

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

PRINTED: 08/19/2010  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185438</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                          |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/05/2010</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE RICHWOOD</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1012 RICHWOOD WAY<br/>LA GRANGE, KY 40031</b> |  |   |
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| F 332   | <p>Continued From page 9</p> <p>Record review for Resident #14 on 08/03/10 revealed the resident was admitted to the facility on 01/08/07 and had no assessments or physician order for self-administration of any of the fourteen (14) medications left at the resident's bedside. The Minimum Data Sheet for Resident #14 revealed a cognition score of 0 which indicates the resident is independent in daily decision-making and may be interviewed.</p> <p>Interview with LPN #6 on 08/03/10 at 11:25am revealed she did leave the medications on the bedside table of Resident #14, she realized this was an error, and she realized that she was not following facility policy or accepted standards of nursing practice regarding administration of medications. LPN #6 stated she had been in-serviced on facility policy and she did know accepted standards of nursing practice but that she felt she could rely on Resident #14 to take the medications. She stated this was not her usual practice.</p> <p>Interview with the facility Pharmacist on 08/03/10 at 1:55pm revealed side effects most likely to occur if other residents ingested the medications left at the bedside for Resident #14 would be drowsiness, nausea, hypotension, increased fall risk, or hypersensitivity. He stated he would have to know the drug regimen for all residents capable of entering Resident #14's room and ingesting the medications left there to be more specific regarding potential harmful side effects. The Pharmacist did review the medication regimen for Resident #14's roommate (who could self-propel in the wheelchair in the room) and stated this unsampled resident could be at increased risk for hypotension or falls if this resident ingested Resident #14's medications.</p> | F 332   | <p>4.4. The D.O.N. shall present the "compliance summary," related to this regulation, to the QA/CQI Committee.</p> <p>4.5. The QA/CQI Committee shall review the D.O.N.'s "compliance summary", monitor trends and issue recommendations to ensure compliance with this regulation.</p> <p><b>Substantial Compliance Completion</b></p> | 08/25/10  |

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| F 332  | Continued From page 10<br><br>Interview with the DON at 12noon on 08/02/10 revealed she was aware this was a medication error, she stated LPN #6 was recently in-serviced on medication errors, and LPN #6 was observed in a medication pass in the past month and had no errors. The DON stated LPN#6 was off duty for a few days and would be re-trained upon return to duty.<br><br>Interview with Resident #14 on 08/06/10 at 1:30pm revealed medications were often (in a week's time) left at the bedside and the nurse does not always observe him/her taking the medications.   | F 332  | <b>F-441: Facility Plan of Correction</b><br><br>The facility corrected resident #7's indwelling catheter for compliance with the facility infection control program; the catheter was removed from the floor, and placed in the appropriate dignity bag at the time of the observation on August 4, 2010.<br><br>2. All nursing staff members were provided with education prior to August 27, 2010 related to Infection Control policy & practices.   |  |
| F 441<br>SS=D                                    | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as Isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must | F 441  | Additional in-servicing, performed by the Staff Development Coordinator, was conducted prior to August 27, 2010. This inservice consisted of the following: infection control policy and procedures, infection control related to Foley catheters and the proper usage of dignity bags for catheters.<br><br>3. The Quality Assurance Nurse shall make daily infection control rounds and will report findings to Director of Nursing.<br><br>3.1. The QA Nurse will summarize infection control surveillance monthly for trend analysis by the DON, and QA/CQI Committee.<br><br>3.2. The Staff Development Coordinator shall conduct educational sessions for |  |



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| F 441  | <p>Continued From page 11</p> <p>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<br/>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:<br/>Based on observation, interview and record review the facility failed to maintain effective infection control practices to prevent infections. One (1) of twenty-one (21) sampled residents was observed with the indwelling catheter bag lying on the floor (Resident #7).</p> <p>The findings include:</p> <p>Observation on 08/04/10 at 10:00am revealed Resident #7 resting in bed. Resident #7 had an indwelling catheter that was observed lying on the floor, not in the dignity bag hanging on the side of the bed.</p> <p>Interview on 08/04/10 at 10:10am with Licensed Practical Nurse (LPN) #7 revealed that she was aware the catheter bag should not be on the floor related to contamination and could cause the resident to get an infection.</p> | F 441  | <p>compliance with infection control regulations as directed by the Director of Nursing.</p> <p>3.3. Further training shall be conducted as outlined in the facility Quality Assurance schedule/calendar, and as needed.</p> <p>4. The Director of Nursing Services will be responsible for overseeing surveillance/monitoring &amp; compliance with this regulation.</p> <p>4.1. The D.O.N. shall present the "compliance summary," related to this regulation, to the QA/CQI Committee.</p> <p>4.2. The QA/CQI Committee shall review the D.O.N.'s "compliance summary", monitor trends and issue recommendations to ensure compliance with this regulation.</p> <p><b>Substantial Compliance Completion</b></p> | 08/27/10                                     |

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| F 441  | Continued From page 12<br><br>Interview on 08/04/10 at 10:25am with Certified Nursing Assistant (CNA) #6 revealed that she was aware the catheter bag should not be on the floor because it would become contaminated and could cause the resident to get an infection. | F 441  |   |  |



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|----------------------------|--|--------------------|---|----------------------|
| K 000<br><br>K 052<br>SS=D | <p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code survey was initiated and concluded on 08/05/2010. 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".</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to test the fire alarm system according to NFPA standards.</p> <p>The findings include:</p> <p>Record review on 08/05/2010 at 11:50 AM, revealed that the facility last had a fire alarm inspection on 03/01/2010.</p> <p>Interview on 08/05/2010 at 11:50 AM, with the</p> | K 000<br><br>K 052 | <p><b>K052 Fire Alarm Inspection</b></p> <p>The facility contacted the contract inspection company on 8/5/2010.</p> <p>The facility Administrator notified the regional manager of the contracting company, and requested an inspection to be conducted to achieve compliance with this regulation.</p> <p>The contracting company completed the required inspection on 8/9/2010; documentation was provided to the facility and is maintained in the LSC Binders located in the NHA and Maintenance offices.</p> <p>The facility Maintenance Director shall be responsible for compliance with this regulation, and maintaining the proper documentation. NHA shall provide oversight.</p> <p>The facility NHA shall audit the LSC compliance binder monthly for the next three months. The NHA shall monitor compliance via monthly LSC audits; the NHA shall present the QA/CQI Committee with a summary of compliance. The audits shall continue until such time that the QA/CQI Committee determines that "focused monitoring" is no longer required. The QA/CQI Committee shall review the NHA "compliance summary", monitor trends and issue recommendations to ensure compliance with this regulation.</p> <p><b>Substantial Compliance Completion Date</b></p> | 08/09/10             |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *L. McArthur, CNHA* TITLE *Administrator* (X8) DATE *8.25.10*

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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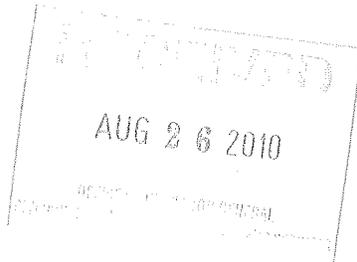
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| <p>K 052</p> <p>K 056<br/>SS=D</p> | <p>Continued From page 1</p> <p>Director of Environmental Services, revealed that she had called the company that performs the facility's fire alarm inspections and the company had stated they had missed that quarter's inspection due to a change in personnel.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure a complete sprinkler system according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 08/05/2010 at 11:30 AM, revealed that the canopy (approximately 5' X 7') with combustible construction, located at the 200 Hall, did not have sprinkler protection. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 08/05/2010 at 11:30 AM, with the</p> | <p>K 052</p> <p>K 056</p> | <p><b>K056 Sprinkler Protection: Canopy</b></p> <p>The facility took corrective action related to this regulation; the contract sprinkler company was contacted by the Maintenance Director. The sprinkler installation was installed in the canopy on 08/11/2010.</p> <p>The Maintenance Director has conducted a walking-inspection of the facility and no other canopy areas were identified; no physical plant expansion plans are under consideration, therefore the facility is current with all NFPA Life Safety Code regulations related to K056.</p> <p>The facility maintains a contractual arrangement with a sprinkler company for sprinkler protection work and maintenance. This arrangement shall be coordinated by the Maintenance Director and overseen by the NHA</p> <p>The NHA shall monitor compliance via monthly LSC audits; the NHA shall present the QA/CQI Committee with a summary of compliance. The QA/CQI Committee shall review the NHA "compliance summary", monitor trends and issue recommendations to ensure compliance with this regulation.</p> <p><b>Substantial Compliance Completion Date</b></p> | <p><b>08/13/10</b></p> |
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| <p>K 056</p> <p>K 062<br/>SS=D</p> | <p>Continued From page 2</p> <p>Maintenance Director, revealed that he was unaware of the canopy needing sprinkler protection.</p> <p>Reference: NFPA 13 (1999 Edition), 5-13.8.1</p> <p>Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that sprinkler systems were maintained according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 08/05/2010 at 9:15 AM, revealed that the outside freezer's sprinkler head had a buildup of ice around the sprinkler head. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 08/05/2010 at 9:15 AM, with the Maintenance Director, revealed he was unaware of the buildup of ice around the sprinkler head.</p> | <p>K 056</p> <p>K 062</p> | <p><b>K062 Sprinkler Protection: Freezer</b></p> <p>The facility took immediate corrective action; the contract sprinkler company was contacted by the Maintenance Director.</p> <ul style="list-style-type: none"> <li>The sprinkler was de-iced on 08/05/2010 per the manufacturer recommendations by the Maintenance Director.</li> <li>QA determined that the ice-build-up was caused by condensation, and not a malfunctioning sprinkler.</li> <li>The Maintenance Direct has resealed around the freezer's conduits as part of the facility's preventative maintenance program (PMP).</li> </ul> <p>The facility conducted surveillance and monitored compliance:</p> <ul style="list-style-type: none"> <li>The NHA verified the corrective action and de-icing on 08/05/2010. NHA monitored sprinkler-head on August 13<sup>th</sup>, August 20<sup>th</sup> &amp; again on August 23, 2010; there was no indication of any ice build-up.</li> <li>The facility retains a contractor for sprinkler protection work and maintenance. NHA oversight.</li> </ul> <p>The facility shall sustain compliance by utilizing the follow:</p> <ul style="list-style-type: none"> <li>Surveillance conducted by Maintenance Director and verified monthly by NHA</li> <li>QA/CQI shall monitor quarterly until directed otherwise by QA Committee.</li> <li>Perform preventative maintenance in conjunction with the facility PMP.</li> <li>Repair any issue identified by audit and/or observation; SNF shall utilize contract sprinkler company as directed by NHA.</li> </ul> | <p>08/05/10</p> <p>08/23/10</p> <p>8/23/10</p> |
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| K 069<br>SS=D | <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure fire extinguishers in the kitchen area were maintained according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 08/05/2010 at 9:10 AM, revealed that the K type fire extinguisher did not have the proper signage.</p> <p>Interview on 08/05/2010 at 9:10 AM, with the Maintenance Director, revealed he was not aware of the K type fire extinguisher needing a sign.</p> <p>Reference: NFPA 96 (1999 edition)<br/>7-2.1.1<br/>A placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area.</p> | K 069 | <p><b>K069 Fire Extinguisher signage</b></p> <p>The facility has taken corrective action to comply with K069 and NFPA standards.</p> <ul style="list-style-type: none"> <li>A temporary water-resistant sign was placed in the dish room to indicate that the K-type fire extinguisher was to be used only as a secondary backup means to the automatic fire suppression system"</li> <li>The Maintenance Director ordered the permanent sign to comply with this regulation on 8/23/2010.</li> </ul> <p>NHA and Maintenance Director conducted LSC surveillance on 8/13/2010; no additional signage was determined as being required</p> <p>The facility safety sustainability plan includes:</p> <ul style="list-style-type: none"> <li>Monthly LSC-inspection rounds by NHA</li> <li>Proper functioning of LSC equipment and signs will continue to be part of the Maintenance Director's preventative maintenance plan (PMP)</li> <li>LSC monitoring and compliance summary shall follow the quarterly QA calendar</li> <li>The QA/CQI Committee shall utilize the Safety &amp; Risk Management Committee's recommendations and resources to sustain compliance with this regulation.</li> <li>The NHA shall be responsible for disseminating and educating QA/CQI members regarding new regulations/requirements.</li> </ul> <p><b>Substantial Compliance Completion Date</b></p> | 08/27/10 |
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