, and the housekeepers who were not wearing gowns were at risk for contamination from the C. Diff organism, due to no stool or body fluids being present. The Administrator revealed she felt like the bed and bathroom areas were not considered at risk of being highly contaminated if no stool or body fluids were present. Even though the CDC Guidelines for Environmental Infection Control in Health Care Facilities, indicated direct exposure to high-touch environmental surfaces which included bathrooms had been implicated as				

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F 441	Continued From page 22 sources of the infection. Further interview with the Administrator on 04/09/15 at 8:00 PM, revealed she felt like staff followed the facility's policy for Isolation Precautions. The Administrator revealed she was not aware staff had provided incontinence care to a resident on Contact Precautions for C. Diff.	F 441		
	<p>2. Review of the facility's policy titled, "Cleaning and Disinfection of Environmental Surfaces", revised August 2009, revealed environmental surfaces were cleaned and disinfected according to CDC recommendations for disinfection of healthcare facilities. Policy review revealed an EPA-registered hospital disinfectant designed for housekeeping purposes was to be used in resident care areas where uncertainty existed about the presence of multidrug-resistant organisms (MDROs) on such surfaces. Further policy review of the Policy, under the section for "Disinfecting Clostridium difficile Units", revealed "currently, no products" were EPA-registered "specifically for inactivating C. difficile spores".</p> <p>Review of the facility's Disinfectant Cleaner: Clorox Clean-Up product information revealed the product contained 1.84% Sodium Hypochlorite and exceeded the CDC recommended 5,000 ppm (parts per million) Sodium Hypochlorite required to kill many of the pathogens of most concern to hospitals. However, continued review of the product information list of organisms the product was effective against, revealed C. diff was not listed as an organism it was identified to be effective against.</p> <p>Interview, on 04/20/15 at 4:51 PM, with a Customer Representative, from the Clorox Professional Products Company, revealed the</p>			

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F 441	<p>Continued From page 23</p> <p>Clorox Clean-Up product information included a list of organisms it was effective against and listed the organisms the EPA claimed it was effective against. She revealed if the organism was not on the product information list, the EPA did not claim it as being effective against that organism. She revealed the Clorox Clean-Up Disinfectant Cleaner did not have an EPA effective claim against C. diff. Continued interview revealed their product Clorox Healthcare Bleach Germicidal Cleaner had an EPA effective claim against the C. diff spore which indicated that product was effective.</p> <p>Review of the Clorox Healthcare Bleach Germicidal Cleaner product information revealed it was effective against C. diff spores with a kill time of five (5) minutes.</p> <p>Continued interview, on 04/09/15 at 5:13 PM, with the ICN revealed there were currently six (6) residents at the facility with C. diff infections, but only two (2) were "in-house" acquired. She revealed not using the proper disinfectant product for C. diff was a contamination concern. Per interview, the product being used at the facility to disinfect the rooms of residents with C. diff infections was a bleach product; however, was not recommended as effective against C. diff.</p> <p>Continued interview, on 04/09/15 at 8:00 PM, with the Administrator revealed the facility's policy addressed disinfecting C. diff Units which did not pertain to their facility. The Administrator revealed according to CDC Guidelines they followed recommended procedures. Per the Administrator, the facility had some disinfectants which were effective against C. diff that were used on critical surfaces, but she did not consider</p>	F 441			

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F 441	Continued From page 24 light switches, bathroom sinks or toilets to be at risk for high contamination.	F 441	It is policy of Richmond Place Health & Rehabilitation Center to provide or obtain laboratory services to meet the needs of its residents.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		
	<p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to obtain laboratory (lab) services to meet the needs of its residents for one (1) of seven (7) sampled residents (Resident #5).</p> <p>The Physician ordered lab tests for Resident #5 on 03/23/15; however, there was no documented evidence attempts were made to obtain the labs as ordered or the MD was notified of the labs not having been obtained. The lab tests were not completed until 03/27/15, after a second order for them was obtained on 03/26/15.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Lab and Diagnostic Test Results - Clinical Protocol", revised April 2013, revealed staff were responsible to "process test requisitions and arrange for tests" ordered by Physicians. Per the Policy, a nurse was to review all lab results, with the lab results communicated to the Physician. However, further review of the Policy revealed no documented evidence of a process in place to ensure the labs were obtained in a timely after</p>		<p>On 4/9/15 Resident #5 was re-assessed by the Nurse Manager (LPN) with no changes in condition.</p> <p>On 4/10/15, the Administrator re-educated the Interdisciplinary Care Plan Team including 3 Unit Coordinators, Assistant Director of Nursing, 3 MDS Coordinators, Activities and (2) Social Service Coordinators regarding the community's policy titled "Lab and Diagnostic Test Results – Clinical Protocol" policies relating to timely receipt of the lab results. Lab requisitions to be monitored for timely (24 hours to 48 hours dependent upon type of culture) receipt of lab results.</p>	

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F 502	Continued From page 25 ordered by the Physician. Although the Policy revealed Physicians, after receiving results of labs from the facility, were expected to respond within one (1) hour regarding a lab test requiring immediate notification, and by the end of the next office day regarding non-immediate lab test notification.	F 502	Nurses (Registered Nurses and Licensed Practical Nurses) will be re-educated by the 3 Unit Managers (1 RN, 2 LPN), Assistant Director of Nursing (RN) and QA Nurse (LPN) regarding the community's policies relating to titled "Lab and Diagnostic Test Results – Clinical Protocol" policies relating to timely receipt of the lab results. Lab requisitions to be monitored for timely (24 hours to 48 hours dependent upon type of culture) receipt of lab results. The (3) three unit coordinators (2 LPN, 1 RN) and the Quality Assurance Nurse will audit 6 lab results per week for 6 weeks for timely completion. The results of the audit 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: May 7, 2015		
	Review of Resident #5's medical record revealed the facility admitted the resident on 09/06/12, with diagnoses which included Long-Term Use of Asprin, Hypertension, and Alzheimer's Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/27/15, revealed the facility assessed Resident #5 as severely cognitively impaired. Continued record review revealed an "SBAR (Situation Background Assessment/Appearence Request) Communication Form" dated 03/19/15, which noted Resident #5 was leaning to the left, had decreased mobility and the resident's private sitter told staff he/she was "not walking anymore". Continued review of the "SBAR" form revealed a Nurse's Note documented under the "Request" section dated 03/19/15 at 12:00 AM, which noted: the nurse had observed Resident #5 leaning to the left; the nurse asked the resident to squeeze her fingers which he/she did with the grip equal but not strong; the nurse observed the resident to have no pain on the left side; no signs or symptoms of facial drooping or pain observed; the Physician and family were "advised"; and the nurse would continue to monitor. Review of the Nurse's Notes revealed the nurses continued to monitor Resident #5 after 03/19/15. Review of the Nurse's Note dated 03/23/15 at 5:30 PM, revealed it was a "late note", which noted the Physician had ordered lab tests for				

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F 502	Continued From page 26 Resident #5 which included a BMP (Basic Metabolic Panel), CBC (Complete Blood Count), TSH (Thyroid Stimulating Hormone) and CT (Computerized Tomography) scan to be performed at the hospital. Continued review of the Nurse's Note dated 03/23/15, revealed the Physician's Orders had been taken off by an agency nurse. Review of the Telephone Physician's Order dated 03/23/15 at 5:30 PM, revealed an order for a BMP, CBC, TSH and CT scan of Resident #5's head without contrast to be obtained at the hospital. Further review of the Nurse's Notes revealed no documented evidence: the lab was contacted regarding the lab orders; the labs were obtained as ordered; or of the Physician having been contacted regarding the labs not being obtained. The Surveyor requested all documentation regarding the 03/23/15 lab order, to include lab requisition forms; however, no documented evidence of a lab requisition form for 03/23/15, was provided by the facility. Interview, on 04/08/15 at 4:50 PM, with Resident #5's private sitter, Sitter #5, revealed she visited and assisted Resident #5 six (6) days a week, which she had done since the resident's admission to the facility. Sitter #5 revealed the week of 03/23/15, Resident #5 had bright red blood in his/her urine, when she observed when assisting with changing the resident's adult brief. Per interview, Resident #5's Physician had ordered blood work, but "it wasn't done for a week". Sitter #5 revealed she was "not sure what the problem was" for the resident's blood work not to be obtained for a week. Further record review revealed a Physician's Order dated 03/26/15 at 6:15 PM, for Resident #5	F 502		

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F 502	Continued From page 27 to have a BMP, CBC, TSH, U/A (urinalysis) and to cancel the CT scan of the resident's head. Review of the lab form dated 03/27/15 at 6:05 AM revealed the BMP, CBC and TSH were obtained. Review of the lab report form revealed the lab results for the BMP, CBC and TSH were faxed to the facility from the lab at 9:16 AM on 03/27/15, with a Note stating the lab report was faxed to the Physician.	F 502		
	Interview with Licensed Practical Nurse (LPN) #3 on 04/09/15 at 2:27 PM, revealed after reviewing Resident #5's medical record, there was no evidence staff attempted to obtain the ordered labs; however, there should have been. LPN #3 stated the facility's lab process was for lab orders to be placed in an accordion folder, and put in the next day. She stated she was not sure what happened in the case of Resident #5's lab orders as the "process for labs was not done". The LPN revealed there might have been a breakdown in the facility's lab system. Per interview, Resident #5's Physician comes to the facility "quite often", and maybe he realized the lab orders for 03/23/15, had not been obtained, so he re-ordered the lab tests on 03/26/15. Further interview revealed Resident #5's lab work could have shown results which could have resulted in Resident #5 receiving quicker treatment. Interview with the acting Director of Nursing (DON) on 04/09/15 at 6:07 PM, revealed labs for Resident #5 were drawn on 03/27/15 and "came back normal". The acting DON revealed there was "no proof in" Resident #5's medical record of the labs being attempted after the order was received on 03/23/15, until 03/27/15 after the second order was received. Per interview, the facility had contacted the lab, and the only lab			

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F 502	Continued From page 28 results they had were for 03/27/15, after the lab was drawn that morning. Interview with the Administrator on 04/09/15 at 8:00 PM, revealed she felt the lab orders done on 03/27/15, for Resident #5 were done timely. Even though record review revealed the lab order for 03/23/15, four (4) days prior. Further interview with the Administrator on 04/09/15 at 8:00 PM revealed as Resident #5's labs "came back normal", there was no "negative consequence" for the resident.	F 502			