

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

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

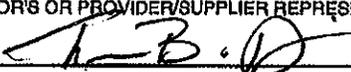
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2010
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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-KENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40475
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>A Recertification Survey was conducted 08/03/10 through 08/05/10 with deficiencies cited. The Life Safety Code Survey was conducted on 08/04/10. The highest scope and severity was an "F".</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide services in accordance with each resident's Comprehensive Plan of Care for one (1) of seventeen (17) sampled residents (Resident #8).</p> <p>The findings include:</p> <p>Review of Resident #8's medical record revealed diagnoses which included Dementia, a History of a Sacral Fracture, and a History of Multiple Falls. Review of the Annual Minimum Data Set (MDS) Assessment dated 07/07/10, revealed the facility assessed the resident as having both short and long term memory loss, as requiring total assistance with transfers, and as being unable to ambulate. Further review of the MDS revealed the facility assessed the resident as having a fall in the past 31-180 days and a fracture in the past 180 days.</p>	F 282	<p>F 282 Corrective Actions for Targeted Resident(s): Resident #8's chair alarm was immediately applied per the plan of care 8/04/2010. Resident #8's entire Plan of Care was reviewed by the DON to ensure staff was following the Plan of Care in all areas on 8/05/2010. Resident #8 did not sustain a fall related to the alarm not being in place on the morning of 8/4/2010.</p> <p>Identification of Other Residents with Potential to Be Affected: 100% of the Comprehensive Plans of Care and Nursing Assistant assignment sheets will be audited by the DON, Unit Managers, Education Training Director and Charge Nurses starting August 10 and will be completed no later than September 15, 2010 to ensure staff are following the Plan of Care in all areas.</p> <p>Systemic Changes: All Nursing Staff will be in-serviced by either the Education Training Director, DON or Unit</p>	

RECEIVED
SEP 10 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/10/10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-KENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40475	
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F 282	<p>Continued From page 1</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 07/05/10, revealed the resident fell several times prior to admission to the facility with one fall resulting in a Sacral Fracture. The fall interventions listed in the RAPS included a scoop mattress, and chair/bed alarm.</p> <p>Review of the Comprehensive Plan of Care dated 04/25/10, revealed the resident was at risk for falls related to a history of falls. The interventions included a chair alarm. Further review of the Plan of Care revealed the resident had sustained falls on 08/28/09 related to the resident sliding out of the wheelchair; and, on 08/30/09 related to the resident sliding out of the wheelchair and tipping the wheelchair over.</p> <p>Observation of Resident #8 on 08/04/10 at 8:15 AM, revealed the resident was sitting in his/ her room in a geri-chair. There was no chair alarm noted on the geri-chair.</p> <p>Interview on 08/04/10 at 8:20 AM with Certified Nursing Assistant #2, who was assigned to the resident, revealed he had assisted the resident from the bed to the geri-chair that morning with a mechanical lift. He stated he did not know if the resident was to have a chair alarm on the geri-chair. He further stated he was to check the CNA Assignment Sheets daily which he carried in his pocket to ensure safety devices were in place at the beginning of the shift. Further interview revealed he was too busy that morning with the call bells ringing and had not checked the CNA Assignment Sheet. CNA #2 reviewed the CNA Assignment Sheet and verified the resident was to have a chair alarm, and the alarm was not in place.</p>	F 282	<p>Managers to follow the Comprehensive Plan of Care and Nursing Assistant Assignment sheets. This in-service will be completed by September 15, 2010.</p> <p>Monitoring: To sustain compliance, three residents will be audited per week beginning the week of September 13, 2010 to ensure care is being provided based on the Comprehensive Plan of Care and is consistent with the nursing assistant assignment sheet. These audits will be conducted by either the Education Training Director, DON or Unit Managers. These audits will be presented to the QA committee (comprised of the Administrator, Director of Nursing, Environmental Services, Maintenance Director, Dietary Manager, Business Office Assistant, Social Services Director, Education Training Director, Life Enrichment Director and Medical Director), beginning October 2010 and will continue monthly for three months. The QA Committee will determine in the December</p>	09/16/10

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F 282	Continued From page 2 Interview on 08/04/10 at 8:25 AM with Licensed Practical Nurse (LPN) #4, revealed she was assigned to the resident; however, was unsure if the resident was to have a chair alarm. She stated, the nurses and the CNAs were to check the CNA Assignment Sheet to ensure safety devices were in place at the beginning of the shift. However, she had not checked the devices yet that morning. Interview on 08/05/10 at 11:15 AM with the Director of Nursing, revealed the oncoming CNAs were to do rounds with the CNAs who were leaving the shift and check to ensure safety devices were in place according to the the CNA Assignment Sheets. Further interview, revealed the nurses were to check the safety devices also and sign them off on the Treatment Administration Record. The DON verified the Plan of Care had not been followed related to the chair alarm.	F 282	meeting if the audits will continue.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to	F 315	F 315 <u>Corrective Actions for Targeted Resident(s):</u> The C.N.A. #3 identified not following policy and procedure on proper perineal care and. Foley care was re-inserviced by Director of Nursing 8/5/10. Resident #1's Physician was notified that C.N.A did not wash hands prior to providing Foley care and after cleansing stool on 8/6/10 by Unit Manager with no new orders received. <u>Identification of Other Residents with Potential to Be Affected:</u> The Plan of Action implemented in June 2010 to observe perineal, Foley care hand washing due to the identification by the QA committee of increased UTI's was expanded to include in-servicing all Nursing Staff. This in-servicing will be completed by September 15, 2010 and will be performed by either the Education Training Director, DON or Unit Managers. The Director of Nursing, ADON, Unit Manager,	

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F 315	<p>Continued From page 3</p> <p>ensure incontinent residents received appropriate treatment and services to prevent Urinary Tract Infections for one (1) of seventeen (17) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of Resident #1's medical record revealed diagnoses which included Dementia, Urinary Retention, Urinary Tract Infections, and Chronic "Foley" (indwelling) Catheter. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 06/21/10, revealed the facility assessed the resident as having severe impairment in cognitive skills, and as requiring extensive to total assistance with Activities of Daily Living. Further review of the MDS, revealed the facility assessed the resident as having an indwelling catheter, and as having a Urinary Tract Infection in the last thirty (30) days.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 06/16/10, revealed the resident had an indwelling catheter related to Urinary Retention, and was dependent on staff for toileting. Further review of the RAPS revealed the indwelling catheter placed the resident at higher risk for Urinary Tract Infections.</p> <p>Review of the Comprehensive Plan of Care dated 12/01/09, revealed the resident had the potential for Urinary Tract Infections related to the chronic use of an indwelling catheter secondary to retention. The interventions included catheter care per protocol.</p> <p>Review of Laboratory Data revealed a Urine Culture was collected on 06/12/10, which showed <i>Escherichia Colibacilli (E. Coll)</i>. Physician's</p>	F 315	<p>and ETD will complete a one time audit of perineal, Foley catheter care and hand washing for all Nursing Assistants by September 15, 2010 to identify any other residents at risk.</p> <p>Systemic Changes: The facility is now requiring all Nursing staff to be in-serviced on the policy and procedures for perineal, Foley care and hand washing. Education on perineal, Foley care and hand washing will be incorporated into the new nursing employee orientation and in an annual nursing in-service, September 2010.</p> <p>Monitoring: Ten return demonstrations of Nursing assistants performing proper peri, foley care and hand washing will be performed monthly beginning in September 2010 by either the Unit Managers, charge nurses, DON or ETD. These return demonstrations will be presented to the QA Committee by the DON beginning October 2010 and will continue monthly for three months. The QA</p>	

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F 315	Continued From page 4 Orders dated 06/15/10 revealed orders for Macrobid 100 milligrams (antibiotic medication) twice a day for seven (7) days related to a Urinary Tract Infection. Observation of catheter care/ perineal care on 08/05/10 at 9:30 AM revealed Certified Nursing Assistant (CNA) #3 cleansed stool from the resident's anal area and buttocks, changed gloves and proceeded to complete catheter care. There was no evidence the CNA washed her hands after cleansing the stool from the anal area and prior to donning new gloves to perform perineal care and "Foley" indwelling catheter care. Interview with CNA #3 on 08/05/10 at 10:15 AM revealed she was unaware she needed to wash her hands as well as change gloves after cleansing stool and prior to performing catheter care. Review of the facility's policy entitled "Providing Catheter Care" revealed providing proper catheter care helps to prevent the person from getting a Urinary Tract Infection.	F 315	Committee will determine in the December meeting if the audits will continue.	09/16/10
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	F 323 Corrective Actions for Targeted Resident(s): Resident #8's chair alarm was immediately applied per the plan of care 8/04/2010. Resident #8 did not sustain a fall related to the alarm not being in place on the morning of 8/4/2010. Identification of Other Residents with Potential to Be Affected: A one time visual audit on all three shifts of all residents with safety devices will be conducted by the DON, ADON, Unit Managers, and ETD to identify any resident and ensure their safety devices are in place. This audit will be completed by September 15, 2010.	

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F 323	<p>Continued From page 5</p> <p>by: Based on observation, interview and record review it was determined the facility failed to provide adequate supervision and/or assistive devices to prevent accidents for one (1) of seventeen (17) sampled residents (Resident #8).</p> <p>The findings include:</p> <p>Review of Resident #8's medical record revealed diagnoses which included Dementia, Osteoporosis, History of a Sacral Fracture, and a History of Multiple Falls. Review of the Annual Minimum Data Set (MDS) Assessment dated 07/07/10, revealed the facility assessed the resident as having severe Impairment in cognitive skills, as requiring total assistance with transfers, and was unable to ambulate. Further review of the MDS revealed the facility assessed the resident as having a fall in the past 31-180 days and a fracture in the past 180 days.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 07/05/10, revealed the resident fell several times prior to admission with one fall resulting in a Sacral Fracture. Further review of the RAPS revealed the resident was at high risk for injury with falls related to Hypertension, Osteoarthritis, and Osteoporosis. The fall interventions listed in the RAPS included a scoop mattress, and chair/bed alarm.</p> <p>Review of the Comprehensive Plan of Care dated 04/25/10, revealed the resident was at risk for falls related to a history of falls. The interventions included a chair alarm. Further review of the Plan of Care revealed the resident had sustained falls on 08/28/09 related to the resident sliding out of the wheelchair, and on 08/30/09 related to the</p>	F 323	<p>Systemic Changes: All Nursing Staff will be in-serviced by September 15, 2010 by either the Education Training Director, DON or Unit Managers on the necessity to prevent accidents and hazards by ensuring safety devices are in place as well as fall risk factors.</p> <p>Monitoring: To sustain compliance, three residents will be audited per week beginning the week of September 13, 2010 to ensure safety devices are in place consistent with the nursing assistant assignment sheet and Plan of Care. These audits will be conducted by either the Education Training Director, DON or Unit Managers. These audits will be presented to the QA committee, beginning October 2010 and will continue monthly for three months. The QA Committee will determine in the December meeting if the audits will continue.</p>	09/16/10

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F 323	<p>Continued From page 6</p> <p>resident sliding out of the wheelchair and tipping the wheelchair over.</p> <p>Observation of Resident #8 on 08/04/10 at 8:15 AM, revealed the resident was sitting in his/ her room in a geri-chair. There was no chair alarm noted on the geri-chair.</p> <p>Interview on 08/04/10 at 8:20 AM with Certified Nursing Assistant #2, revealed he was assigned to the resident and took care of the resident often. He further stated he had assisted the resident from the bed to the geri-chair that morning; however, he did not know if the resident was to have a chair alarm on the geri-chair. He further stated the CNAs were to check the CNA Assignment Sheets daily to ensure safety devices were in place at the beginning of the shift. He stated he was too busy that morning with the call bells ringing and had not had time to check the CNA Assignment Sheet. After reviewing the CNA Assignment Sheet, the CNA indicated the resident was to have a chair alarm.</p> <p>Interview on 08/04/10 at 8:25 AM with Licensed Practical Nurse (LPN) #4, revealed she was assigned to the resident, and she did not know if the resident was to have a chair alarm. She stated, both she and the CNA's were to check the CNA Assignment Sheet to ensure safety devices were in place at the beginning of the shift. She had not checked the devices that morning.</p> <p>Interview on 08/05/10 at 11:15 AM with the Director of Nursing, revealed there was no written policy regarding safety devices or checking bed/ chair alarms. However, she stated, the oncoming CNAs were to do rounds with the CNAs who were leaving the shift and check the safety devices with</p>	F 323		

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F 323	Continued From page 7 the CNA Assignment Sheets. She further stated the nurses were to check the safety devices also and sign them off on the Treatment Administration Record.	F 323		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</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; (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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and</p>	F 441	<p>F 441 Corrective Actions for Targeted Resident(s): Resident #8 received a UA and was started August 4, 2010 on Augmentin 875 mg BID x 7 days. On August 12, 2010 Residents Care Plan was updated to complete Augmentin monitor for temperature and pain and encourage increased PO intake of fluids. The C.N.A #4 identified not following policy and procedure on proper hand washing, perineal care was re-in serviced by Director of Nursing 8/4/10.</p> <p>Identification of Other Residents with Potential to Be Affected: The Plan of Action implemented in June 2010 to observe perineal, Foley care hand washing due to the identification by the QA committee of increased UTI's was expanded to include in-servicing all Nursing Staff. This in-servicing will be completed by September 15, 2010 and will be performed</p>	

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F 441	<p>Continued From page 8</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to maintain an infection control program in order to prevent the development and transmission of disease and infection within the facility.</p> <p>The findings include:</p> <p>Review of Resident #8's medical record revealed diagnoses which included Dementia, and Arthritis. Review of the Annual Minimum Data Set (MDS) dated 07/07/10 revealed the facility assessed the resident as being incontinent of bowel and bladder and as requiring extensive to total assistance with Activities of Daily Living.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 07/07/10, revealed the resident had inadequate control of bladder all of the time and wore briefs for management of incontinent episodes.</p> <p>Review of the Comprehensive Plan of Care dated 07/14/10, revealed the resident had the potential for infections related to a history of an Upper Respiratory Infection and Urinary Tract Infection.</p> <p>Observation of Resident #8's perineal care on 08/04/10 at 10:00 AM for revealed Certified Nursing Assistant (CNA) #4 performed the perineal care. The CNA then obtained the tube of Moisture Barrier Antifungal with her soiled gloves</p>	F 441	<p>by either the Education Training Director, DON or Unit Managers. The Director of Nursing, ADON, Unit Manager, and ETD will complete a one time audit of perineal, Foley catheter care and hand washing for all Nursing Assistants by September 15, 2010 to identify any other residents at risk.</p> <p>Systemic Changes: The facility is now requiring all Nursing staff to be in-serviced on the policy and procedures for perineal, Foley care and hand washing. Education on perineal, Foley care and hand washing will be incorporated into the new nursing employee orientation and in an annual nursing in-service, beginning September 2010.</p> <p>Monitoring: Ten return demonstrations of Nursing assistants performing proper peri, foley care and hand washing will be performed monthly beginning in September 2010 by either the Unit Managers, charge nurses, DON or ETD. These return demonstrations will be presented to the QA Committee by the DON beginning October</p>	

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F 441	<p>Continued From page 9</p> <p>and applied the Moisture Barrier to the residents perineal/anal area and buttocks. The CNA then proceeded to place the tube of Moisture Barrier in her pocket. Further observation revealed Licerised Practical Nurse (LPN) #4, who was assisting, obtained the Moisture Barrier from the CNA and placed it on the resident's bedside table. The LPN stated she would place the Moisture Barrier back in the treatment cart. The CNA then went to the resident's closet and obtained a pillow and placed it under the resident's legs, pulled up the covers, adjusted the side rail of the bed and handed the resident the call bell while wearing the soiled gloves.</p> <p>There was no evidence the CNA removed her soiled gloves and washed her hands prior to obtaining the tube of Moisture Barrier. In addition, there was no evidence the CNA removed the soiled gloves and washed her hands prior to obtaining a pillow from the resident's closet, pulling up the covers, adjusting the side rail and handling the call bell.</p> <p>Interview on 08/04/10 at 10:15 AM with CNA #4 revealed she was unaware she had contaminated the tube of Moisture Barrier by touching the tube with the same gloves in which she had performed perineal care. In addition, she was unaware she had contaminated other items in the room by touching them with soiled gloves.</p> <p>Interview on 08/05/10 at 11:15 AM with the Director of Nursing, revealed the CNA should not have touched the tube of Moisture Barrier with her soiled gloves, and the Moisture Barrier should not have been placed in the treatment cart afterwards. In addition, she indicated the CNA should have removed her soiled gloves after</p>	F 441	<p>2010 and will continue monthly for three months. The QA Committee will determine in the December meeting if the audits will continue.</p>	09/16/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2010
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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-KENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40475
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F 465	Continued From page 11 Interview on 08/05/10 at 2:20 PM with the Administrator, revealed he was aware of the problems with the General Bathroom on the C Wing. He stated the other General Bathrooms had been remodeled and he had plans to refurbish the C Wing General Bath. He further stated he had been pricing tiles and was in the process of talking to Corporate about the remodel.	F 465	areas in need of repair are addressed. The in-servicing will be completed by September 15, 2010. The Maintenance Director will inspect all showers and general bathrooms at least monthly for repair. Monitoring: The Maintenance Director will bring his monthly inspection report of all shower and general bathrooms to the Quality Assurance Committee monthly beginning October 2010 and continuing for three months unless the QA Committee sees a need to continue to monitor the inspections.	09/16/10
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2010
NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-KENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40475	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 08/04/2010. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and severity deficiency identified was an "F".	K 000		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that fire extinguishers were maintained according to NFPA standards. This condition has the potential to affect all staff in the kitchen area. The findings include: Observation on 08/04/2010 at 10:38 AM, revealed the sign which has the operation instructions for the "K" type extinguisher was not noticeable because it was covered up with numerous "Post it Notes". This was confirmed with the Maintenance Director. Interview on 08/04/2010 at 10:38 AM, with the Maintenance Director, revealed he was unaware of the sign being blocked by the posted notes. Reference: NFPA 96 (1999 edition) 7-2.1.1 A placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the	K 069	K 069 Corrective Actions for Targeted Resident(s): All visual obstructions were removed from the Type "K" extinguisher located in the Kitchen on 08/04/10. Identification of Other Residents with Potential to Be Affected: All fire extinguishers in the building were inspected by the Maintenance Director on 08/27/10 to ensure they were maintained according to NFPA standards. Systemic Changes: The Maintenance Director will inspect the extinguishers monthly to ensure they meet NFPA standards. Monitoring: The Maintenance Director will bring his monthly inspection report to the Quality Assurance Committee monthly beginning October 2010 and continuing for three months unless the QA Committee sees a need to continue to monitor the inspections.	09/16/10

RECEIVED
AUG 27 2010
BY: _____

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

R.B.D.

TITLE

Administrator

(X8) DATE

8/27/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185081	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2010
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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-KENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40476
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069 K 072 SS=E	Continued From page 1 cooking area. NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 069 K 072	K 072 <u>Corrective Actions for Targeted Resident(s):</u> All linen carts, other equipment, obstructions and impediments are being moved from the corridors when not in use or at least every twenty minutes when in use, to ensure no exit access, egress from or visibility of exits is obstructed incase of fire or other emergency.	
	This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. This deficient practice affected five (5) of five (5) smoke compartments, staff and all residents. The findings include: Observation on 08/04/2010 at 10:55 AM, revealed that a linen cart was left unattended on the D Hallway. The cart was located between rooms D8 and D9. Further observation on 08/04/2010 at 12:02 PM revealed the linen cart was still located in the D Hallway between rooms D8 and D9. The observation was confirmed with the Director of Maintenance. Further observation revealed other linen carts that were noted during the survey to be unattended in Hallways A, B, C and E. Corridors are intended for means of egress, internal traffic and emergency use, not storage spaces. The Life Safety Code has specific requirements for		<u>Identification of Other Residents with Potential to Be Affected:</u> The Maintenance Director, Director of Nursing and Administrator reviewed all potential obstructions and identified objects that could potentially affect the residents. The objects identified were; clean and soiled linen carts, lifts, scales, dietary carts, wheel chairs, broda chairs and motorized chairs. <u>Systemic Changes:</u> All staff will be in-serviced by the Maintenance Director and Education Training Director by September 16, 2010 on the need to keep the means of egress clear of obstructions and how to manage the use of	

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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-KENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40475
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K 072	Continued From page 2 storage spaces. These items would also limit the use of the hand rails by occupants of the building when needed.	K 072	equipment needed on a temporary basis in the corridors.	
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain the emergency generator according to NFPA standards. The facility failed to ensure that the emergency generator had a yearly load test performed. This condition has the potential to affect all residents and staff.</p> <p>The findings include:</p> <p>Record review on 08/04/2010 at 10:19 AM, revealed that the emergency generator was being tested at 10% of the rated capacity for the emergency generator. This was confirmed with the Director of Maintenance.</p> <p>Interview on 08/04/2010 at 10:19 AM, with the</p>	K 144	<p>Monitoring: Corridor Round Sheets will be completed at least three times per week beginning August 30, 2010 and ending November 30, 2010. These round sheets are to ensure obstructions are moved at least every twenty minutes or placed in storage if not in use. The completed Corridor Round Sheets will be presented by the Maintenance Director to the Quality Assurance Committee monthly beginning October 2010 and continuing for three months unless the QA Committee sees a need to continue to monitor for compliance.</p> <p>K 144 Corrective Actions for Targeted Resident(s): Kenwood contracted for an annual generator load test to be performed and the 2010 annual load test will be conducted on or before September 16, 2010 with Nixon Power Service Company.</p>	09/16/10

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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-KENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY, 40475	
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K 144	<p>Continued From page 3</p> <p>Maintenance Director, revealed that he believed that the yearly load test had been performed but was unable to find documented evidence that the test had been performed.</p> <p>Reference: NFPA 101 (1999 edition) 6-4.1*</p> <p>Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>6-4.2*</p> <p>Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>6-4.2.2</p> <p>Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes,</p>	K 144	<p>Identification of Other Residents with Potential to Be Affected: The Administrator and Maintenance Director reviewed the NFPA 100 Life Safety Code Standards regarding generators on August 23, 2010 to ensure facility was complying with all other standards for maintaining our EPSS.</p> <p>Systemic Changes: The facility modified it's existing contract to include an annual EPSS load test at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.</p> <p>Monitoring: The Quality Assurance Committee will review the Annual EPSS load test results in October 2010 and confirm the monthly maintenance load tests are being performed beginning October 2010 and continuing for three months unless the QA Committee sees a need to continue to monitor for compliance.</p>	09/16/10

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K 144	Continued From page 4 followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144			