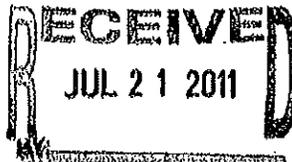


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509	
(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
{F 000}	INITIAL COMMENTS On 06/24/11, an onsite revisit to the Abbreviated Survey (06/06/11) was conducted which determined Immediate Jeopardy (IJ) had been removed at F-323, F-454, F-490, F-518, and F-520 on 06/18/11 as alleged in the acceptable Allegation of Compliance (AOC). While the IJ was removed at F-323, F-454, F-490, F-518 and F-520, continued non-compliance remained as follows: F-323, F-454, F-490, F-518, and F-520 at a Scope and Severity (S/S) of an "E". The facility had not completed staff education on new policies and procedures, developed and implemented an acceptable Plan of Correction (POC), or completed ongoing monitoring of the new evacuation system through the monthly Quality Assurance meetings which includes the Medical Director. The non-IJ deficiencies, F-281, F-387 and F-441 cited during the Abbreviated Survey (06/06/11) were not reviewed for compliance as the facility had not submitted an acceptable POC. Therefore, the deficiencies detailed on this Statement of Deficiencies for the revisit on 06/24/11 include the F-281, F-382 and F-441 deficiencies identified on the Abbreviated Survey dated 06/06/11.	{F 000}		
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	{F 281}	F 281 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #10's clinical record, all physicians orders, and comprehensive care	7/26/11
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>			TITLE RNHA (X6) DATE	



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 281)	<p>Continued From page 1</p> <p>review, it was determined the facility failed to ensure Physician's Orders were followed for one (1) of twelve (12) sampled residents (Resident #6). Resident #6 had a Physician's Order for a sensor alarm to the wheelchair for safety; however, observation on 06/06/11 revealed the resident was sitting in a wheelchair in the dining room during lunch without a sensor alarm in place.</p> <p>The findings include:</p> <p>Review of Resident #10's medical record revealed diagnoses which included Anxiety, Depression, and Prostate Cancer. Review of the Admission Minimum Data Set (MDS) Assessment dated 05/27/11 revealed the facility assessed the resident as being oriented, as requiring limited assistance with transfers and ambulation, and as sustaining a fall prior to admission.</p> <p>Review of the Physician's Orders dated 06/11 revealed an order for a sensor alarm to the wheelchair for safety.</p> <p>Observation of Resident #10 on 06/06/11 at 12:30 PM revealed the resident was sitting in a wheelchair in the dining room. A sensor alarm cord was hanging on the back of the wheelchair; however, there was no sensor alarm attached to the cord.</p> <p>Interview with Licensed Practical Nurse (LPN) on 06/06/11 at 12:40 PM revealed the alarm box was missing from the alarm cord. She stated she checked to ensure the alarms were in place as ordered once a shift, and signed the Treatment</p>	(F 281)	<p>plan were reviewed.</p> <p>Further the appropriate safety alarm device was applied to wheelchair 06/06/11 by the unit coordinator. The resident in reference was discharged on June 8, 2011.</p> <p>2.How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>Physicians' orders on all residents have the potential to be affected by the alleged deficient practice. A complete review of all active residents' physician orders was completed by the unit coordinators and director of nursing on 6/30/11. Safety device audits by the unit charge nurse/CNA</p>		

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{F 281}	<p>Continued From page 2</p> <p>Administration Record (TAR) to indicate the alarm was in place. Further interview revealed the same alarm box was used for the bed and the chair; and staff was to disconnect the alarm box from the bed sensor pad and connect it to the wheelchair sensor pad when the resident was transferred from bed to chair. She stated she had observed the alarm on the wheelchair earlier in the day.</p> <p>Interview on 06/06/11 at 2:30 PM with Certified Nursing Assistant (CNA) #15, who was assigned to Resident #10, revealed he was new to the facility and had his group of residents for the first time by himself. He stated he reviewed the Nurse Aide Care Plan at the nurse's station the first thing that morning and also referred to the Nurse Aide Care Plans which were inside the closet doors during the day for reference on providing care, including safety devices such as alarms for the residents. He further stated Resident #10 was assisted out of the bed by the night shift staff at change of shift and the resident did not want to be assisted to bed afterwards. Continued interview revealed the resident had been toileted by the nurse at 9:00 AM and had been toileted by therapy later in the morning. Further interview revealed he had observed the resident to have the sensor alarm on the wheelchair earlier in the shift, and he was unsure why the alarm was not in place during lunch because he had never seen the resident remove the alarm himself/herself.</p> <p>Interview with the Unit Coordinator on 06/06/11 at 3:30 PM revealed the nurse was to sign the TAR to indicate the bed and chair alarms were in place. However, it was the CNA's responsibility to make sure the alarm was in place.</p>	{F 281}	<p>team leader were completed on 06/10/11 with a comparison to the physician orders, safety device list, CNA care plan, and actual devices in place. Immediate corrections were made on any discrepancies.</p> <p>3. What systemic changes will be made to ensure that the deficient practice will not recur?</p> <p>All nursing associates had mandatory reeducation beginning on 6/17/11 and were completed by June 30, conducted by the Staff Development Nurse which included but was not limited to following physician's orders with an emphasis on safety device monitoring, and CNA care plan</p>	

procedures. Education will be conducted by the staff development coordinator semi-annually, and placed on the community annual reeducation calendar. All nursing staff new hires will be in-serviced by the staff development coordinator on the resident physician orders during the initial orientation.

Charges nurse make daily rounds, including weekends. And observe all residents to assure that the safety devices are applied correctly and being used as ordered. Physician's orders are reviewed daily and documented during the 24 hour chart checks conducted by 11pm-7am charge nurses.

The Director of Nursing
and/or Unit

Coordinators review all
new physician orders
during daily scheduled
stand up meetings,
Monday through
Friday, and update the
comprehensive
careplan accordingly.

The central supply clerk
is assigned to update
the CNA care plan daily,
Monday through
Friday, to communicate
physician order
changes.

In addition, a master
safety device list
consisting of physician
orders for equipment is
maintained daily,
Monday through
Friday, by the central
supplies clerk. This
master safety device list
is used by the central
supplies clerk to track

and monitor safety device utilization two (2) days a week. These master safety device rounds will include visualization of safety device utilization and application for each resident as it pertains to physician orders. The completed master safety device list review is discussed at the weekly Quality of Care meeting on Wednesday and monthly at the Quality Assurance meeting. Immediate action is taken to address any concerns noted on the rounds.

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

New physician orders are and will continue to be reviewed daily, 7

days a week, and documented during the 24 hour chart checks conducted by the 11pm-7am charge nurses. The facility evening nurse supervisor monitors for charge nurse compliance with physician orders by reviewing medication records, treatment records and 24 chart checks one (1) time a week, Monday through Friday, for eight (8) weeks, every other week for four (4) weeks and then once (1) monthly thereafter to review for compliance. The results of this monitoring are provided to the director of nursing and discussed at the weekly Quality of Care meeting on Wednesday. Changes to this

monitoring process will be reviewed by the Quality Assurance committee and approved.

In addition, all physicians' orders are reviewed during the end of the month order reconciliation process completed by unit coordinators and/or director of nursing/designee.

In order to monitor ongoing compliance a master safety device list consisting of physician ordered device will be updated daily, Monday through Friday, by the central supplies clerk. The central supplies clerk e-mail updates of this master safety device list daily, Monday through Friday, to members of

the quality assurance committee. Environmental QA rounds conducted by the quality assurance committee members utilizes this master safety device list to compare the CNA care plan to physician orders. On June 1st, an in-service with members of the quality assurance committee was conducted by the administrator and social services director on the use of the Environment QA Form. These environmental rounds include visualization of safety device utilization and application for each resident as it pertains to physician orders. These environmental rounds are conducted one (1) time throughout each week, Monday through

Friday, and documented evidence of the rounds turned into the Admissions coordinator each Wednesday. The completed Environmental QA rounds utilizing the master safety device list is discussed at the weekly Quality of Care meetings on Wednesday. If problems are found, immediate corrections are made and noted on the Environmental QA Form. Follow-up rounds are made by Wednesday of each week and to verify the corrective action has been sustained, it will be noted on the form. These environmental QA rounds are completed one (1) time a week, Monday through Friday, for

eight (8) weeks, bi-weekly for four (4) weeks and then once (1) monthly thereafter to review for compliance. The results of this monitoring are provided to the administrator and discussed at the weekly Quality of Care meeting on Wednesday. Any changes to this review process deemed necessary by the Quality Assurance committee will be reviewed and approved by the executive director of Richmond Place.

Members of the Quality Assurance committee met daily to develop changes and revisions and competencies of data collected from all systemic changes. Beginning 6/28/11, the

Administrator, Director of Nursing and at least three members of management met and will continue to meet with the Medical Director weekly or more often if deemed necessary to review and evaluate the effectiveness of the action plans as described above in order to ensure corrective action is sustained. Adjustments to these schedules can be made with the approval of the medical director, corporate clinical nurse consultant and executive director.

5. **The date that the corrective action will be completed;**
All processes as stated above provide evidence to show all corrective action was

completed for F 281
by 7/1/11.

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(F 323) SS-E	<p>403.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the acceptable Allegation of Compliance (AOC) it was determined Immediate Jeopardy (IJ) identified during the Abbreviated Survey (06/06/11) had been removed related to supervision to prevent accidents; however, non-compliance continued to exist, as the facility had not completed staff education, nor developed and implemented a Plan of Correction (POC) related to accidents and supervision. In addition, the facility continued to monitor the newly developed evacuation plan through the Quality Assurance (QA) program to ensure the effectiveness of the plan and new systems implemented to prevent recurrence and maintain compliance.</p> <p>The findings include: Review of the acceptable Allegation of Compliance (AOC) received on 06/20/11 revealed the facility sealed the emergency exits leading to the construction site from the outside. After completion of a walkway, one exit was reopened as an evacuation route. In addition, a fence was</p>	(F 323)	<p>F 323 Supervision to Prevent Accidents</p> <p>The resident environment at the facility is as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility has updated evacuation plans to reflect necessary changes to fire exits related to construction. The facility's accessible exits have a safe path to a public way. The facility has also trained associates on which fire exits are appropriate for evacuation during construction and on required monitoring to prevent accidents.</p> <p>1. How will the corrective action be accomplished for those residents found to have been.</p>	

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{F 323}	<p>Continued From page 4</p> <p>built to enclose the construction site, preventing public access to the area. The evacuation plan was revised and new signs were posted to direct staff and residents to a safe area in the event of fire or other emergency. Physical monitoring of the exit around the clock was initiated.</p> <p>Further review of the AOC revealed daily rounds for identification of potential hazards were conducted, utilizing the newly-developed Environment Quality Assurance (QA) Form. The Maintenance Director was conducting four (4) safety rounds daily. Staff re-education of new policies and procedures related to the evacuation plan had been conducted. Facility administration was conducting random competency checks on the new procedures six (6) times daily. Fire, Evacuation, Elopement and Hazard Drills had been conducted on all three (3) shifts. All data collection from daily rounds, random competencies, and analysis of drill responses were reported at daily QA meetings and will be taken to the next monthly QA meeting.</p> <p>The above information was verified through staff interviews and record reviews. However, record review and interview with the Administrator revealed not all staff had received the training and assessment of competencies, specifically those staff on leave or staff who were PRN (as needed).</p> <p>Interview with the Administrator on 06/24/11 at 8:00 PM revealed facility staff currently on leave or who work on a PRN (as needed) basis had been mailed training materials which included acknowledgement forms. The Administrator stated all forms had not been received back by</p>	{F 323}	<p>affected by the deficient practice?</p> <p>On June 1, during the abbreviated standard partial extended survey (facility reported incident), the Life Safety Code Officer from the Office of the Inspector General requested that first, the facility seal the two emergency exits that lead to the construction site and secondly, initiate an immediate fire watch. Immediately following this request on June 1, 2011, the exits were sealed and the fire watch was initiated.</p> <p>American Constructors, Inc. sealed two exits, one located next to the therapy department and the second exit next to rooms 231 and 232. These exits were sealed from the outside to eliminate the possibility of exit into an unsafe area. The facility administrator placed additional</p>	

prominent signage on the interior of two (2) exit doors indicating that they were not an exit. Additionally on June 1, Fayette Electric Company removed the illuminated exit signs from above the sealed exits.

On June 1, 2011 immediately following sealing the exits and removal of illuminated exit signage, the facility's emergency evacuation route plan was revised as a result of the previous mentioned exits being sealed, by the social services director, with direction and approval provided by the administrator, to exclude the sealed emergency exits. A QA meeting was held on June 1, 2011 with director of nursing, staff development coordinator, north unit coordinator, social services director, administrator and maintenance director to

formulate plans to reeducate associates on accessible exits and emergency procedures. The training included, but was not limited to: specifics on the exits that were sealed and plans to build a safe walkway from the exit at rooms 231 and 232 to a public way, evacuation route education and attention to the importance of monitoring exits during any disablement of the doors, safe evacuation procedures, and emergency response including the acronym (R.A.C.E.) Rescue, Alarm, Confine, Extinguish/ Evacuate and fire extinguisher procedures acronym (P.A.S.S.) Pull the pin, Aim at the base of the fire, Squeeze the handle, Sweep from side to side. Training for all associates on duty was conducted by the director of nursing, staff development coordinator, north unit coordinator and

social service director on June 1, 2011. All associates who were not on duty were trained on the above-mentioned topics prior to June 30, 2011 by the staff development coordinator, social services director, RN weekend supervisor, administrator, or director of nursing.

On June 1, 2011 at 6pm, the north unit coordinator and the staff development coordinator, both who are licensed practical nurses initiated a 24-hr fire watch. All associates involved in the fire watch underwent training in fire watch policy procedures prior to being assigned to fire watch duties. Training included, but was not limited to: process of monitoring for signs of fire or smoke, instruction to immediately investigate any door alarm that sounds,

monitoring and procedures for unforeseen protection system disablement, directing inquiries concerning fire watch procedures to the administrator. All training and related scheduling of associates was conducted by the staff development coordinator. Associates acknowledged their receipt of the fire watch policy and training in the fire watch policy by providing signatures on the fire watch policy for fire watch duties.

The associates assigned to fire watch duties documented the fire watch rounds every 15 minutes during their assigned periods. During each fire watch round the designated associate monitored for any signs of fire or smoke and listened for the annunciation of alarms that would indicate that an exterior door had been opened.

Associates were instructed to follow the procedures outlined in the fire safety policy and training they had received to maintain resident safety.

Initiation of monitoring for immediate accident and fire hazards was discussed at a QA team meeting attended by the administrator, the director of nursing, staff development coordinator, two MDS coordinators, supplies coordinator, social services director, admissions coordinator, healthcare liaison, north unit coordinator, south unit coordinator, lifestyles coordinator, medical records coordinator, business office manager, dietary manager, and housekeeping team leader on June 1, 2011. The QA team members present at the meeting on June 1, 2011 developed a monitoring system

designed to identify accidents and hazards in resident rooms to provide a safe physical environment within the facility. The monitoring system uses a tool called the quality assurance review form for environmental rounds (hereinafter referred to as Environment QA Form). On June 1st, an In-service with members of the quality assurance committee was conducted by the administrator and social services director on the use of the Environment QA Form. Using this Environment QA Form, all resident rooms were searched on June 1, 2011 by members of the Angel round manager assignment. Any items that were deemed potentially hazardous were removed from the environment immediately by the angel round managers. Removed items were then discussed at the QA meeting on

June 2, 2011 and appropriate interventions for items were discussed. Items determined by the team as potentially hazardous were removed from the building by family members.

On June 8, the Medical Director, Director of Nursing and the facility managers approved the Environmental QA form for evaluation of the residents environment to remain as free of accident hazards as possible by increasing supervision and assistance to prevent accidents.

On June 9th the Environment QA Form was revised to include checking nursing stations for proper storage of chemical or drugs, checking for locking of chemical cabinets and checking residents for safety devices as indicated on care plans.

On June 28, a QA meeting was held by the Administrator with the Medical Director, Director of Nursing and at least three other members of management, to discuss the Environmental QA form weekly summaries for monitoring of the effectiveness of the new systems implemented.

Fall investigations have been reviewed by the interdisciplinary care plan team at each stand up meeting, Monday through Friday, to determine if acceptable interventions were initiated at the time of the incident and for follow through documentation.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

Based on the finding of two emergency exits which were allegedly not safe and the incident of a fire in a resident's room on May 29, 2011, all associates and residents have the potential to be affected.

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

On June 1, 2011, American Constructors, Inc. built a safe walkway from the exit next to rooms 231 and 232 directly to the public way. The walkway includes a fence-like hand rail that acts as a barrier to access to the construction area. The Life Safety Code Officer from the Cabinet for Health Services observed the walkway and indicated verbally to the construction superintendant and the administrator, on June 1, 2011 and again at the exit.

interview on June 3, 2011, that this walkway was an acceptable safe path to a public way to end the alleged immediate jeopardy. The facility relied on the clearance by the Life Safety Code Officer to proceed with reopening the exit. The exit at rooms 231 and 232 was reopened after appropriate education of all on-duty RPRHC associates and the evacuation route plans were updated by the social services director on June 1, 2011 to reflect accessible exits, fire extinguisher locations and pull station locations. All associates who were not on duty were trained on the above-mentioned topics prior to returning to work.

As part of the evacuation route education, the new and current evacuation plan was posted on June 2, 2011 by the social

service director and the weekend supervisor on each hall indicating the appropriate emergency exit to use for each resident hall. This was accomplished to provide for safe egress in the event of an emergency evacuation.

A reeducation with all on-duty associates on June 2, 2011, conducted by the staff development coordinator, north unit coordinator, social services director and administrator, educated all RPRHC associates who were on duty on the revised evacuation route signage, fire extinguisher locations and pull station locations, including updated exits. All associates who were not on duty were trained on the above-mentioned topics prior to June 30.

To address the allegation of immediate jeopardy related to

supervision of residents for prevention of incidents and accidents, a four (4) feet high cattle fence secured by steel post with gates was erected by American Constructors, Inc. on June 10, 2011 to close off public access to areas of construction including the retention pond.

During a QA meeting on June 1, 2011, managers were assigned to areas of the facility to monitor for potentially hazardous items. Training and instruction of this monitoring was provided by the administrator for the assigned managers consisting of the quality assurance committee and the individual assistants to each department. The assigned managers and assistants complete Environmental QA rounds throughout the week, Monday through Friday starting June 1, 2011. If problems were

found, immediate corrections were made and noted on the Environment QA Form. Follow-up rounds were made by Wednesday of each week and noted to verify the corrective action has been sustained. Completed Environment QA Forms were submitted to the admissions coordinator every Wednesday to verify all resident rooms have been monitored. This monitoring system is reviewed through the Quality Assurance process and adjusted as necessary according to the results of the findings of the Environment QA Form and any changes are approved by the Executive Director of Richmond Place.

The community enhanced our emergency evacuation drills and test procedures, beginning June 4, to monitor competency in all education. This enhanced

education assist in evaluating the associate's competency in response to door alarms related to resident safety and assistive devices to prevent accidents. The drills included elopement drills conducted, by the social services director, to test associate's competency related to potential elopement. Associates also received fire drills, which addressed exit doors and emergency system disablement of the magnet lock system. All hazard drills were also conducted by the maintenance and staff development coordinator to cover a range of possible hazardous situations.

The facility's maintenance director received re-education on June 9, 2011 from the administrator on door check procedures and on checking the sealed door by the therapy

department each day to verify that it remained sealed. The fire watch rounds were re-evaluated by QA team members (administrator, maintenance director, staff development coordinator, north unit coordinator) and modified on June 9, 2011 from every 15 minutes to monitoring done by the maintenance director four times each day. Monitoring by the maintenance director four times daily includes a check of the sealed doors from the exterior of the building to verify that the exits remain sealed and monitoring for means of egress to be maintained free of obstructions or impediments, allowing access in the case of fire or emergency.

On June 17, the facility, per the Administrator's approval implemented twenty four (24)

hour coverage, seven (7) days a week monitoring in the hallway in front of the exit that is closest to the construction area next to rooms 231 and 232. An associate (door sentry) is assigned, by the staff development coordinator, to remain at the door to prevent any attempts to exit the door except in an emergency. Upon first shift of door sentry duties associates are trained by staff development coordinator and sign an acknowledgement form in regard to the door sentry's responsibility of supervision of construction site access. Associates also sign door sentry roster to ensure compliance for door access monitoring occurs for each scheduled door sentry shift.

4. How will the facility monitor its performance to make

sure that solutions are sustained?

Physical monitoring in the hallway in front of the exit that is closest to the construction area next to rooms 231 and 232 will continue until the construction area is cleared or an alternative means of monitoring resident safety is approved. The QA committee has reviewed results of the hallway monitoring daily and is confident that the systems are adequate. The current schedules can be modified and approved by the QA committee, the Executive Director of Richmond Place and the regional clinical nurse consultant as deemed appropriate or necessary.

The completed Environmental QA rounds are discussed at the weekly Quality of Care meetings on Wednesday. If problems are found, immediate corrections are made and noted on the Environment QA Form.

Follow-up rounds are made by Wednesday of each week and noted to verify the corrective action has been sustained.

These environmental QA rounds are completed one (1) time a week, Monday through Friday, for eight (8) weeks, bi-weekly for four (4) weeks and then once (1) monthly thereafter to review for compliance. The results of this monitoring are provided to the administrator and discussed at the weekly Quality of Care meeting on Wednesday. Any changes to deem necessary by the Quality Assurance committee are reviewed and approved by the executive director of Richmond Place.

Falls are tracked and trended for frequency, severity and effectiveness of Interventions by the director of nursing daily. The results are reported at the monthly QA meeting to implement action plans for identified issues.

The facility medical director, corporate clinical nurse consultant and executive director have receive one (1) time a week updates and notification provided by the Administrator utilizing the community Quality Assessment and Assurance form for plan of correction and follow up record. Any changes or revisions of the facility's current policies made by the administrator or Executive Director to enhance safety, emergency response, and evacuation training was and will continue to be reviewed weekly by the Vice-President of Clinical Services telephonically by the Regional Director of Clinical Services. The facility's progress to enhance safety, emergency response and preparedness, and evacuation training was and will continue to be reviewed every two weeks and more often if deemed necessary by the Divisional Vice-President of Operations. The Director of Development

for Brookdale Senior Living has and will continue to provide onsite review of construction project every week until the construction is completed.

Members of the Quality Assurance committee met daily to review the resident environment at the facility is as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Members of the Quality Assurance committee met daily to develop changes and revisions and competencies of data collected from all systemic changes. Beginning 6/28/11, the Administrator, Director of Nursing and at least three members of management met and will continue to meet with the Medical Director weekly or more often if deemed necessary to review and evaluate the effectiveness of the action plans as described above in order to ensure

corrective action is sustained.
Adjustments to these schedules
can be made with the approval
of the medical director,
corporate clinical nurse
consultant and executive
director.

5. The date that the
corrective action was
completed;

All processes as stated above
provide evidence to show all
corrective action was
completed for F 323 by 7/1/11.

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: 185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
(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	
{F 323}	Continued From page 5 the facility and training would not be completed until those staff members reported for their next assigned shift. Continued interview revealed the Environment Quality Assurance forms, data collected from dally rounds, and competencies would be reviewed at the next monthly QA meeting which was scheduled for 07/13/11 and would be attended by the Medical Director.	{F 323}			
{F 387} SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure two (2) of thirteen (13) sampled residents (Residents #5 and #6) were seen by a Physician at least once every sixty (60) days. Review of Resident #6's medical record revealed the Physician had last documented a visit on 03/07/11. Review of Resident #5's medical record revealed the Physician had last documented a visit on 03/14/11. The findings include: 1. Record review revealed the facility admitted Resident #5 on 12/17/09 with diagnoses which	{F 387}	F387 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Residents #5 and #6 were seen by the attending physician by 6/8/11.		

- 2. How will the facility identify other residents having the potential to be affected by the same deficient practice?**

All residents who are under the care of a physician have the potential to be affected by the alleged deficient practice. An audit of all active medical records was completed by the medical records clerk on 6/9/11. Any residents identified as needing physician visits were seen by the attending physician and all records updated on 6/9/11.

- 3. What systemic changes will be made to ensure**

**that the deficient
practice will not recur?**

The medical records clerk was in-serviced and re-educated by the administrator on 6/8/11 pertaining to physician visits being made in a timely manner and documentation of such being placed in the medical record. The medical records clerk will audit charts monthly for physician visits and report findings to the Administrator. The Administrator/Health Information Manager/Medical Records Clerk will contact attending

physician or APRN for visits to be made timely via telephone or e-mail prior to the due date.

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

Administrator/Health Information Manager/Director of Nursing will monitor five (5) resident charts to verify timeliness of physician visits for specific resident two (2) times weekly for four (4) weeks, weekly times four (4) weeks, and monthly thereafter. Administrator/Health Information Manager/Director of Nursing will report to the QA committee to

maintain compliance
times three (3) months.
QA committee will
review for compliance
monthly to assist with
compliance of this
standard.

Members of the Quality
Assurance committee
met daily to develop
changes and revisions
and competencies of
data collected from all
systemic changes.
Beginning 6/28/11, the
Administrator, Director
of Nursing and at least
three members of
management met and
will continue to meet
with the Medical
Director weekly or
more often if deemed
necessary to review and
evaluate the
effectiveness of the
action plans as
described above in

order to ensure corrective action is sustained. Adjustments to these schedules can be made with the approval of the medical director, corporate clinical nurse consultant and executive director.

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

All processes as stated above provide evidence to show corrective action for F 387 was completed by 7/1/11.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 08/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
(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	
{F 387}	Continued From page 6 Included Senile Dementia with behaviors, Muscle Weakness, Fracture of the Humerus, Alzheimer's Disease and Psychosis. Review of Resident #5's medical record on 06/06/11 revealed the last documented Physician's visit was 03/14/11. 2. Record review revealed the facility admitted Resident #6 on 12/03/09 with diagnoses which included recurrent Urinary Tract Infections, Alzheimer's Disease, Pernicious Anemia, Depressive Disorder, Dementia and Psychotic Disorder. Review of Resident #6's medical record revealed the last documented Physician's visit was 03/07/11. Interview with the Administrator on 06/06/11 at 2:40 PM revealed the facility follows the regulation and there should have been a Physician's visit documented every sixty (60) days. Interview with the Director of Nursing on 06/06/11 at 3:13 PM revealed there was no Physician's visit in May for Resident #5 and Resident #6 and the Physician was the same Physician for both residents. She further stated the Physician's office did not have a copy of any documentation to reveal there was a Physician's visit in May. She indicated there should be a documented Physician visit every sixty (60) days per the facility's policy.	{F 387}			
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	{F 441}			

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NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509	
(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 441}	<p>Continued From page 7</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 transport linens so as to prevent the spread of infection.</p>	{F 441}	<p>are not maintained. However other residents were not determined to be affected by this alleged deficient practice. Training and instruction for proper perineal care, hand washing and infection control and prevention of cross contamination began as a mandatory reeducation given by the staff development nurse on 06/06/11 for all nursing staff including PRN and was completed by 6/30/11. Training for hand washing and infection control and preventing cross contamination was given to non nursing staff beginning 6/6/11 and completed by 6/30/11 by the staff development nurse.</p> <p>3. What systemic changes will be made to ensure that the deficient practice will not recur? Education and return demonstration for infection control and prevention of cross contamination in the environment has been added as</p>	

a requirement for new hires, which is to be completed by the Staff Development nurse upon initial orientation.

Direct observation of perineal care being given by SRNA's doing direct care was conducted by licensed nursing personnel, staff development coordinator, evening supervisor and the SRNA team leader beginning on June 6, 2011 and completed by 6/30/11.

A plan to review the community infection control program perineal care procedure and technique will continue for at least four (4) sessions annually, (June, September, December, March) presented by the Staff Development nurse.

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

SRNAs were required to complete perineal care demonstrations during

Infection control QA audits which began on June 20, 2011 conducted by the evening nurse supervisor, weekend nurse supervisor, licensed charge nurses, staff development coordinator, and dayshift Unit Coordinators. Audits for Infection control and prevention of cross contamination in the environment with resident care are being done with three (3) associates three (3) times a week for four (4) weeks completed by the evening nurse supervisor, weekend nurse supervisor or dayshift Unit Coordinators, licensed charge nurses or staff development nurse. Additional training sessions will occur as determined by the Quality Assurance Committee if audit and observation results identify areas of concern.

Inservice training records and orientation checklist reflect training compliance. Tracking and trending of infection

occurrence will be monitored by monthly infection control listing and submitted for QA team review at monthly meetings. Additional training sessions will occur if audit and infection results warrant if identified by team review. QA committee will review for compliance daily to assist with compliance of this standard.

Members of the Quality Assurance committee met daily to develop changes and revisions and competencies of data collected from all systemic changes. Beginning 6/28/11, the Administrator, Director of Nursing and at least three members of management met and will continue to meet with the Medical Director weekly or more often if deemed necessary to review and evaluate the effectiveness of the action plans as described above in order to ensure corrective action is sustained. Adjustments to these schedules can be made with the approval

of the medical director,
corporate clinical nurse
consultant and executive
director.

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

All processes as stated above
provide evidence to show all
corrective action was
completed for F 441 by 7/1/11.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509	
(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 441}	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to maintain an effective Infection Control Program designed to help prevent the development and transmission of disease and infection for one (1) of twelve (12) sampled residents, (Resident #1) and one (1) unsampled resident (Unsampled Resident A). Observation of peri-care on 06/06/11 for Resident #1 and Unsampled Resident A revealed improper infection control technique. Further observation revealed staff failed to use proper hand hygiene after performing perineal care and prior to performing oral care for Unsampled Resident A.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation of peri-care on 06/06/11 at 5:30 PM for Unsampled Resident A, revealed Certified Nursing Assistant (CNA) #14 cleansed stool from the resident's anal area, then with the same soiled gloves cleansed the resident's genitalia. The CNA then proceeded to change gloves; however, did not wash her hands prior to performing oral care on the resident using a toothette sponge. Interview on 06/06/11 at 7:45 AM with CNA #14, revealed she should have cleansed the resident's genitalia prior to cleansing stool from the resident's anal area. She further stated she should have washed her hands after performing perineal care and before performing oral care. 2. Observation of peri-care on 06/06/11 at 5:40 AM for Resident #1 revealed CNA #14 cleansed the resident's anal area and buttocks with wipes, 	{F 441}	<p>F 441</p> <ol style="list-style-type: none"> 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Instruction of proper performance technique was given to SRNA #14 by the 3-11 supervisor nurse regarding pericare, hand washing, and infection control to prevent cross contamination on 06/06/11. Resident #1 and a sampled resident (a) will be monitored for any signs and symptoms of infection and further testing will be initiated if deemed necessary. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are at risk for adverse effects when proper procedures for infection control 	

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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		
(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	
{F 441}	Continued From page 9 and with the same gloves performed pericare of the vaginal area.	{F 441}			
{F 454} SS=E	Interview on 06/06/11 at 7:45 AM with CNA #14 revealed she should have removed her gloves and washed her hands after cleansing stool and prior to cleansing the resident's vaginal area. 483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the acceptable Allegation of Compliance (AOC) it was determined that Immediate Jeopardy (IJ) identified during the Abbreviated Survey (08/06/11) had been removed related to Life Safety from Fire; however, the facility had not completed staff education, developed and implemented an acceptable Plan of Correction (POC) related to Life Safety from Fire, and had not discussed monitoring data analysis at the monthly QA meeting in order to evaluate the effectiveness of the new system implemented to prevent recurrence and maintain compliance. The findings include: Review of the acceptable AOC received on 06/20/11 revealed the facility, on 06/01/11, sealed the emergency exits which had been identified as unsafe evacuation routes, as they opened onto a construction site. The facility revised the	{F 454}	F-454 Physical Environment <u>Introduction</u> Introduction The facility is currently in compliance with the 2000 Edition of the Life Safety Code of the National Fire Protection Associate in that all emergency fire exits are accessible to associates, residents, and visitors providing a safe path to a public way in the event of an emergency. 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		

American Constructors, Inc. sealed two exits, one located near the therapy department and the second exit at rooms 231 and 232. These exits were sealed from the outside to eliminate the possibility of exit into an unsafe area. The facility administrator placed additional prominent signage on the interior of these doors indicating that they were not an exit. Additionally on June 1, Fayette Electric Company removed the illuminated exit signs from above the sealed exits.

On June 1, 2011, American Constructors, Inc. built a safe walkway from the exit near rooms 231 and 232 directly to the public way. The walkway includes a fence-like hand rail that acts as a barrier to access to the construction area. The Life Safety Code Inspector from the Cabinet for Health Services observed the walkway and indicated verbally to the construction

superintendent and the administrator, on June 1, 2011 and again at the exit interview on June 3, 2011, that this walkway was an acceptable safe path to a public way to abate the alleged immediate jeopardy. The facility relied on the clearance by the Life Safety Code Officer to proceed with reopening the exit. The exit at rooms 231 and 232 was reopened after appropriate education of all on-duty RPRHC associates and the evacuation route plans were updated by the social services director on June 1, 2011 to reflect accessible exits, fire extinguisher locations and pull station locations. All associates who were not on duty were trained on the above-mentioned topics by June 30, 2011.

As part of the evacuation route education the new and current evacuation plan was posted on June 2, 2011 by the

social service director and the weekend supervisor on each hall indicating the appropriate emergency exit to use for each resident hall. This was accomplished to provide for safe egress in the event of an emergency evacuation.

A reeducation with all on-duty associates on June 2, 2011, conducted by the director of nursing, staff development coordinator, north unit coordinator, social services director and administrator, educated all RPRHC associates on the revised evacuation route signage, fire extinguisher locations and pull station locations, including updated exits. All associates who were not on duty were trained on the above-mentioned topics by June 30.

Initiation of monitoring for immediate accident and fire hazards was discussed at a QA team meeting attended by the administrator, the director of

nursing, staff development coordinator, two MDS coordinators, supplies coordinator, social services director, admissions coordinator, healthcare liaison, north unit coordinator, south unit coordinator, lifestyles coordinator, medical records coordinator, business office manager, dietary manager, and housekeeping team leader on June 1, 2011. The QA team members present at the meeting on June 1, 2011 developed a monitoring system designed to identify accidents and hazards in resident rooms to provide a safe physical environment within the facility. The monitoring system uses a tool called the quality assurance review form for environmental rounds (hereinafter referred to as Environment QA Form). On June 1st, an in-service with all members of the Angel round manager assignment was

conducted by the administrator and social services director on the use of the Environment QA Form. Using this Environment QA Form, all resident rooms were searched on June 1, 2011 by members of the Angel round manager assignment. Any items that were deemed potentially hazardous were removed from the environment immediately by the angel round managers. Removed items were then discussed at the QA meeting on June 2, 2011 and appropriate interventions for items were discussed. Items determined by the team as potentially hazardous were removed from the building by family members.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

Based on the finding of two emergency exits which were allegedly not safe secondary to existing construction, and interviews with associates who were not aware of which emergency exits to use, and an associates inability to accurately describe emergency procedures related to fire, it was determined that all residents, visitors and associates could be affected.

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

The maintenance director was educated by the administrator on June 9th on door check procedures and monitoring exits for egress. Monitoring by the maintenance director occurring four times daily, 7 days a week, includes a check of the sealed doors from the exterior of the building to

verify that the exits remain sealed and monitoring for means of egress to be maintained free of obstructions or impediments to allow access in the case of fire or emergency. The four (4) times a day, 7 days a week, monitoring by maintenance continues to be submitted to the administrator daily.

During a QA meeting on June 1, 2011, managers were assigned to areas of the facility to monitor for potentially hazardous items. Training and instruction of this monitoring was provided by the administrator for the assigned managers consisting of the quality assurance committee and individual assistants to each department. The assigned managers and assistants complete Environmental QA rounds throughout the week, Monday through Friday starting June 1, 2011. If problems are found,

Immediate corrections will be made and noted on the Environment QA Form. Follow-up round will be made by Wednesday of each week and noted to verify the corrective action has been sustained. Completed Environment QA Forms will be submitted to the admissions coordinator every Wednesday to verify all resident rooms have been monitored. This monitoring system will be reviewed through the Quality Assurance process and adjusted as necessary according to the results of the findings of the Environment QA Form and any changes will be approved by the Executive Director of Richmond Place.

On June 17, the facility, per the Administrator's approval implemented twenty four (24) hour coverage, seven (7) days a week monitoring in the hallway in front of the exit that is closest to the construction area next to

rooms 231 and 232. An associate (door sentry) shall be assigned; by the staff development coordinator, to remain at the door to prevent any attempts to exit the door except in an emergency. Upon first shift of door sentry duties associates were trained by the staff development coordinator and sign an acknowledgement form in regard to the door sentry's responsibility of supervision of construction site access. Associates also sign door sentry roster to ensure compliance for door access monitoring occurs for each scheduled door sentry shift.

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

The facility's maintenance director checked the sealed door by the therapy department each day to verify

that it remained sealed. The fire watch rounds were re-evaluated by QA team members (administrator, maintenance director, staff development coordinator, north unit coordinator) and modified on June 9, 2011 from every 15 minutes to monitoring done by the maintenance director four times each day. Monitoring by the maintenance director four times daily, seven days a week, includes a check of the sealed doors from the exterior of the building to verify that the exits remain sealed and monitoring for means of egress to be maintained free of obstructions or impediments to allow access in the case of fire or emergency. Four (4) times a day, seven days a week monitoring by maintenance will continue to be submitted to administrator daily.

On June 17, the facility, per the Administrator's approval

implemented twenty four (24) hour coverage, seven (7) days a week monitoring in the hallway in front of the exit that is closest to the construction area next to rooms 231 and 232. An associate (door sentry) shall be assigned, by the staff development coordinator, to remain at the door to prevent any attempts to exit the door except in an emergency. Upon first shift of door sentry duties associates were trained by the staff development coordinator and signed an acknowledgement form in regard to the door sentry's responsibility of supervision of construction site access. Associates also sign door sentry roster to ensure compliance for door access monitoring occurs for each scheduled door sentry shift.

Physical monitoring in the hallway in front of the exit that is closest to the construction area next to

rooms 231 and 232 will continue until the construction area is cleared or an alternative means of monitoring resident safety is approved by the QA committee and implemented.

Members of the Quality Assurance committee met daily to develop changes and revisions and competencies of data collected from all systemic changes. Beginning 6/28/11, the Administrator, Director of Nursing and at least three members of management met and will continue to meet with the Medical Director weekly or more often if deemed necessary to review and evaluate the effectiveness of the action plans as described above in order to ensure corrective action is sustained. Adjustments to these schedules can be made with the approval of the medical director, corporate clinical

nurse consultant and
executive director.

5. **The date that the
corrective action will be
completed;**
F454 was corrected by 7/1/11.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
(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 454)	Continued From page 10 evacuation plan on 06/02/11 and new signs were posted to direct staff and residents safely out of the building in the event of a fire or other emergency. After completion of an outside walkway, one exit was reopened on 06/03/11 for use in the event resident evacuation was required. The revised "All Hazards" manual was placed at each nursing station and staff inservices were conducted on safe evacuation in any emergency. Further review of the (AOC) revealed the Maintenance Director was conducting four (4) safety rounds daily, including monitoring of the emergency exit doors. Fire, Elopement, and Hazard drills were conducted on all shifts and random competency evaluations by facility administrators were conducted six (6) times daily. This information and action plan was verified through direct observation, staff interviews, and record review. During interview, on 06/24/11 at 8:00 PM, the Administrator stated the facility mailed training materials and an acknowledgement form to staff who worked PRN (as needed) or who were on leave at the time. However, the facility had not received all the acknowledgement forms from these staff. Continued interview revealed all data collected from the competencies, safety rounds, and analysis of drill responses were reported at daily Quality Assurance meeting; however had not been discussed at the monthly QA meeting. The Administrator stated the monthly QA meeting was scheduled for 07/13/11 and the Medical Director would be attending.	(F 454)			
(F 490) SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	(F 490)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
(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 490)	<p>Continued From page 11</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the acceptable Allegation of Compliance (AOC) it was determined that Immediate Jeopardy (IJ) identified during the Abbreviated Survey (06/06/11) had been removed related to Administration; however, non-compliance continued to exist as the facility had not completed staff education, developed and implemented an acceptable Plan of Correction (POC) related to facility administration, or monitored new systems (developed and implemented) through the monthly Quality Assurance (QA) meetings.</p> <p>The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC) received on 06/20/11 revealed the facility implemented Quality Assurance (QA) activities to ensure administrative oversight of safety concerns identified on the Abbreviated Survey (06/06/11). Revision of policies and procedures related to fire safety and emergency evacuation was completed by the QA Committee on 06/08/11, with review by the Vice President of Clinical Services (VP) and the Regional Director of Clinical Services (RD). Daily random staff competency evaluations and analysis of fire,</p>	(F 490)	<p>F 490 Administration The facility is administered in a manner that uses its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>On June 1, 2011 immediately following sealing the exits and removal of illuminated exit signage, the facility's emergency evacuation route plan was revised by the social services director, with direction and approval provided by the administrator; to exclude the sealed emergency exits. A QA meeting was held on June 1,</p>		

2011 with the director of nursing, staff development coordinator, north unit coordinator, social services director, administrator and maintenance director to formulate plans to reeducate associates on accessible exits and emergency procedures. The training included, but was not limited to: specifics on the exits that were sealed and plans to build a safe walkway from the exit at rooms 231 and 232 to a public way, evacuation route education and attention to the importance of monitoring exits during any disablement of the doors, safe evacuation procedures, and emergency response including the acronym (R.A.C.E.) Rescue, Alarm, Confine, Extinguish/ Evacuate and fire extinguisher procedures acronym (P.A.S.S.) Pull the pin, Aim at the base of the fire, Squeeze the handle, Sweep from side to side. Training for all associates (including off duty and PRN associates) was conducted by

the director of nursing, staff development coordinator, north unit coordinator and social service director beginning on June 1, 2011 and was completed June 30, 2011.

On June 8, the administrator and Medical Director addressed current issues and concerns with the Executive Director, Regional Director of Clinical Services, Vice-President of Clinical Services, and the Regional Director of Operations to develop a revised plan to maintain a safe environment for residents, associates, and public and to focus on revising the emergency training program.

On June 8, 2011 a QA team meeting was conducted with the Medical Director, the Vice President of Clinical Services for Brookdale Senior Living, the Regional Director of Clinical Services for Brookdale Senior Living, and the community QA team

members that include director of nursing, medical director (a physician), the administrator, director of social services, director of admissions, director of lifestyles programming, the unit coordinators, the MDS nurses, medical records coordinator, business office manager, environmental services team leader, the maintenance director and the dietary manager. During the meeting, action plans were reviewed and approved as well as revisions to the emergency preparedness and response policy and procedure manual.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

Based on the finding of two emergency exits which were allegedly not safe secondary to existing construction, and interviews with associates who were not aware of which

emergency exits to use, and an associates inability to accurately describe emergency procedures related to fire, it was determined that all residents and associates could be affected.

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

The administrator approved all changes made to the orientation packet, produced by staff development coordinator, to assist in compliance and competency of all associates hired.

Administrator reviewed and approved all policies and procedures, QA audit forms, training and education, comprehensive tests and quizzes, which were developed to evaluate staff competency. Members of the quality assurance committee reviewed the results daily and weekly summaries, beginning June 28, 2011 were reviewed

by Administrator, Medical Director, Director of Nursing and members of the QA team to make revisions if needed.

An annual inservice calendar was developed and submitted to administrator for approval to assure training topics are included on an ongoing basis. Comprehensive test and quiz results were assessed by the QA team were used to assess topics for further ongoing training per the Administrator's discretion. The Executive Director of Richmond Place is available daily for oversight and assistance. Due to the severity of the deficiencies cited, the corporate office increased the oversight of and assistance to this facility to maintain a safe environment for residents, associates and the public, and to verify the effectiveness of the emergency training program

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

Members of the QA team (the administrator, the director of nursing, staff development coordinator, two MDS coordinators, medical supplies clerk, social services director, admissions coordinator, healthcare liaison, north unit coordinator, south unit coordinator, lifestyles coordinator, medical records coordinator, business office manager, dietary manager, and housekeeping team leader, maintenance director, weekend supervisor, evening supervisor) are meeting daily seven days a week to review monitoring results of the Quality Assessment and Assurance form for plan of correction and follow up record. The QA team revises meeting frequency and monitoring as deemed necessary by the administrator and the Executive Director of

Richmond Place. The Executive Director reviews the QA minutes for QA team meetings.

The facility Medical Director, Regional Director of Clinical Services and Executive Director receive one (1) time a week updates and notification from the facility Administrator by utilizing the community Quality Assessment and Assurance form for plan of correction and follow up record. The Regional Director of Clinical Services provide oversight and direction for continued compliance and to the effectiveness of safety, emergency response, and evacuation training through telephonic discussions weekly with the administrator. The weekly review utilizes the community Quality Assessment and Assurance form for plan of correction and follow up record. Any changes or revisions of the facility's current policies made

by the administrator or Executive Director to enhance safety, emergency response, and evacuation training are reviewed weekly by the Vice-President of Clinical Services telephonically by the Regional Director of Clinical Services. The facility's progress to enhance safety, emergency response and preparedness, and evacuation training will be reviewed every two weeks and more often if deemed necessary by the Divisional Vice-President of Operations. The Director of Development for Brookdale Senior Living is providing onsite review of the construction project every week until the construction is completed.

Members of the Quality Assurance committee met daily to develop changes and revisions and competencies of data collected from all systemic changes. Beginning 6/28/11, the Administrator, Director of Nursing and at least three members of

management met and will continue to meet with the Medical Director weekly or more often if deemed necessary to review and evaluate the effectiveness of the action plans as described above in order to ensure corrective action is sustained. Adjustments to these schedules can be made with the approval of the medical director, corporate clinical nurse consultant and executive director.

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

All processes as stated above provide evidence to show all corrective action was completed for F 490 by 7/1/11.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509	
(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
{F 490}	Continued From page 12 elopement and hazard drills conducted on all shifts were being reported at daily QA meetings, attended by all department heads. Staff re-education was conducted by the Director of Nursing and Staff Development Coordinator and their designees. However, based on record review and interview with the Administrator, staff who were on leave or worked only on a PRN (as needed) basis and have not yet been called to work, had not been trained on the new procedures. Training packets and acknowledgement forms had been mailed but not all had been returned. Those staff members were to receive inservices on their first return to work. Interview with the Administrator, on 06/24/11 at 8:00 PM, revealed the next monthly QA meeting would be held on 07/13/11 and would include the Medical Director. In addition, the facility would engage in ongoing consultation with the VP and RD to evaluate the effectiveness of the POC.	{F 490}		
{F 518} SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the acceptable Allegation of Compliance (AOC) it was determined that Immediate Jeopardy (IJ)	{F 518}	F-518 Employee Training for Emergencies The facility is training all associates in emergency procedures when they begin to work in the facility; periodic review of the procedures with the existing associates; and carries out unannounced associate drills using those procedures. 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On June 1, 2011 immediately following sealing the exits and removal of illuminated exit signage, the facility's emergency evacuation route plan was revised by the social services director, with direction	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
(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	
{F 518}	<p>Continued From page 13</p> <p>Identified during the Abbreviated Survey (06/06/11) had been removed related to training of staff on emergency response; however, non-compliance continued to exist as the facility had not completed staff education, nor developed and implemented an acceptable Plan of Correction (POC) related to staff education.</p> <p>The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC) received on 06/20/11 revealed the facility implemented a revised emergency evacuation plan and began conducting mandatory educational activities for all staff related to fire safety and emergency evacuation procedures. The Director of Nursing and the Staff Development Coordinator and their designees conducted the inservices, which included written tests. In addition, random competency evaluations of staff knowledge of the new procedures were being conducted daily. Fire, elopement and evacuation drills were conducted on all shifts. Interview with the Staff Development Coordinator, on 06/24/11 at 5:15 PM, revealed data collected from written tests, random competency checks and analysis of drills were being reported to daily Quality Assurance (QA) meetings attended by all department heads. Random interviews with staff from all departments revealed ready knowledge of emergency preparedness and new evacuation procedures.</p> <p>Interviews conducted on 06/24/11 with direct care staff, nursing staff, and other facility staff revealed verification the facility had provided training on the new emergency evacuation policy and</p>	{F 518}	<p>and approval provided by the administrator, to exclude the sealed emergency exits. A QA meeting was held on June 1, 2011 with director of nursing, staff development coordinator, north unit coordinator, social services director, administrator and maintenance director to formulate plans to reeducate associates on accessible exits and emergency procedures. The training included, but was not limited to: specifics on the exits that were sealed and plans to build a safe walkway from the exit at rooms 231 and 232 to a public way, evacuation route education and attention to the importance of monitoring exits during any disablement of the doors, safe evacuation procedures, and emergency response including the acronym (R.A.C.E.) Rescue, Alarm, Confine, Extinguish/ Evacuate and fire extinguisher procedures acronym (P.A.S.S.) Pull the pin, Aim at the base of the fire, Squeeze the handle, Sweep from side to side. Training for all associates</p>		

(Including off duty and PRN associates) was conducted by the director of nursing, staff development coordinator, north unit coordinator and social service director beginning on June 1, 2011 and was completed June 30, 2011.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

Based on the finding of two emergency exits which were allegedly not safe secondary to existing construction, and interviews with associates who were not aware of which emergency exits to use, and an associates inability to accurately describe emergency procedures related to fire, it was determined that all residents and associates could be affected.

3. What systemic changes will be made to ensure

**that the deficient
practice will not recur?**

As part of the evacuation route education, the new and current evacuation plan was posted on June 2, 2011 by the social service director and the weekend supervisor on each hall indicating the appropriate emergency exit to use for each resident hall (Appendix 1).

Reeducation with on-duty associates on June 2, 2011, conducted by the director of nursing, staff development coordinator, north unit coordinator, social services director and administrator, educated RPRHC associates on the revised evacuation route signage, fire extinguisher locations and pull station locations, including updated exits. Training for all associates (including off duty and PRN associates) on the above mentioned topics was completed by June 30.

The revised evacuation plan (developed by the social

services director on June 2, 2011) has been added to the orientation education program developed by the staff development coordinator on June 5, 2011, so that new associates are trained appropriately on safe evacuation procedures, safe exits and monitoring of exits to prevent unsafe egress.

The community has enhanced our emergency evacuation drills to ensure competency in all hazard performance. Elopement drills were conducted, by the social service director, to test the associates competency related to education of supervision and performance for preparation in the event of an elopement. Associates also received fire drills, including each shift, which addressed exit doors and emergency system disablement of the magnet lock system. All hazard drills were also conducted by the maintenance and staff development coordinator to cover a wide

range of possible hazardous situation

A comprehensive test was developed to test associate competency covering emergency preparedness, disaster planning, and fire policy and procedures. The comprehensive test was developed on June 12, 2011 by the social service director and the weekend RN supervisor. All active associates were tested by 6/30/11 and were required to score 75% or greater to demonstrate competency. If associates score less than 75% then one on one re-education by staff development coordinator, social service director, and weekend RN supervisor is completed. Test scores and one on one reeducation is monitored by the administrator during daily QA meetings.

Compilation of the test result are assessed by the QA team and utilized to identify specific topics for future and ongoing training. An annual inservice calendar including training topics of emergency procedures was developed and submitted to the administrator for approval to assure training topics are included on an ongoing basis. To ensure continued compliance the staff development coordinator will conduct this comprehensive test annually and at orientation to assess identify and implement training needs.

Fire safety training was presented by the Lexington Fire Department on June 7, 2011 and was filmed and formatted as a DVD. All new associates are required to watch the Fire Safety DVD as part of the new hire orientation process conducted by the staff development coordinator. The Lexington Fire Department will be included in fire and safety all

hazards bi-annual required training.

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

Eloperment drills are conducted monthly, by the social service director, to test the associates competency related to education of supervision and performance for preparation in the event of an elopement. Associates also participate in fire drills monthly, including each shift quarterly, which addresses exit doors and emergency system disablement of the magnet lock system. All hazard drills are also conducted by the maintenance and staff development coordinator, quarterly, to cover a wide range of possible hazardous situations. These elopement drills, fire drills and all hazard drills are documented and copies are provided to the community director of engineering, and the regional

director of maintenance per Brookdale Senior Living oversight requirements These drills will also be discussed monthly with the Executive Director of Richmond Place by the administrator to discuss any potential concerns related to associate competency and to institute any necessary training and oversee any corrective action.

On June 5, 2011, the QA team (administrator, director of nursing, staff development coordinator, RN weekend supervisor, social services director, south unit coordinator, north unit coordinator) discussed how to monitor associate competency in evacuation plans, fire safety and emergency response. The north unit coordinator developed a monitoring tool, the quality assurance review form on June 5, 2011, to evaluate the effectiveness of associate education to confirm associate competence regarding evacuation plans, fire

safety and emergency response. This monitoring is completed at least six (6) times per day, seven days a week and is conducted by the administrator, director of nursing, staff development coordinator, RN weekend supervisor, social services director, south unit coordinator, north unit coordinator, healthcare liaison, admissions coordinator, supplies coordinator, or MDS nurse. The associates were tested both individually and in groups to determine level of competency. Any lack of appropriate knowledge that is discovered is immediately addressed with one-on-one or group re-education by the individual conducting the monitoring. Results of the monitoring are reviewed daily by members of the QA committee consisting of the administrator, director of nursing, staff development coordinator, RN weekend supervisor, social services director; south unit

coordinator, north unit coordinator, healthcare liaison, admissions coordinator, supplies coordinator, maintenance director, or MDS nurse. This monitoring system will be reviewed through the Quality Assurance process and adjusted as necessary according to the results of the findings of the quality assurance review form and any changes will be approved by the Executive Director of Richmond Place.

To ensure continued compliance the staff development coordinator will conduct the comprehensive test annually and at orientation to assess identify and implement training needs. Completion of the test result are assessed by the QA team and utilized to identify specific topics for future and ongoing training. An annual inservice calendar including training topics of emergency procedures was developed and submitted to the administrator for approval to assure training

topics are included on an ongoing basis. Test scores for new hires will be monitored by the quality assurance committee during monthly QA meetings and for the annual testing the month following annual education and testing.

Members of the Quality Assurance committee met daily to develop changes and revisions and competencies of data collected from all systemic changes. Beginning 6/28/11, the Administrator, Director of Nursing and at least three members of management met and will continue to meet with the Medical Director weekly or more often if deemed necessary to review and evaluate the effectiveness of the action plans as described above in order to ensure corrective action is sustained. Adjustments to these schedules can be made with the approval of the medical director, corporate clinical nurse consultant and executive director.

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

All processes as stated above
provide evidence to show all
corrective action was
completed for F 518 by 7/1/11.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
(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	
{F 518}	Continued From page 14 procedure. The education was also verified through record review. However, record review and interview with the Administrator revealed not all staff had received the training and assessment of competencies, specifically those staff on leave or staff who were PRN (as needed).	{F 518}			
{F 520} SS=E	<p>Interview with the Administrator on 06/24/11 at 8:00 PM revealed the next QA monthly meeting on 07/13/11 would be attended by the Medical Director. He stated all QA activities to that point, including drill response audits and staff competency evaluations, would be reviewed and revisions made as deemed necessary by the QA Committee.</p> <p>483.76(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p>	{F 520}	<p>F 520 Quality Assessment and Assurance</p> <p>The facility maintains a quality assessment and assurance committee (QA team members that include director of nursing, medical director (a physician), the administrator, director of social services, director of admissions, director of lifestyles programming, the unit coordinators, the MDS nurses, medical records coordinator, business office manager, environmental services team leader, the maintenance director and the dietary manager) that develop and implement appropriate plans of action to correct identified quality deficiencies.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40809		
(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	
{F 520}	Continued From page 15 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the acceptable Allegation of Compliance (AOC) it was determined that Immediate Jeopardy (IJ) identified during the Abbreviated Survey (06/06/11) had been removed related to Quality Assessment and Assurance (QA); however, non-compliance continued to exist as the facility had not completed staff education, nor developed and implemented an acceptable Plan of Correction (POC) related to QA. The findings include: Review of the acceptable Allegation of Compliance (AOC) received on 06/20/11 revealed the facility QA committee was made up of the Administrator, the Medical Director and all department heads. In addition, since identification of IJ, the Vice President of Clinical Services, the Regional Director of Clinical Services and the Divisional Vice President of Operations were involved in committee activities. On 06/08/11, the QA committee approved revisions to the facility's fire safety and emergency evacuation policies and procedures. Daily QA meetings, attended by all department heads, address data collected from daily environmental rounds, daily random staff competency evaluations and analysis of fire, elopement and hazard drills response.	{F 520}	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On June 1, 2011 at 6 pm, the north unit coordinator and the staff development coordinator, both who are licensed practical nurses initiated a 24-hr fire watch. All associates involved in the fire watch underwent training in fire watch policy procedures prior to being assigned to fire watch duties. Training included, but was not limited to: process of monitoring for signs of fire or smoke, instruction to immediately investigate any door alarm that sounds, monitoring and procedures for unforeseen protection system disablement, directing inquiries concerning fire watch procedures to the administrator. All training and related scheduling of associates was conducted by the staff		

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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 R-C 06/24/2011
NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
(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	
{F 520}	Continued From page 16 Interview with the Administrator, on 06/24/11 at 8:00 PM, revealed the QA Committee would evaluate the effectiveness of the Plan of Correction (POC). Data collected daily would be used for ongoing monitoring and revisions would be developed by the committee as needed. He stated the next monthly meeting would be held 07/13/11 and would include the Medical Director.	{F 520}	development coordinator. Associates acknowledged their receipt of the fire watch policy and training in the fire watch policy by providing signatures on the fire watch policy for fire watch duties. The associates assigned to fire watch duties documented the fire watch rounds every 15 minutes during their assigned periods. During each fire watch round the designated associate monitored for any signs of fire or smoke and listened for the announcement of alarms that would indicate that an exterior door had been opened. Associates were instructed to follow the procedures outlined in the fire safety policy and training they had received to maintain resident safety. Initiation of monitoring for immediate accident and fire hazards was discussed at a QA team meeting attended by the		

administrator, the director of nursing, staff development coordinator, two MDS coordinators, supplies coordinator, social services director, admissions coordinator, healthcare liaison, north unit coordinator, south unit coordinator, lifestyles coordinator, medical records coordinator, business office manager, dietary manager, and housekeeping team leader on June 1, 2011. The QA team members present at the meeting on June 1, 2011 developed a monitoring system designed to identify accidents and hazards in resident rooms to provide a safe physical environment within the facility. The monitoring system uses a tool called the quality assurance review form for environmental rounds (hereinafter referred to as Environment QA Form or. On June 1st, an in-service with all members of the Angel round

manager assignment was conducted by the administrator and social services director on the use of the Environment QA Form. Using this Environment QA Form, all resident rooms were searched on June 1, 2011 by members of the Angel round manager assignment. Any items that were deemed potentially hazardous were removed from the environment immediately by the angel round managers. Removed items were then discussed at the QA meeting on June 2, 2011 and appropriate interventions for items were discussed. Items determined by the team as potentially hazardous were removed from the building.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

Based on the finding of two emergency exits which were

allegedly not safe secondary to existing construction, and interviews with associates who were not aware of which emergency exits to use, and an associates inability to accurately describe emergency procedures related to fire, it was determined that all residents and associates could be affected.

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

Throughout the week, Monday through Friday, starting June 1, 2011, the Quality Assurance committee was assigned areas to monitor for potentially hazardous items. If problems were found, immediate corrections were made and noted on the Environment QA Form. Follow-up round was made by Wednesday of each week and noted to verify the corrective action had been sustained. Completed

Environment QA Forms were submitted to the admissions coordinator every Wednesday to verify all resident rooms have been monitored. Any concerns or potential problems are reviewed and addressed in the daily, Monday through Friday, stand up meetings. This monitoring system is reviewed through the Quality Assurance process and adjusted as necessary according to the results of the findings of the Environmental QA form and any changes will be approved by the Executive Director of Richmond Place.

On June 8, 2011 a QA team meeting was conducted with the Medical Director, the Vice President of Clinical Services for Brookdale Senior Living, the Regional Director of Clinical Services for Brookdale Senior Living, and the community QA team members that include director of nursing, medical

director (a physician), the administrator, director of social services, director of admissions, director of lifestyles programming, the unit coordinators, the MDS nurses, medical records coordinator, business office manager, environmental services team leader, the maintenance director and the dietary manager. During the meeting, Appendices were reviewed and approved as well as revisions to the emergency preparedness and response policy and procedure manual.

On June 8, 2011 the Regional Director of Clinical Services reviewed Brookdale policies and reeducated the administrator on the Quality Assurance overview policy and procedures to assist with quality assurance compliance. The facility Medical Director, Regional Director of Clinical Services and Executive Director of Richmond Place will

receive one (1) time a week updates and notification from the facility Administrator by utilizing the community Quality Assessment and Assurance form for plan of correction and follow up record. These updates will consider QA committee changes and will identify which quality assessment and assurance activities are necessary in order to develop and implement appropriate measures.

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

Elopement drills are conducted monthly, by the social service director, to test the associates competency related to education of supervision and performance for preparation in the event of an

elopement. Associates also participate in fire drills monthly, including each shift quarterly, which addresses exit doors and emergency system disablement of the magnet lock system. All hazard drills are also conducted by the maintenance and staff development coordinator, quarterly, to cover a wide range of possible hazardous situations. These elopement drills, fire drills and all hazard drills are documented and copies are provided to the community director of engineering, and the regional director of maintenance per Brookdale Senior Living oversight requirements. These drills will also be discussed monthly with the Executive Director of Richmond Place by the administrator to discuss any potential concerns related to associate competency and to institute and oversee any corrective action.

On June 5, 2011, the QA team (administrator, director of nursing, staff development coordinator, RN weekend supervisor, social services director, south unit coordinator, north unit coordinator) discussed how to monitor associate competency in evacuation plans, fire safety and emergency response. On June 5, the north unit coordinator developed a monitoring tool, the quality assurance review form to evaluate the effectiveness of associate education to confirm associate competence regarding evacuation plans, fire safety and emergency response. This monitoring of education is completed at least six (6) times per day with one on one or group interviews, seven days a week and is conducted by the administrator, director of nursing, staff development coordinator, RN weekend supervisor, social services

director, south unit coordinator,
north unit coordinator,
healthcare liaison, admissions
coordinator, supplies
coordinator, or MDS nurse. . The
associates were tested both
individually and in groups to
determine level of competency.
Any lack of appropriate
knowledge that is discovered is
immediately addressed with one-
on-one or group re-education by
the individual conducting the
monitoring. Results of the
monitoring are reviewed daily by
the administrator, director of
nursing, staff development
coordinator, RN weekend
supervisor, social services
director; south unit coordinator,
north unit coordinator,
healthcare liaison, admissions
coordinator, supplies
coordinator, maintenance
director, or MDS nurse. This
monitoring system will be
reviewed through the Quality
Assurance process and adjusted

as necessary according to the results of the findings of the quality assurance review form and any changes are approved by the Executive Director of Richmond Place.

Members of the Quality Assurance committee met daily to develop changes and revisions and competencies of data collected from all systemic changes.

Beginning 6/28/11, the Administrator, Director of Nursing and at least three members of management met and will continue to meet with the Medical Director weekly or more often if deemed necessary to review and evaluate the effectiveness of the action plans as described above in order to ensure corrective action is sustained. Adjustments to these schedules can be made with the approval of the medical director, corporate clinical nurse consultant and executive director.

**5. The date that the corrective
action was completed;**

All processes as stated above
provide evidence to show all
corrective action was completed
for F 520 by 7/1/11.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 06/24/2011
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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{K 000}	<p>INITIAL COMMENTS</p> <p>42 CFR 483.70(a)</p> <p>K3 Building: 0101 K6 Plan Approval: 03/08/1991 K7 Survey Under: 2000 Existing K8 SNF Type of Structure: A 1991 one story Type V (000) unprotected construction. The facility is fully sprinklered. The facility has two (2) smoke compartments.</p> <p>An onsite revisit to the abbreviated Life Safety Code Survey (06/06/11) ARO#00016496 was conducted on 06/24/11. It was determined Immediate Jeopardy (IJ) related to ARO#00016496 had been removed at K-38 on 06/18/11 as alleged in the acceptable Allegation of Compliance (AOC) received on 06/20/11. While IJ was removed at K-38 continued non-compliance remained at K-38 at a Scope and Severity (S/S) of an "E". The facility had not developed and implemented an acceptable Plan of Correction (POC), ensured all staff were re-educated on accessible exits, or completed ongoing monitoring of the new evacuation system through the monthly Quality Assurance meeting which includes the Medical Director.</p> <p>The facility continued to be in non-compliance at the non-IJ deficiency, K-48 cited during the Abbreviated Survey (06/06/11) due to the facility had not completed re-education for all staff in regards to the written plan for the protection of all residents and for their evacuation in the event of an emergency. The following findings demonstrate noncompliance:</p>	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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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{K 038}	<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 interview, record review and review of the acceptable Allegation of Compliance (AOC), it was determined Immediate Jeopardy (IJ) identified during the Abbreviated Survey (06/06/11) had been removed related to K38 (Exit access); however, non-compliance continued to exist as the facility had not completed staff education for K38 (emergency procedures during a fire), nor developed and implemented an acceptable Plan of Correction (POC) related to K48 (exit access) and K38 (emergency procedures during a fire). In addition, the facility continued to monitor the newly developed evacuation plan through the Quality Assurance (QA) program to ensure the effectiveness of the Allegation of Compliance (AOC). The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC) received on 06/20/11 revealed the facility sealed the emergency exits leading to the construction site from the outside. After completion of a walkway, one exit was reopened as an evacuation route. In addition, a fence was built to enclose the construction site,</p>	{K 038}			

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{K 038}	<p>Continued From page 2</p> <p>preventing public access to the area. The evacuation plan was revised and new signs were posted to direct staff and residents to a safe area in the event of fire or other emergency. Physical monitoring of the exit around the clock was initiated.</p> <p>Further review of the AOC revealed daily rounds for identification of potential hazards were conducted, utilizing the newly-developed Environment Quality Assurance (QA) Form. The Maintenance Director was conducting four (4) safety rounds daily. Staff re-education of new policies and procedures related to the evacuation plan had been conducted. Facility administration was conducting random competency checks on the new procedures six (6) times daily. Fire, Evacuation, Elopement and Hazard Drills had been conducted on all three (3) shifts. All data collection from daily rounds, random competencies, and analyses of drill responses were reported to daily QA meetings and will be taken to the next monthly QA meeting.</p> <p>The above information was verified through staff interviews and record reviews.</p> <p>Interview with the Administrator, on 06/24/11 at 8:00 PM, revealed facility staff currently on leave or who work on a PRN (as needed) basis had been mailed training materials which included acknowledgement forms. All forms had not been received back by the facility and training would not be completed until those staff members reported for their next assigned shift. Continued interview revealed the Environment Quality Assurance forms, data collected from daily rounds, and competencies would be reviewed at</p>	{K 038}			

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{K 038}	Continued From page 3 the next monthly QA meeting which was scheduled for 07/13/11 and would be attended by the Medical Director.	{K 038}			
{K 048}	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation, interview and review of the facility's policies, it was determined that the facility staff failed to follow proper procedures and/or protocols per the facility's fire safety and evacuation plan. The deficiency affects two (2) of two (2) smoke compartments, ninety (90) residents, nine(9) staff and visitors. On 05/29/11 at 4:00 AM staff was alerted to a fire in resident room #117 by a single room smoke detector sounding. The resident in room #117 was not removed immediately from the room. The buildings fire alarm system was not activated at any time by facility staff. Evacuation routes that were posted in hallways were not correct and did not properly identify were pull stations and fire extinguishers were located. The R.A.C.E. (Rescue, Alarm, Confine, Extinguish) protocols were not utilized per facility's emergency policy and procedure manual. The findings include: Interview on 05/31/11 at 12:54 PM with the facility Administrator and Maintenance Director revealed during review of the Emergency Preparedness and Response Policy and Procedure Manual	{K 048}			

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{K 048}	<p>Continued From page 4</p> <p>(used for employee orientation) that employees are trained to utilize the R.A.C.E. procedure in the event of fire.</p> <p>Copies of the facilities emergency plan were obtained to affirm the findings. The administrator gave a brief summary of the fire event on 05/29/11 and a review of the facility evacuation procedures were discussed. Documents collected from the Administrator include: staff statements, sprinkler inspections, fire alarm inspections, fire drills, and evacuation plan.</p> <p>Interview on 05/31/11 at 1:00 PM with Licensed Practical Nurse in charge of staff development (LPNSD) #1 revealed that she trains all new employees in emergency response which includes: fire, disaster and facility evacuation. Record review revealed that 0.5 hours are spent on each subject.</p> <p>Interview on 05/31/11 at 3:21 PM with State Registered Nursing Aide (SRNA) #1 by phone confirmed her hand written statement given the morning of 05/29/11. The interview revealed SRNA #1 was told (by RN #1) to call the fire department and notify the front nurse's station of the fire. SRNA #1 stated she did not know the telephone number to the North Nurse Station, so she ran approximately (176) feet from room #117 to the North Nurse's Station to notify staff of the fire location. She then ran back from the North Nurse's Station to the South Nurse's Station approximately (262) feet to call the fire department. She notified the fire department via telephone and told the dispatcher there was a fire in the facility. She returned to room #117 where she found the resident in the corridor sitting in a</p>	{K 048}			

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{K 048}	<p>Continued From page 5</p> <p>broda chair . She then proceeded to take the resident to the North Unit. After that she began closing doors to other adjacent rooms. SRNA #1 also stated she had not been trained on what to do in case of fire or emergency.</p> <p>Interview on 05/31/11 at 3:36 PM by phone with SRNA #2 confirmed her hand written statement given the morning of 05/29/2011. The interview revealed SRNA #2 and SRNA #1 were doing paperwork in the lounge area across from South Nurse's Station and heard an alarm sound. She stated they went to investigate along with (RN) #1 and LPN #1 (who were at the South Nurse's Station) they all entered room #117 and saw flames coming from the far side of the bed where a facility bed pillow was on fire. SNRA #2 stated that RN #1 and LPN #1 went to get a fire extinguisher and SRNA #1 went to call the fire department . She then got wet towels from the resident ' s bathroom and put them on the fire, extinguishing it. RN #1 and LPN #1 returned to the room and all three (3) tried to remove the resident and the bed from the room but could not get the bed to move. The resident was then transferred to a broda chair and removed from the room and placed in hallway where SRNA #1 took resident to North Unit smoke compartment. SRNA #2 also stated that she and SRNA #1 were just in room #123 ten (10) minutes before the alarm activated in room #117, which was three (3) doors down from room #117 and did not see anyone in the hallway. SRNA #2 confirmed that she was aware to use the R.A.C.E. protocols. Interview on 06/01/11 at 12:13 PM by phone with Licensed Practical Nurse (LPN) #1, confirmed hand written statement given on the morning of</p>	{K 048}			

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{K 048}	<p>Continued From page 6</p> <p>05/29/11. She also confirmed she tried to locate a fire extinguisher without success. When she returned to room #117 the fire was out and she helped remove the resident from the room. LPN #1 also stated that she closed the room doors as she was going to the South Nursing Station to get wet towels to put in front of the door to room #117. LPN #1 confirmed she was trained to use the R.A.C.E. protocols in the event of fire.</p> <p>Interview on 06/01/2011 at 1:12 PM by phone with Registered Nurse (RN) #1 confirmed information in a hand written statement given on the morning of 05/29/11. Interview confirmed that she knew that the resident should have been removed first but she had been burned at an early age and wanted to put the fire out first. The RN confirmed that she was trained to use R.A.C.E. protocols in the event of fire.</p> <p>Interview on 06/01/11 at 10:30 AM with the Maintenance Director revealed that he conducts the facility fire drills each month and all fire drills are up to date, as required. Further interview with the Maintenance Director confirmed comments that he made on fire drill reports about some staff not knowing what to do during the fire drills. The Maintenance Director also stated that when someone is identified as not knowing what to do, he personally orients that individual, as needed.</p> <p>19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to</p>	{K 048}			

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{K 048}	<p>Continued From page 7</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices.</p> <p>19.7.2 Procedure in Case of Fire.</p> <p>19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and</p>	{K 048}			

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{K 048}	Continued From page 8 effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy ' s fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to firealarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan.	{K 048}			