

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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/17/2013
--	--	--	--

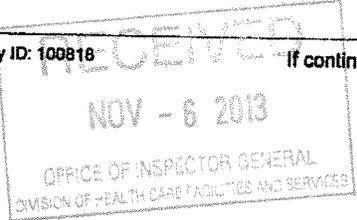
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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  F 279 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was initiated on 10/15/13 and concluded on 10/17/13 with deficiencies cited at the highest scope and severity of a "D". A Life Safety Code survey was conducted on 10/16/13 with deficiencies cited at the highest scope and severity of an "F" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,</p>	F 000  F 279	<p>This plan of Correction is submitted under Federal and State regulations and status applicable to long-term-care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.</p>	
----------------------------	---	--------------------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Arusti Noah* TITLE: *Administrator* (X6) DATE: *11/6/13*

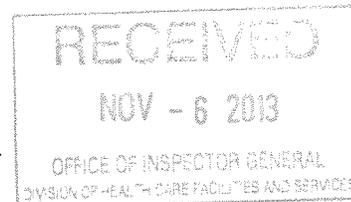
A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

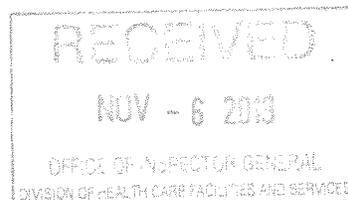
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/17/2013
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031		
(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 279	<p>Continued From page 1 and review of the facility's Care Plan policy, it was determined the facility failed to develop a comprehensive plan of care for prevention of development of contractures for one (1) of sixteen (16) sampled residents (Resident #4).</p> <p>The findings include:</p> <p>Review of the facility's Care Plan Policy, revised 03/01/13, revealed the comprehensive care plan must include review of the Care Area Assessments as identified through completion of the Minimum Data Set (MDS). The comprehensive care plan would be updated as needed based upon a change in the existing treatment plan. The care plan would be reviewed and revised quarterly and/ or with a significant change in condition.</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident, on 05/22/08, with diagnoses of Dementia, and Alzheimer's. The facility assessed the resident using the Minimum Data Set (MDS), dated 08/09/13, as requiring a two (2) person physical assistance with transfers, dressing, and bathing. The MDS identified the resident had an active diagnosis at that time of contracture of the hand joint. Review of the Restorative Nursing Care Program Plan of Care revealed the resident was to receive gentle passive range of motion to both upper and lower extremities then apply the splint to the left hand for 4 hours as tolerated. Review of the Resident's Comprehensive Plan of Care revealed there was no care plan for the resident's contractures or use of the splint to prevent worsening of the identified contracture.</p> <p>Observations of the resident on: 10/15/13 at 1:40</p>	F 279	<p>F-279</p> <ol style="list-style-type: none"> <li>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? The MDS Coordinator developed a comprehensive plan of care for the contracture of the Residents left hand.</li> <li>2. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective actions(s) will be taken? All residents with contractures and splinting had their comprehensive plan of care reviewed and revised to include an individualized care plan for contracture.</li> <li>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?  The DON in-serviced the MDS Coordinator on 10-31-13 about the importance of individualizing care plans that meet a residents medical, nursing, mental and psychosocial needs. The Restorative Nurse will give the MDS Coordinator the restorative care plans for splints. The MDS Coordinator will then make a comprehensive care plan for the Resident.</li> <li>4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur?</li> </ol>	



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/17/2013
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
(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 279	<p>Continued From page 2</p> <p>PM; 2:32 PM; 4:51 PM; on 10/16/13 at 9:33 AM; 10:35 AM; 11:04 AM; 2:00 PM; 4:45 PM; and on 10/17/13 at 9:02 AM; and 11:12 AM; revealed no splint was in place to the resident's left hand.</p> <p>Interview with Licensed Practical Nurse (LPN), on 10/17/13 at 2:05 PM, revealed the resident used a hand splint to prevent worsening of the contracture to the residents left hand. The LPN revealed she was aware the resident did not have the splint in place and had not seen it for three (3)days. The LPN revealed she should have looked for the splint, or found an alternate splint, when she noticed it was not in place. Further interview, on 10/17/13 at 4:15 PM, revealed everyone was responsible to ensure the splint was placed and should be on the comprehensive plan of care. After reviewing the resident's care plan, the LPN revealed she was not able to see where the residents contracture was addressed and only found the splint mentioned as an intervention to relieve pain. The LPN revealed the MDS Coordinator was responsible for developing the plan of care.</p> <p>Interview with the A Unit Manager, on 10/17/13 at 4:25 PM, revealed the resident should have a care plan for contractures to prevent worsening and maintain skin integrity due to the risk of injury from the resident's fingernails. The Unit Manager revealed she did not monitor the care plans and that the MDS Coordinator was responsible for developing the comprehensive plan of care.</p> <p>Interview with the MDS Coordinator, on 10/17/13 at 4:35 PM, revealed she was aware the resident used a splint for his/her left hand contracture. The MDS Coordinator revealed she did not develop a care plan for use of the splint because</p>	F 279	<p>An audit will be completed on resident care plans by the QA Nurse or DON on residents' comprehensive care plans to ensure the care plan meets the residents medical, nursing, mental and psychosocial needs. This audit will be weekly X 4 weeks, then monthly X 6 months. If the audit results in 100% compliance, it will be recommended to the QA committee to be discontinued.</p> <p>5. Completion Date: 11/9/13</p>	



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

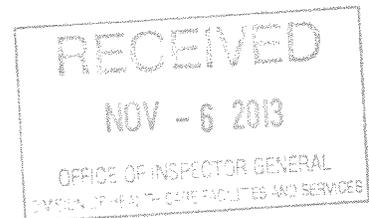
PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/17/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 279	<p>Continued From page 3</p> <p>It was covered by the Restorative Program plan of care. The MDS Coordinator revealed she was aware the restorative plan was not comprehensive as to what care needed to be provided to a resident with a contracture, but stated that was just how it was done.</p> <p>Interview with the Director of Nursing (DON), on 10/17/13 at 4:40 PM, revealed Resident #4 should have a care plan for contractures, and she was aware the facility did not create a comprehensive plan of care for residents with contractures. The DON revealed she had been working on developing the Restorative Program and did not have the care plan as a priority.</p>	F 279	<p>F318</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>Resident #4's hand splint was found and placed in residents' left hand per restorative staff.</p> <p>2. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective actions(s) will be taken?</p>	
F 318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy Restorative Nursing Program, it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents (Resident #4) had a hand splint in place that was used to prevent worsening of a contracture.</p> <p>The findings include:</p>	F 318	<p>An audit of all Residents with splints was completed by the Restorative Nurse and DON on 10/31/13 to ensure splints were appropriately placed.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</p> <p>The Restorative Nursing Staff were in-serviced on 10/31/13 by the DON about the importance of applying splints as ordered. The system for alerting the nursing staff that a residents' splint is not being placed as ordered was changed on 11/1/13. The restorative assistants will notify the charge nurse</p>	



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

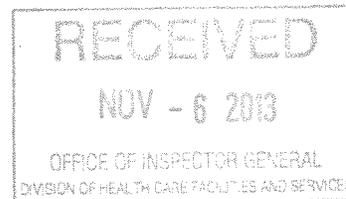
PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/17/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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
--------------------	--	---------------	---	----------------------

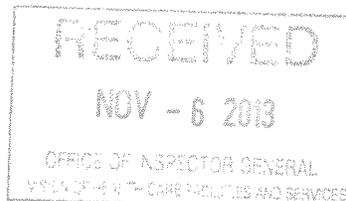
F 318	<p>Continued From page 4</p> <p>Review of the facility's Restorative Nursing Program policy, dated 2004, revealed the designated Restorative Nursing Assistants carried out the restorative interventions as care planned and documented on a flow record on the day performed. The Restorative Nursing Assistants were to notify the supervising nurse or Restorative Nurse Coordinator when there was a problem such as a resident's refusal to participate; the resident was unable to perform the interventions; pain; or special needs of the resident; etc.</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident, on 05/22/08, with diagnoses of Dementia, and Alzheimer's. The facility assessed the resident using the Minimum Data Set (MDS), dated 08/09/13, as requiring a two (2) person physical assist with transfers, dressing, and bathing. The MDS identified the resident with an active diagnosis at that time of contracture of the hand joint. Review of the Occupational Therapy Plan of Treatment, dated 05/21/13, revealed the resident had a left hand contracture and was being seen due to the resident's inability to tolerate a previous splint and decreased range of motion. The resident was discharged back to Restorative Therapy with a new soft roll hand splint with finger separators to be worn up to eight (8) hours a day. Review of the Restorative Nursing Care Program Plan of Care revealed the resident was to receive gentle passive range of motion to both upper and lower extremities then apply the splint to the left hand for 4 hours as tolerated. Review of the Resident's Comprehensive Plan of Care revealed there was no care plan for the resident's contractures or use of the splint to prevent</p>	F 318	<p>on the residents' hall in writing of the reason the splint cannot be placed. The charge nurse will document the omission in the residents' record and ensure the splint is back in place within twenty-four (24) hours.</p> <p>4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur?</p> <p>The DON or QA nurse will audit residents with splints on a weekly basis X 4 weeks, then monthly for six months to ensure compliance. If compliance is achieved, the QA committee will be asked for the audit to be discontinued.</p> <p>5. Completion Date: 11/4/13</p>	
-------	---	-------	---	--



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/17/2013
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031		
(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 318	Continued From page 5 worsening of the identified contracture.  Observations of the resident: on 10/15/13 at 1:40 PM; 2:32 PM; 4:51 PM; on 10/16/13 at 9:33 AM; 10:35 AM; 11:04 AM; 2:00 PM; 4:45 PM; and on 10/17/13 at 9:02 AM; and 11:12 AM; revealed no splint was in place to the resident's left hand.  Interview with Certified Nursing Assistant (CNA) #7, on 10/17/13 at 1:55 PM, revealed she was aware the resident did not have their hand splint in place. The CNA revealed she had put a rolled up wash cloth in the contractured hand because the restraint was not on. The CNA revealed the resident had the splint to prevent worsening of the contracture and restorative therapy was responsible to ensure splints were placed. After looking through the resident's room and the facility's laundry department, the CNA revealed she was unable to even find the resident's hand splint.  Interview with Licensed Practical Nurse (LPN) #6, on 10/17/13 at 2:05 PM, revealed she was aware the resident had not worn his/her splint for several days. The LPN revealed she had not even seen it for several days. The LPN recalled last seeing the splint, on 10/14/13. The LPN revealed the splint was being used to prevent worsening of an already present contracture. The LPN revealed if the splint had been sent to laundry, it was normally back the next day and should have already been returned. The LPN revealed she did monitor to ensure the splint had been placed, if she remembered to, and she should have tried to find it when she noticed it was not there. The LPN revealed Restorative was usually responsible for splints and she was not sure how long the resident should even wear	F 318			



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/17/2013
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031		
(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 318	<p>Continued From page 6 the splint.</p> <p>Review of the facility's Treatment Administration Records (TAR) revealed the splint was not listed for Resident #4.</p> <p>Interview with Certified Nursing Assistant (CNA) #8, on 10/17/13 at 2:20 PM, revealed she was also the Restorative Aide. The CNA revealed she applied the splint on 10/15/13, but had to send the splint to laundry, on 10/16/13, because the splint was soiled. The CNA revealed the Restorative Department was responsible to apply the splint and monitor. When told the resident's splint had not been seen for three (3) consecutive days by the surveyor, the CNA did not provide a response.</p> <p>Interview with Laundry Aide #3, on 10/17/13 at 3:32 PM, revealed she had worked the past three (3) days and did not see the resident's splint. The Laundry Aide revealed splints were washed and returned to the nursing units within a 24 hour time period.</p> <p>Interview with the A Unit Manager, on 10/17/13 at 4:25 PM, revealed the facility did have a restorative department that applied resident splints; however, it was ultimately nursing's responsibility to ensure the splints were in place. The Unit Manager revealed she did not realize it was a problem and had not been monitoring to ensure they were being applied.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 10/17/13 at 4:30 PM, revealed she was the Restorative Nurse. The LPN revealed Resident #4 had a splint to prevent further contracture of the left hand. The LPN revealed she did make</p>	F 318			



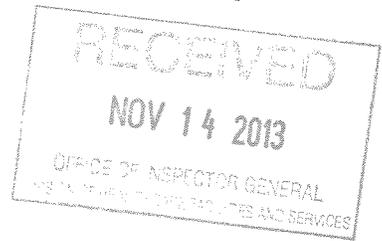
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/17/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 318	Continued From page 7 rounds to make sure splints were being placed. The LPN revealed she was told Resident #4's splint was sent to laundry, on 10/15/13, and should have returned the next day. The LPN revealed she was not notified the splint had not been returned from laundry, or she would have found a replacement splint. The LPN revealed there was a lack of communication with the Restorative Aides and nursing which she felt was partly the reason the resident did not have the splint. The LPN revealed it was everyone's responsibility to make sure treatment was provided to ensure there was not a decline in a residents functional status.  Interview with the Director of Nursing (DON), on 10/17/13 at 4:40 PM, revealed the restorative program was new and they were still trying to work out some problems. However, the DON revealed the resident should have had the splint and restorative should have been monitoring.	F 318	F463 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?  The two restrooms in the lobby were locked. The keys to the restrooms must be obtained from the receptionist.  2. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective actions(s) will be taken?  All resident accessible restrooms in the facility without an emergency call system were audited to ensure they are locked.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure two (2) of two (2) unlocked restrooms, located in the lobby, accessible to residents, were equipped with an emergency call system to alert staff of a resident's needs.	F 463	3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?  The restrooms will remain locked at all times. A sign has been placed by the restrooms in the lobby informing users to obtain a key from the receptionist.  4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur?  The QA nurse or Administrator will audit the restroom doors in the lobby	



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/17/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 463 Continued From page 8

The findings include:

Review of the facility's policy regarding the use of Call Lights, undated, revealed the purpose was to assure the call system was in proper working order and the emergency call light was in functioning order.

Observations, on 10/15/13 at 1:30 PM and 10/16/13 at 8:20 AM, revealed the two (2) restrooms located in the lobby, were accessible to residents; however, they were not equipped with an emergency call system.

Observation of Unsampled Resident A, on 10/16/13 at 1:30 PM, revealed he/she had self-propelled into the lobby of the facility near the two (2) unlocked restrooms.

Record review of the facility's Brief Interview of Mental Status (BIMS) provided during initial tour, revealed Unsampled Resident A, was cognitively impaired. The facility assessed Unsampled Resident A at less than eight (8) out of fifteen (15) as a cognition score.

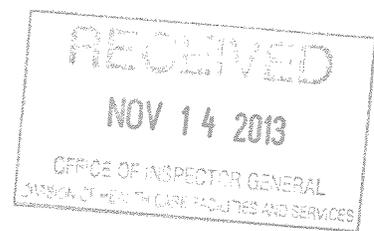
Interview with Certified Nurse Aide (CNA) #8 in the dining room, on 10/17/13 at 4:00 PM, revealed Unsampled Resident A did self propel in the wheelchair to travel around the facility. The CNA reported the resident wore an alarm on the wheelchair. The resident tries to get out of the wheelchair at times. He/she would have used the call light when in the bathroom.

Interviews, with the Administrator, Director of Nursing (DON) and the Director of Maintenance, during the facility tour, on 10/17/13 at 3:40 PM,

F 463

daily X 5 days/week, then weekly X 4 weeks to ensure the doors are locked. Results will be reviewed at monthly QA meeting and if 100% compliance has been achieved, the audit may be discontinued.

5. Completion Date: 11/4/13



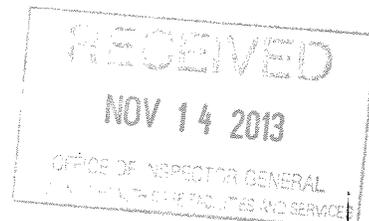
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/17/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 463	Continued From page 9 revealed the two (2) restrooms located in the lobby were unlocked restrooms and were accessible to residents. The DON stated the resident accessible restrooms should have the emergency call lights. The Administrator, DON and the Maintenance Director were unable to determine when the restrooms became unlocked and resident accessible; however, they indicated the emergency call system was not in place and should have been in place when the restrooms became resident accessible.	F 463		



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1997, 2000</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 10/16/13. The Richwood was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred twenty (120) beds with a census of seventy four (74) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>This plan of Correction is submitted under Federal and State regulations and status applicable to long-term-care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.</p> <div data-bbox="998 1417 1347 1638" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED</p> <p>NOV 14 2013</p> <p>OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES</p> </div>	
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shaunice Noah</i>	TITLE <i>x Administrator x</i>	(X6) DATE <i>11/6/13</i>
---	-----------------------------------	-----------------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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.

RW

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

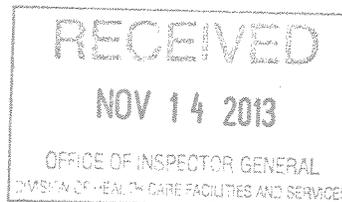
PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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
--------------------	--	---------------	---	----------------------

<p>K 000</p> <p>K 038 SS=E</p>	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy four (74) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/16/13 between 11:00 AM and 2:30 PM, with the Maintenance Director revealed the delayed egress doors located in the Therapy Room, at B Nurses Station, Main Entrance, 200 Exit, and Rear Entrance were equipped with delayed egress locks; however, the delayed egress signage did not have a contrasting background making the signage easily visible.</p>	<p>K 000</p> <p>K 038</p>	<p>K 038</p> <p>No specific residents were identified as being affected by the delayed egress doors or exit access.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>The Maintenance Director removed the shelf on 11/4/13.</p> <p>The Maintenance Director conducted an audit of the building to ensure that all means of egress were free of obstructions and impediments. The audit on 11/1/13 revealed compliance with all other exits.</p> <p>The Maintenance Director ordered signs with a contrasting background and replaced the previous existing signs on 11/8/13.</p> <p>The Maintenance Director will conduct a monthly audit for on all exits. The findings will be reviewed during the monthly QA meeting to ensure compliance.</p> <p>Completion Date: 11/12 /13</p>	
------------------------------------	---	---------------------------	--	--



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

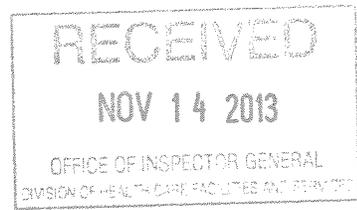
PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 038	<p>Continued From page 2</p> <p>Interview, on 10/16/13 between 11:00 AM and 2:30 PM, with the Maintenance Director revealed he was not aware the delayed egress signage was required to be on a contrasting background.</p> <p>Observation, on 10/16/13 between 11:00 AM and 2:30 PM, with the Maintenance Director revealed a shelf projecting out thirteen (13) inches from the wall located in the egress path at the Receptionist Window.</p> <p>Interview, on 10/16/13 between 11:00 AM and 2:30 PM, with the Maintenance Director revealed he was not aware of the requirement</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat</p>	K 038		
-------	---	-------	--	--



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

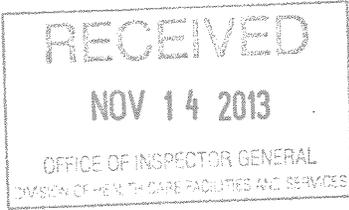
PRINTED: 10/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 038	<p>Continued From page 3</p> <p>detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p>	K 038		
-------	--	-------	--	--



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

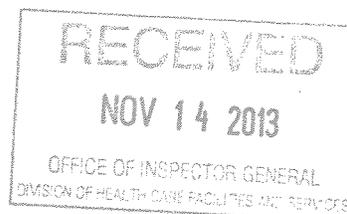
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 038 Continued From page 4

7.10.8.1\* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:  
NO  
EXIT  
Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.

7.5.2.2\* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met:  
(a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress.  
(b) They are installed across an opening that is at least 6 ft (1.8 m) in width.  
(c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.  
Reference NFPA 101 (2000 edition)

K 038



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185438</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>THE RICHWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1012 RICHWOOD WAY LA GRANGE, KY 40031</b>
---	---

(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 038** Continued From page 5  
7.3.2\* Measurement of Means of Egress.  
The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration.  
Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.

**K 045** Reference: S&C-12-21-LSC  
SS=D NFPA 101 LIFE SAFETY CODE STANDARD

illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility did not meet the requirements for illumination of means of egress in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy four (74) on the day of the survey. The facility failed to provide required illumination outside an exit for discharge.

The findings include:  
  
Observation, on 10/16/13 between 10:30 AM and 2:30 PM, with the Director of Maintenance revealed the exit located in the Therapy Room,

**K 038**

**K 045**

**K 045**  
  
No specific residents were identified as being affected by the single lighting fixtures at the exit located in the Therapy Room, Kitchen, and the Dining Room.

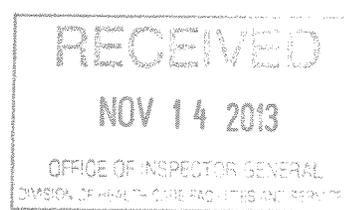
All Residents have the potential to be affected by the alleged deficient practice.

The Maintenance Director examined all facility exits required to have a double light fixture. No other areas were identified as needing a double light fixture.

The Maintenance Director will switch the single light fixture to double light fixtures at the exit located in the Therapy Room, Kitchen, and the Dining Room.

The Maintenance Director will audit the exit areas to ensure proper lighting monthly. The findings will be reviewed at the QA meeting monthly to ensure compliance.

Completion Date: 11/30/13



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

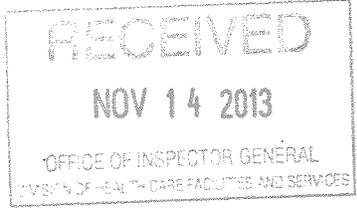
PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 045	<p>Continued From page 6</p> <p>Kitchen, and the Dining Room did not have a light fixture installed outside to provide the required illumination for exit discharge. All three exits were equipped with a light fixture with only one light bulb.</p> <p>Interview, on 10/16/13 between 10:30 AM and 2:30 PM, with the Director of Maintenance revealed he was not aware the exits did not have the required illumination for egress lighting.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in</p> <p>7.7 DISCHARGE FROM EXITS</p> <p>7.7.1*</p> <p>Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.</p> <p>Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.</p> <p>Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.</p> <p>Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.</p> <p>7.7.2</p> <p>Not more than 50 percent of the required number of exits, and not more than 50 percent of the</p>	K 045		
-------	---	-------	--	--



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

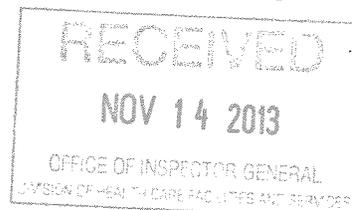
**PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185438</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>THE RICHWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1012 RICHWOOD WAY LA GRANGE, KY 40031</b>
---	---

(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 045	<p>Continued From page 7</p> <p>required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1) through (3) are met:</p> <p>(1) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit.</p> <p>(2) The level of discharge shall be protected throughout by an approved, automatic sprinkler system in accordance with Section 9.7, or the portion of the level of discharge used for this purpose shall be protected by an approved, automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for the enclosure of exits (see 7.1.3.2.1).</p> <p>Exception: The requirement of 7.7.2(2) shall not apply where the discharge area is a vestibule or foyer meeting all of the following:</p> <p>(a) The depth from the exterior of the building shall not be more than 10 ft (3 m) and the length shall not be more than 30 ft (9.1 m).</p> <p>(b) The foyer shall be separated from the remainder of the level of discharge by construction providing protection not less than the equivalent of wired glass in steel frames.</p> <p>(c) The foyer shall serve only as means of egress and shall include an exit directly to the outside.</p> <p>(3) The entire area on the level of discharge shall be separated from areas below by construction having a fire resistance rating not less than that required for the exit enclosure.</p> <p>Exception No. 1: Levels below the level of discharge shall be permitted to be open to the level of discharge in an atrium in accordance with 8.2.5.6.</p>	K 045		
-------	---	-------	--	--



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

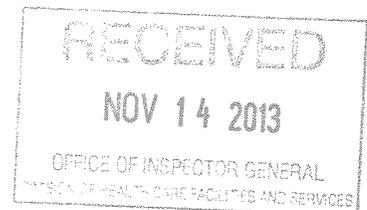
PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185438</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>THE RICHWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1012 RICHWOOD WAY LA GRANGE, KY 40031</b>
---	---

(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 045	<p>Continued From page 8</p> <p>Exception No. 2: One hundred percent of the exits shall be permitted to discharge through areas on the level of exit discharge as provided in Chapters 22 and 23.</p> <p>Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met.</p> <p>7.7.3 The exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means.</p> <p>7.7.4 Doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components.</p> <p>7.7.5 Signs. (See 7.2.2.5.4 and 7.2.2.5.5.)</p> <p>7.7.6 Where approved by the authority having jurisdiction, exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where the following criteria are met:</p> <p>(1) The roof construction has a fire resistance rating not less than that required for the exit enclosure.</p> <p>(2) There is a continuous and safe means of egress from the roof.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS</p>	K 045		
-------	---	-------	--	--



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

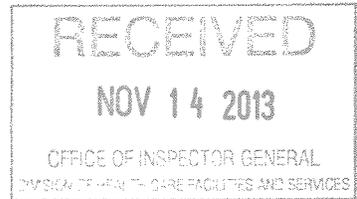
PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185438</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>THE RICHWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1012 RICHWOOD WAY LA GRANGE, KY 40031</b>
---	---

(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
--------------------	--	---------------	---	----------------------

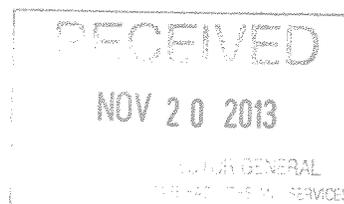
K 045	<p>Continued From page 9</p> <p>7.8.1 General.</p> <p>7.8.1.1*</p> <p>Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2</p> <p>Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.</p> <p>7.8.1.3*</p> <p>The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor.</p> <p>Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed</p>	K 045		
-------	---	-------	--	--



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

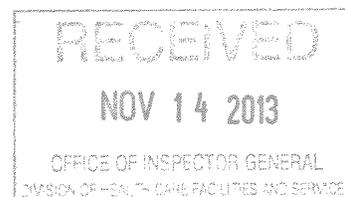
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  10/16/2013
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031		
(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 045	Continued From page 10 light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. NFPA 101 LIFE SAFETY CODE STANDARD	K 045	K046  No specific residents were identified as being affected by the lack of battery light testing.  All Residents have the potential to be affected by the alleged deficient practice.  The Maintenance Director was in-serviced by the Administrator on the requirement of documenting emergency lighting testing on 10/21/13.  The Maintenance Director created a form to record battery light testing.  The Maintenance Director conducted a 30 second test and a 90 Minute test on 10/21/13.  The battery light testing form will be reviewed at the monthly QA meeting to ensure the tests are being conducted.  Completion Date: 10/22/13		
K 046 SS=F	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on battery light testing record review, and interview, it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, seventy four (74) residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy four (74) on the day of the survey. The facility failed to test emergency battery lighting for thirty (30) seconds monthly and ninety (90) minutes annually.  The findings include:  Battery light testing record review, on 10/16/13 at 2:10 PM, with the Director of Maintenance revealed the facility did not have documentation for the thirty (30) second monthly test, or the ninety (90) minute annual testing of emergency battery lighting located in the facility.	K 046			



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
(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 045	Continued From page 10 light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. NFPA 101 LIFE SAFETY CODE STANDARD	K 045	K046  No specific residents were identified as being affected by the lack of battery light testing.  All Residents have the potential to be affected by the alleged deficient practice.  The Maintenance Director was in-serviced by the Administrator on the requirement of documenting emergency lighting testing on 10/21/13.  The Maintenance Director created a form to record battery light testing.  The Maintenance Director conducted a 30 second test and a 90 Minute test on 10/21/13.  The battery light testing form will be reviewed at the monthly QA meeting to ensure the tests are being conducted.  Completion Date: 10/21/13 - <i>10-22-13</i>	
K 046 SS=F	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on battery light testing record review, and interview, it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, seventy four (74) residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy four (74) on the day of the survey. The facility failed to test emergency battery lighting for thirty (30) seconds monthly and ninety (90) minutes annually.  The findings include:  Battery light testing record review, on 10/16/13 at 2:10 PM, with the Director of Maintenance revealed the facility did not have documentation for the thirty (30) second monthly test, or the ninety (90) minute annual testing of emergency battery lighting located in the facility.	K 046		



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

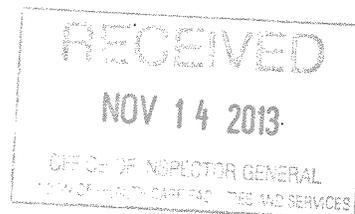
PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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
--------------------	--	---------------	---	----------------------

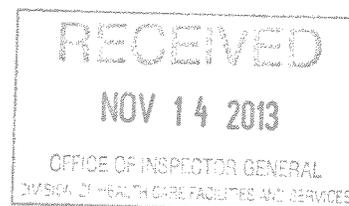
K 046	<p>Continued From page 11</p> <p>Interview, on 10/16/13 at 2:10 PM, with the Director of Maintenance revealed he was not aware documentation was to be kept for emergency battery light testing.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by</p>	K 046		
-------	--	-------	--	--



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
(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 046  K 050 SS=F	Continued From page 12 a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, one hundred twenty (120) residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy four (74) on the day of the survey. The facility failed to ensure the fire drills were conducted quarterly at unexpected times.  The findings include:  Fire Drill record review, on 10/16/13 at 11:12 AM, with Maintenance Director revealed the facility failed to conduct fire drills quarterly at unexpected	K 046  K 050	K 050  No specific residents were identified as being affected by this alleged deficient practice.  All residents have the potential to be affected by this deficient practice.  Maintenance Director was in-serviced on the requirement of quarterly drills being conducted at varying times on all shifts by the Administrator on 10/21/13.  Maintenance Director is responsible for ensuring the drills are conducted as required.  Maintenance Director will provide a copy of the fire drill report to the Administrator and QA committee monthly to ensure completion.  Quarterly, the Administrator and QA committee will review the monthly drills to ensure drills were completed at varying times and provide appropriate follow-up or changes as necessary.  Completion Date: 11/30/13	



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 050	<p>Continued From page 13</p> <p>times under varied conditions. The facility has three (3) shifts. First shift is from 7:00 AM -3:00 PM, second shift is from 3:00 PM - 11:00 PM, and third shift is from 11:00 PM - 7:00 AM. The facility failed to conduct fire drills for the third (3rd) quarter of 2013 on second (2nd) shift, and the fourth (4th) quarter on third (3rd) shift of 2012. The fire drills for first (1st) and second (2nd) shift that were not varied conditions are as follows;</p> <p>First Shift: 09/03/13 @ 9:25 AM 04/03/13 @ 9:40 AM 01/04/13 @ 10:30 AM 10/25/12 @ 10:15 AM</p> <p>Second Shift: 3rd quarter missed 05/09/13 @ 3:05 PM 02/28/13 @ 3:33 PM 12/06/12 @ 3:01 PM</p> <p>Interview, on 10/16/13 at 11:12 AM, with the Maintenance Director revealed the facility had been without a Maintenance Director for several months and he had only been with the facility for one month.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire</p>	K 050		
-------	--	-------	--	--

**RECEIVED**  
 NOV 14 2013  
 OFFICE OF INSPECTOR GENERAL  
 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

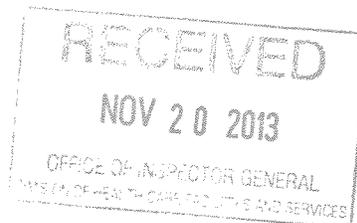
PRINTED: 10/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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
--------------------	--	---------------	---	----------------------

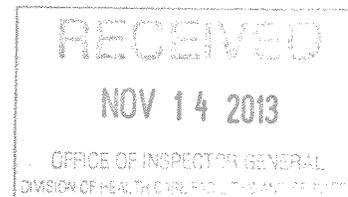
K 050	Continued From page 14 Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator 's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050	K062  No specific resident was identified as being affected by this alleged deficient practice.  All residents have the potential to be affected by this alleged deficient practice.  The Maintenance Director contacted Brown Sprinkler on 11/7/13 and scheduled them to provide the necessary replacement of the sprinkler heads located on the porch ceiling, kitchen exit and rear entrance that have a heavy build up of corrosion. The repairs are scheduled to be completed on 11/29/13.  The Maintenance Director will inspect from the floor level, 10% of all sprinkler heads monthly to ensure sprinklers are free of corrosion, foreign materials, paint, and physical damage. The Maintenance Director will schedule maintenance/replacement when necessary.	
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	K 062	The Maintenance Director will report findings to the QA committee monthly. QA committee will review and provide follow-up or changes as necessary.  Completion Date: 11/30/13.	



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

PRINTED: 10/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

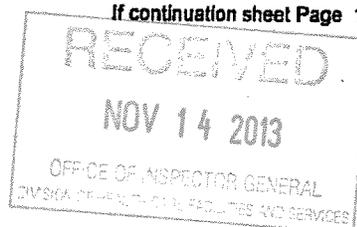
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
(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 050	Continued From page 14 Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator 's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 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	K 050	K062  No specific resident was identified as being affected by this alleged deficient practice.  All residents have the potential to be affected by this alleged deficient practice.  The Maintenance Director contacted Brown Sprinkler and scheduled them to provide the necessary replacement of the sprinkler heads located on the porch ceiling, kitchen exit and rear entrance that have a heavy build up of corrosion.  The Maintenance Director will inspect from the floor level, 10% of all sprinkler heads monthly to ensure sprinklers are free of corrosion, foreign materials, paint, and physical damage. The Maintenance Director will schedule maintenance/replacement when necessary.  The Maintenance Director will report findings to the QA committee monthly. QA committee will review and provide follow-up or changes as necessary.  Completion Date: 11/30/13.	
K 062 SS=D		K 062		



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

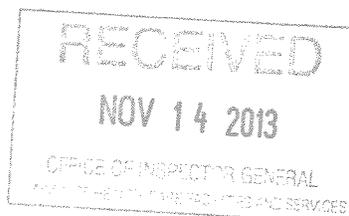
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185438</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE RICHWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1012 RICHWOOD WAY LA GRANGE, KY 40031</b>	
(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 062	Continued From page 15  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy four (74) on the day of the survey.  The findings Include:  Observation, on 10/16/13 between 11:00 AM and 2:30 PM, with the Maintenance Director revealed a heavy build-up of corrosion on the sprinkler heads located on the porch ceiling of the Kitchen Exit and the Rear Entrance.  Interview, on 10/16/13 between 11:00 AM and 2:30 PM, with the Maintenance Director revealed he was not aware of the corrosion on the sprinkler heads.  Reference: NFPA 13 (1999 Edition)  2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.  hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the	K 062		



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
(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 062	Continued From page 16 density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062	K 076  No specific resident was affected by the alleged deficient practice.  All residents have the potential to be affected by the alleged deficient practice.  The Maintenance Directed inspected all oxygen storage areas to ensure compliance.  The Maintenance Director removed the light switch and receptacle from the 500 Hall Oxygen Storage Room. There is now no ignition source in the room.  The QA Nurse will inspect all oxygen storage rooms monthly to ensure compliance.  Compliance date: 11/5/13	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		



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

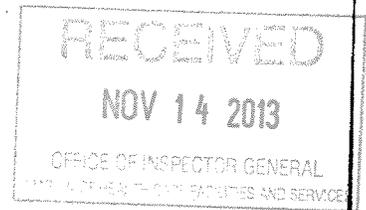
PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 076	<p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy four (74) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/16/13 at 1:20 PM, with the Maintenance Director revealed twenty four (24) E type oxygen tanks stored in the 500 Hall Oxygen Storage Room. The room had a light switch and a receptacle installed below five (5) foot from the floor. Oxygen storage greater than 300 cubic feet cannot have an ignition source installed below five (5) feet from the floor.</p> <p>Interview, on 10/16/13 at 1:20 PM, with the Maintenance Director revealed he was not aware of the requirements for oxygen storage.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible</p>	K 076		
-------	---	-------	--	--



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

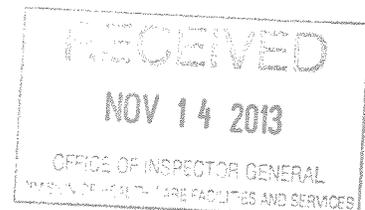
PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185438</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>THE RICHWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1012 RICHWOOD WAY LA GRANGE, KY 40031</b>
---	---

(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
--------------------	--	---------------	---	----------------------

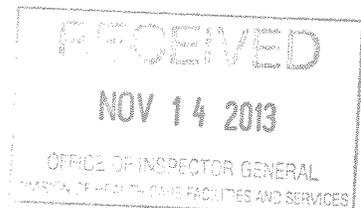
K 076	<p>Continued From page 18</p> <p>construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>(b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) A minimum distance of 6.1 m (20 ft)</p> <p>(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p> <p>(d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.</p> <p>(e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations.</p> <p>(f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d.</p> <p>(g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13.</p> <p>(h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27.</p> <p>(i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations.</p> <p>(j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.</p> <p>8-3.1.11.3 Signs. A precautionary sign, readable</p>	K 076		
-------	---	-------	--	--



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
(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 076	Continued From page 19 from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: <b>CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</b> NFPA 101 LIFE SAFETY CODE STANDARD	K 076	K 147  No specific resident was affected by the alleged deficient practice.  All residents have the potential to be affected by the alleged deficient practice.  The Maintenance Director repaired and replaced the GFI receptacles in the Women's and Men's restrooms located in the front lobby.  The Maintenance Director inspected all facility GFI's to ensure they were functioning properly and wired correctly.  The Maintenance Director will inspect Facility GFI's quarterly (on-going) to ensure they are functioning properly and wired correctly.  Inspections will be reviewed at Quarterly QA Meeting to ensure compliance.  Compliance date: 11/30/13	
K 147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy four (74) on the day of the survey. The facility failed to maintain receptacles.  The findings include:  Observations, on 10/16/13 at 2:18 PM, with the Maintenance Director revealed the ground fault receptacle (GFI) located in the Women's bathroom of the Front Lobby did not function. Further observation revealed the GFI located in the Men's bathroom of the Front Lobby had an open neutral.  Interview, on 10/16/13 at 2:18 PM, with the Maintenance Director revealed he was not aware	K 147		



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

PRINTED: 10/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
--	---

(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 20 the GFI receptacles were not functioning properly or not wired correctly.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p>	K 147		
-------	---	-------	--	--

