

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

PRINTED: 04/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

*Acceptable  
POC  
date*

*4/27/13*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/05/2013
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NAME OF PROVIDER OR SUPPLIER  RICHMOND PLACE REHABILITATION AND HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
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F 000	INITIAL COMMENTS	F 000		
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F 431	An abbreviated survey to investigate KY00019930 was initiated on 04/03/13 and concluded on 04/05/13. KY00019930 was substantiated with deficiencies cited. 483.60(b), (d), (e) DRUG RECORDS.	F 431	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of	
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SS=D	LABEL STORE DRUGS & BIOLOGICALS		Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.	
	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can</p>			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>[Signature]</i>	<i>OMHA, UNHA</i>	<i>4/22/13</i>

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

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F 431	Continued From page 1 be readily detected.	F 431			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy it was determined the facility failed to ensure all medications were stored and in locked compartments for two (2) out of two (2) medication carts on the locked unit of the facility. Observation on 04/04/13 revealed the facility failed to ensure the medication cart for the 315 through 328 resident rooms was locked. Further observation revealed two (2) vials of insulin were left unattended on top of the medication cart for rooms 301 through 314. .		<b>F 431 483.60 Drug records, Label/ Store Drugs and Biologicals</b>		
	The findings include:  Review of the facility's policy titled "Medication Pass", dated 10/2006, revealed the medication cart was to be locked when not in attendance by the nurse passing the medications. Further review revealed no medications were to be stored or left on the top of the medication cart.		<b>1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</b>		
	1. Observation during the initial tour, on 04/04/13 at 12:05 PM, revealed the medication cart for rooms 315 through 328 on the locked unit of the facility was unattended and unlocked.  Interview with Registered Nurse (RN) #1, on 04/04/13 at 12:15 PM, revealed RN #1 was responsible for the medication cart which supplied medications to rooms 315 through 328. Further interview revealed the medication cart should have been locked per the facility's policy.		The nursing staff members, RN #1 and LPN #1, exhibiting deficient practice have been re-educated and a medication pass audit completed on drug records, labels/ storage and biological storage including medication access and storage by the Director of Nursing, Staff Development Nurse and Pharmacy Consultant on 4/12/13.		
			<b>2. How will the facility identify other residents</b>		

**having the potential to be affected by the same deficient practice?**

All residents are at risk for being affected by the same deficient practice. To identify other residents at risk, the pharmacy consultant, Director of Nursing, Staff Development Nurse, Evening Shift Supervisor, Weekend Supervisor, and QA Nurse Supervisor completed medication observation reports in all areas of the facility.

**3. What systemic changes will be made to ensure that the deficient practice will not recur?**

Nurses and Certified Medication Aides were re-educated by the Staff Development Nurse, Unit

Coordinators, Evening Shift  
Supervisor, Weekend  
Supervisors on the facilities  
medication pass policy  
including drug records, proper  
labeling/ storage of  
medications and biological  
and education completed by  
4/21/13. Any nurse or  
certified medication aide who  
have not been scheduled to  
work prior to 4/21/2013 will  
receive the education via mail  
by 4/21/13.

Nursing management  
consisting of the Director  
Nursing, Staff Development  
Nurse, Unit Coordinators,  
Evening Supervisor and  
Weekend Supervisor will be  
monitoring for locked  
medication carts and proper  
storage of medications and  
biological during daily rounds  
Monday thru Sunday.

At least 4 nurses and/or certified medication aides will be checked off per week Monday thru Sunday for six(6) weeks using the facility medication check off by the QA Nurse Supervisor, Staff Development Nurse, Director of Nursing, Assistant Director of Nursing, Evening Shift Supervisor, or Weekend Supervisor. Any issues or concerns will be taken to the Director of Nursing and addressed by the Director of Nursing or designee. Results of rounds will be discussed by the Interdisciplinary team at the weekly Quality of Care meeting.

Medication Pass Policy re-inservices including proper storage of medication and biologicals will be done biannually by the Staff Development Nurse, Director

of Nursing, or QA Nurse  
Supervisor.

- 4. How will the facility monitor its performance to make sure that solutions are sustained?**

The Quality Assurance nurse or designee will be completing rounds using a Quality Assurance tool designed to address facility medication pass policy including drug records, proper storage of medications and biological on 2 nurses daily three(3) times a week Monday thru Sunday for four (4) weeks, then weekly for four (4) weeks, and monthly for three (3) months to identify and correct any issues. Results of the audit will be reported to the Director of Nursing. The Director of Nursing will verify that issues

have been addressed and corrections have been made according to facility policy and procedure.

The Director of Nursing will provide a summary of staff compliance to the Quality Assurance Committee, consisting of Quality Assurance Coordinator, Medical Director, Administrator, Director of Nursing and Staff Development Nurse for the next three (3) meetings and revisions made to the plan, if needed, as directed by the committee.

**S. The date that the corrective action will be completed;**

F 431 was corrected by 4/22/13.

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F 431	Continued From page 2	F 431			
	2. Observation, on 04/04/13 at 12:05 PM, revealed the medication cart for rooms 301 through 314 on the locked unit of the facility had two (2) vials of insulin sitting on top of the medication cart.				
F 441 SS=D	<p>Interview with Licensed Practical Nurse (LPN) #1, on 04/4/13 at 12:10 PM, revealed LPN #1 was responsible for the medication cart which supplied medications to rooms 301 through 314. Further interview revealed the insulin should not have been left on the cart and should have been secured in the appropriate compartment within the medication cart per the facility's policy.</p> <p>Interview with the Rehabilitation Clinical Director, on 04/4/13 at 12:05 PM, revealed the insulin should be in the cart and all carts should be locked per the facility's policy.</p> <p>Interview with the Director of Nursing, on 04/04/13 at 3:10 PM, revealed the facility's policy was the medication carts were to be kept locked.</p> <p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;</p>	F 441	<p><b>F 441 483.65 Infection Control, Prevent Spread, Linens</b></p> <p>1. <b>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The associates exhibiting deficient practice and providing care for resident #2</p>		

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F 441	Continued From page 3  (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy it was determined the facility failed to isolation Observations on 04/05/13 revealed State Registered Nurse Aide (SRNA) # 2 and Social Services Worker (SSW) #1 failed to follow isolation precautions while they were in the room of Resident #2 who was on isolation precautions for C. diff In addition observations, on 04/04/13 at 10:30 AM, revealed room #121, room #226 had unlabeled and uncovered soiled	F 441	and room #121, room #226, room #231, room #316 and room #317 have been re-educated on infection control standards, including proper hand washing, cleaning and disinfecting and storage of resident care items and isolation precautions and changing of gloves by the Staff Development Nurse. The associates involved in the deficient practice provided return demonstration to Staff Development Nurse demonstrating proper infection control standards while providing care to residents on 4/4/13 and 4/5/13.  2. How will the facility identify other residents having the potential to be affected by the same deficient practice?		

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F 441	Continued From page 4  bedpans on the floor of the residents' bathroom, room #231 had an unlabeled and uncovered collection bowl for a bedside toilet lying on the floor in the bathroom under the sink; room #317 had an unlabeled and uncovered soiled bedpan wedged behind the safety grab bar in the resident's bathroom and room #316 had a soiled urine graduate unlabeled and uncovered sitting on top of the bedside toilet in the resident's bathroom.  The findings include:  1. Review of the facility's policy titled "Isolation Precautions" dated 04/01/11, revealed standard precautions should be used when caring for residents at all times regardless of their suspected or confirmed infection status. Further review of the policy revealed gloves should be worn upon entering the resident's room and a gown was to be worn for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment.  Review of the facility's policy/procedure titled "Handwashing/Hand Hygiene" undated, revealed employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the conditions that included before and after entering isolation precautions settings, before and after assisting a resident with meals and after contact with a resident with infectious diarrhea including but not limited to infections caused by Clostridium difficile or C.diff (a bacterium that could cause symptoms ranging from diarrhea to life threatening inflammation of the colon).	F 441	All residents are at risk for being affected by the same deficient practice. To identify other residents at risk, the nurse manager team, including Director of Nursing, Staff Development Nurse, Unit Coordinators, Evening Shift Supervisor, Weekend Supervisors monitored staff for proper infection control standards, including hand washing, disinfecting resident care items and following isolation protocols per facility policy and reported findings to the Director of Nursing on 4/20/13.  3. What systemic changes will be made to ensure that the deficient practice will not recur?  Associates from each department including dietary,		

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F 441	Continued From page 5  Review of Resident #2's medical record revealed the facility admitted Resident #2, on 01/08/13, with diagnoses which included Orthopedic Aftercare, Debility, Rhabdomyolysis and Paranoid Schizophrenia. Review of an Admission Minimum Data Set (MDS), dated 01/15/13, revealed the facility assessed Resident #2 as having a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicating the resident was cognitively intact. Further review of the MDS revealed Resident #2 required supervision, oversight and setup help with eating and was frequently incontinent of bowel and bladder.  Review of Physician's orders, dated 03/07/13, revealed Resident #2 was placed in contact isolation for potential C-diff, on 03/07/13. Further review of Physician's orders, dated 03/24/14, revealed Resident #2 had a positive C.diff result and remained in contact isolation.  Observation, on 04/05/13 at 8:05 AM, revealed there was a sign on Resident #2's door indicating for visitors to report to the nurse's station. Further observation revealed Personal Protective Equipment (PPE), which included single use gloves and gowns, was located in the bathroom just inside Resident #2's private room. Continued observation revealed SRNA #2 was in Resident #2's room and was not wearing gloves or a gown. Additional observation revealed SRNA #2 touched personal items on the resident's bedside tray, exited the room, applied sanitizer to her hands, went into the nourishment area, obtained a straw and then went back into Resident #2's room to complete the meal set up. SRNA #2 exited Resident #2's isolation room sanitized hands with gel product then proceeded to room	F 441	housekeeping, social services, nursing, therapy, admissions, administrative staff, and billing will be re-educated by the Staff Development Nurse, Unit Coordinators, Evening Shift Supervisor, Weekend Supervisors, and department managers regarding infection control standards, including hand washing, changing of gloves, isolation precautions and cleaning and disinfection of resident care items by 4/21/13. Any associate who has not been scheduled to work by 4/21/13 will receive the education via mail prior to 4/21/13.  Monitoring for infection control practices including return demonstration by associates will be added to the nurse manager rounds completed by the unit coordinators, Staff		

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F 441	Continued From page 6 229 without washing hand with soap and water per the facility's policy.  Further observation during meal pass, on 04/05/13 at approximately 8:15 AM, revealed SSW #1 entered the isolation room of Resident #2 without putting on gloves and a gown. SSW #1 assisted Resident #2's with obtaining the resident's water pitcher and placement of the resident's call bell. SSW #1 touched Resident #2's personal belongings on the bedside tray, Resident #2's night gown and bed linens and then washed her hands with soap and water prior to leaving the resident's room.  Interview with SRNA #2, on 04/05/13 at 8:40 AM, revealed she had knew Resident #2 was in isolation for C-diff and thought the protocol for isolation of residents with C-diff was to wash hands or use the facility provided hand sanitizer gel. SRNA #2 stated she did not wear a gown when going into the resident's room unless she was going to have direct contact with the resident. SRNA #2 was not aware she should wash her hands and not just use hand sanitizing.  Interview with Unit Coordinator #2, on 04/05/13 at 9:00 AM, revealed she did not know if the staff should be wearing gloves when touching personal items in an isolation resident's room. Further interview revealed the hand sanitizer provided by the facility did not destroy C-diff and hand washing was required if giving personal care; however, the hand sanitizer was acceptable hygiene after tray set up.  2) Review of the facility's policy/procedure titled "Cleaning and Disinfecting Non-Critical	F 441	Development Nurse, Evening Shift Supervisors, and Weekend Supervisor once a day Monday thru Sunday and returned to the Director of Nursing. Any issues or concerns will be addressed by the auditing manager and individual reeducation will be given to the associates involved.  Quarterly in-services related to Infection Control Standards will be added to the yearly in-service calendar.  4. How will the facility monitor its performance to make sure that solutions are sustained?  The nurse management team including the Staff Development Nurse, Unit Coordinators, Evening Shift Supervisor, and Weekend		

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F 441	Continued From page 7 <del>Resident Care Items</del> undated, revealed single use resident items were to be marked with the resident's name and or room number and discarded upon transfer or discharge. Further review of the policy revealed bedpans should be disinfected in the resident's bathroom and returned to the resident's bedside cabinet.	F 441	Supervisor will be completing rounds using a Quality Assurance tool addressing infection control standards including hand washing, cleaning and disinfecting resident care items and isolation precautions five(5) residents daily four (4) times a week Monday thru Sunday for four (4) weeks, then weekly for four (4) weeks, and monthly for three (3) months to identify and correct any issues. Results of the audit will be reported to the Director of Nursing. The Director of Nursing will verify that issues have been addressed and corrections have been made according to facility policy and procedure.  The Director of Nursing will provide a summary of staff compliance to the Quality Assurance Committee,		
	Observation, on 04/04/13 at 10:30 AM, revealed room #121 had an unlabeled and uncovered soiled bedpan on the floor of the resident's bathroom; room #231 had a unlabeled and uncovered collection bowl for a bedside toilet lying on the floor in the bathroom and under the sink; room #226 had an unlabeled and uncovered soiled bedpan on the floor of the resident's bathroom, room #317 had an unlabeled and uncovered soiled bedpan wedged behind the safety grab bar in the resident's bathroom and room #316 had a soiled urine graduate unlabeled and uncovered sitting on top of the bedside toilet in the resident's bathroom.  Interview with SRNA #1, on 04/04/13 at 11:20 AM revealed the bedpans should be disinfected in the resident's bathroom then placed in a plastic bag. Further interview revealed she was not aware if the bedpan was to be labeled with the resident's name.  Interview with Unit Coordinator #2, on 04/04/13 at 11:25 AM, revealed the bedpans should be disinfected in the resident's bathroom and placed in a plastic bag. Further interview revealed the bedpan should be labeled with the resident's name unless the resident was in a private room or only one of the resident's used a bedpan.				

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F 441	Continued From page 8 Interview with the Director of Nursing (DON), on 04/05/13 at 11:35 AM, revealed her expectation would be for staff to wash hands with soap and water when entering or exiting a C-diff isolation resident's room, per the facility's policy. Further interview revealed her expectation was for staff to wear gloves into the isolation room and if there was to be personal care given then gowns were to be worn. Further interview revealed her expectation of the cleaning and storage of the bedpans was they were to be disinfected in the resident's bathroom and placed in a plastic bag. Additionally the bedpans were to be labeled with the resident's name.	F 441	consisting of Quality Assurance Coordinator, Medical Director, Administrator, Director of Nursing, Staff Development Nurse for the next three (3) meetings and revisions made to the plan, if needed, as directed by the committee.  5. The date that the corrective action will be completed; F441 was corrected by 4/22/13.		