

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

PRINTED: 10/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/13/2010
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	F 000		
F 282 SS=E	<p>A Recertification/Abbreviated Survey was conducted 10/10/10 through 10/13/10, and a Life Safety Code Survey was conducted 10/11/10. Deficiencies were cited with the highest Scope and Severity of a "F". ARO KY00015415 was substantiated with no deficiencies cited. ARO KY00015416 was substantiated with no deficiencies cited and ARO KY00015418 was substantiated with no deficiencies cited.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services were provided in accordance with each residents' Comprehensive Plan of Care for fourteen (14) of twenty-one (21) sampled residents (Residents #7, #2, #20, #12, #1, #4, #11, #15, #8, #10, #17, and #21) related to providing weekly skin assessments.</p> <p>The findings include:</p> <p>1. Clinical Record review revealed Resident #1 was admitted on 07/13/10 with diagnoses which included Dementia and Parkinson's Disease. In addition, the resident had a history of Cerebral Vascular Accident (Stroke).</p> <p>Review of the Admission MDS assessment dated</p>	F 282	<p>I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating actions.</p> <p>1. The corrective action that took place for the resident found to have been affected by the deficient practice; A weekly skin assessment was completed by a licensed nurse on the following</p>	

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Administrator 11/15/10

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

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F 282	Continued From page 1 07/26/10 revealed Resident #1 was assessed by the facility to have a Stage II pressure ulcer. Review of the RAPS also revealed the presence of a Stage II ulcer. Continued review revealed Resident #1 was at risk for further pressure ulcers due to impaired mobility and bowel and bladder incontinence. Review of the Plan of Care dated 07/26/10 revealed an intervention for weekly skin assessments. Review of the Weekly Skin Assessments revealed no documented evidence Resident #1 was provided a skin assessment, per the Plan of Care between 09/04/10 and 09/19/10 or from 09/25/10 to 10/09/10, periods of fifteen (15) days and fourteen (14) days, respectively. Further review of the Plan of Care revealed the Stage II pressure ulcer was healed on 08/03/10. However, review of the Wound Evaluation Record revealed the area reopened on 08/14/10, was closed on 08/26/10, and reopened again on 09/11/10. Although the wound was evaluated on 09/11/10, there was no documented evidence a full skin assessment was completed at that time, placing the resident at risk for additional unidentified pressure ulcers. Interview with CNA #8 on 10/11/10 at 11:00 AM revealed she was assigned to care for Resident #1 that day. She stated she had assisted the resident to the toilet but had not noticed the pressure area. Continued interview revealed she thought the area was healed. Interview with LPN #4 on 10/11/10 at 11:30 AM revealed she was responsible for the care of Resident #1 that day. The nurse did not know if Resident #1 had a pressure ulcer or not. She	F 282	dates for those residents identified: Resident #7 = 10/11/10, Resident #2 = 10/10/10, Resident #20 = 10/15/10, Resident #12 = 10/12/10, Resident #1 = 10/15/10, Resident #4 = 10/11/10, Resident #11 = 10/15/10, Resident #8 = 10/15/10, Resident #10 = 10/12/10, Resident #17 = 10/12/10. Resident #21 who was admitted on October 7, 2010 was done on 10/14/10. Resident #15 has been discharged from the facility. None of these residents were found to have skin breakdown that had not been previously identified. 2. How the facility addressed how it would identify if other resident's were affected by the deficient practice; A complete review to determine if services were provided in accordance with each resident's Comprehensive Plan of Care was	

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F 282	Continued From page 2 suggested the surveyor "ask the aide."	F 282	completed by 11/15/10 by facility nurse managers.	
	<p>Observation of the skin assessment completed by LPN #1 on 10/12/10 at 3:00 PM revealed an open area on the coccyx which measured 1.1 cm by 1.0 cm. The Nurse described the open area as a Stage II ulcer. She stated the area was closed the last time she saw it, "one day last week".</p> <p>2. Review of Resident #21's medical record revealed the resident was admitted to the facility on 10/07/10 with diagnoses which included Dysphagia and Status Post Gastrostomy Tube Placement. Further record review revealed there was no Minimum Data Set (MDS) Assessment due to the recent admission.</p> <p>Review of the Interim Plan of Care dated 10/07/10 revealed the resident had a feeding tube and the goal stated the resident would tolerate feeding without complications. The interventions included elevating the head of the bed thirty (30) degrees during tube feedings.</p> <p>Observation on 10/13/10 at 4:20 PM revealed Certified Nursing Assistant (CNA) #13 lowered the resident's head of the bed to perform per-care while the tube feeding was infusing. When the surveyor questioned the CNA about the tube feeding infusing while the head of bed was flat, the CNA pushed the button on the tube feeding pump in order to place the tube feeding on hold.</p> <p>Interview on 10/13/10 at 4:40 PM with CNA #13 at 4:40 PM revealed she should not have lowered the head of the bed with the tube feeding infusing.</p> <p>Interview on 10/13/10 at 5:10 PM with the Unit</p>		<p>Appropriate interventions were implemented for individual residents' needs. Since all of the residents have the potential to be affected by the concern of having weekly skin assessments completed, an audit was completed on 10/14/10 of the status of all weekly skin assessments. All resident weekly skin assessments were updated by 10/15/10. Any residents identified as not having a completed skin assessment in the past week had one completed by 10/15/10.</p> <p>3. The measures put into place or systemic change made to insure that the deficient practice will not recur; Charge nurses will implement care plan interventions relating to acute changes of conditions and care plans will then be reviewed and updated by</p>	

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F 282	<p>Continued From page 3</p> <p>Manager of the 200 Hall where Resident #21 resided, revealed the nurse should be asked to stop the tube feeding prior to incontinence care and the head of the bed should not be lowered while tube feeding was infusing due to the risk of aspiration.</p> <p>Continued review of Resident #21's Interim Plan of Care revealed the resident was incontinent of bowel and bladder and was at risk for skin breakdown. The goal stated the resident would establish an individual bowel/ bladder routine and would have no signs and symptoms of skin breakdown. The interventions included monitoring incontinence, utilizing briefs, turning and repositioning every two hours and as needed, and incontinent care as needed.</p> <p>Interview on 10/13/10 at 4:20 PM with the resident's private sitter, revealed she arrived at 10:00 AM and the resident did not receive incontinence care or turning and repositioning after she arrived. She further stated she performed incontinence care for the resident at 1:00 PM, and shortly afterward the resident was checked for incontinence and then assisted to physical therapy by staff. She stated the resident was assisted back to bed after physical therapy and had not been checked for incontinence since 1:00 PM.</p> <p>Observation of peri-care on 10/13/10 at 4:30 PM, after surveyor intervention, revealed the resident's brief was saturated with urine. CNA #13 who was performing peri-care stated the resident's brief was "pretty wet".</p> <p>Further interview with CNA #13 immediately after the peri-care was performed, revealed she had</p>	F 282	<p>the Nurse Manager who will then validate that the intervention is occurring. The weekly skin assessment schedule was revised. An audit tool was initiated by the quality assurance director that requires weekly review of all weekly skin assessments by the facility nurse manager or designee. The licensed nursing staff was reeducated on the facility policy for completion of weekly skin assessments by the staff development coordinator or designee which was completed by 11/4/10.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by; Nurse Manager or designee will monitor that compliance related to implementation of care plan interventions has occurred by review at the weekly quality of care meeting. Completed</p>		

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F 282	<p>Continued From page 4</p> <p>just arrived on the unit at 4:30 PM and the CNA who was assigned to the resident on the previous shift must have "got caught up in showers". The CNA further indicated there was not enough staff at times to ensure the incontinence care was completed every two hours.</p> <p>Interview was attempted with CNA #14 who was assigned to the resident on the previous shift; however, the CNA was unable to be reached.</p> <p>Interview on 10/13/10 at 4:50 PM with Licensed Practical Nurse (LPN) #6, revealed she was assigned to the resident from 7:00 AM until 7:00 PM. She stated she was assigned to twenty or more residents and was unable to do frequent rounds; however, she checked the residents and the rooms for appearance and odors when administering medications and treatments. Further interview, revealed if the resident received incontinence care at 1:00 PM, he/ she should have received incontinence care again at 3:00 PM, and the resident should have been turned and positioned every two hours.</p> <p>3. Review of Resident #7's medical record revealed diagnoses which included Dementia, and Cerebral Vascular Accident. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/12/10 revealed the facility assessed the resident as having both short and long term memory loss, as requiring extensive assistance with transfers, ambulation, and hygiene, and as having incontinence of bowel and bladder.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 03/17/10, revealed the resident was at risk for skin breakdown due to requiring staff assistance for mobility and was at</p>	F 282	<p>auditing tools relating to skin assessments will be reviewed by the quality assurance director or designee once weekly times four (4) weeks then once monthly times three (3) months then as needed thereafter to assist with compliance. Reeducation will be provided as needed by the staff development coordinator or designee.</p> <p>5. The date that the corrective action will be completed; 'ID Prefix Tag' F 282</p>	11/16/10

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F 282	Continued From page 5 risk for Urinary Tract Infections, odor, and soiled clothing-related to incontinence of urine.	F 282		
	<p>Review of the Comprehensive Plan of Care dated 03/29/10 revealed the resident had an alteration in elimination related to incontinence of bowel/bladder. The interventions included checking for incontinence and change if wet/soiled.</p> <p>Observation on 10/11/10 at 8:35 AM, 8:55 AM, 9:15 AM, 9:30 AM, 9:45 AM, 10:00 AM, and 10:20 AM revealed the resident was sitting in a wheelchair in the dayroom. Observation at 10:45 AM and 11:05 AM revealed the resident was in the dining room taking part in an exercise group activity. Observation at 1:15 PM revealed the resident was sitting in a wheelchair in the day room attending an ice cream social. Observation at 1:20 PM revealed the resident was still sitting in a wheelchair in the dayroom.</p> <p>Observation on 10/11/10 at 1:30 PM revealed the resident was transferred from the wheelchair to the bed by two CNA's after surveyor intervention. Observation of peri-care performed by CNA #15 at that time, revealed the residents brief was saturated with urine.</p> <p>Interview on 10/11/10 at 1:45 PM with Certified Nursing Assistant (CNA) #15 who was assigned to the resident, revealed the resident had been sitting up in the wheelchair since 7:00 AM. She further stated, she had toileted the resident sometime between 9:00 AM and 10:00 AM, and the resident should have been toileted again at 12:00 noon. She stated she was passing lunch trays from 12:15 PM until 12:30 PM, and asked the resident if she/he would like to be toileted at 1:00 PM. Continued interview revealed the</p>			

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F 282	<p>Continued From page 6</p> <p>resident refused to be toileted at 1:00 PM and the resident had not been repositioned in the wheelchair since the resident had last received incontinence care between 9:00 AM and 10:00 AM.</p> <p>Interview on 10/13/10 at 7:15 PM with Licensed Practical Nurse (LPN) #8, revealed she was assigned to the resident on 10/11/10 on the day shift. She stated the CNA's were to check and change the residents every few hours, and especially right after lunch. She said she usually asked the aids if they had completed the incontinence care and assisted the aides if needed. She further stated she was unaware Resident #7 had not been checked and changed every two hours on 10/11/10.</p> <p>Further review of the Comprehensive Plan of Care revealed the resident had the potential for impaired skin integrity related to impaired mobility. The interventions included completing skin assessments weekly.</p> <p>Review of the Weekly Skin Assessments revealed there was no documented evidence of weekly skin assessments completed from 08/29/10 until 9/19/10 (twenty-one (21) days), and 9/19/10 until 10/3/10 (fourteen days (14)).</p> <p>4. Review of Resident #2's medical record revealed diagnoses which included Dementia, Malignant Ascites, and Chronic Lymphocytic Leukemia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/20/10 revealed the facility assessed the resident as having both short and long term memory loss, and as having a Stage I Pressure Ulcer.</p> <p>Review of the Resident Assessment Protocol</p>	F 282			

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F 282	Continued From page 7 Summary (RAPS) dated 01/29/10 revealed the resident required staff assistance with mobility related to Malignant Ascites and Chronic Lymphocystic Leukemia. The RAP further stated the risks could include skin breakdown. Review of the Comprehensive Plan of Care dated 02/01/10 revealed the potential for impaired skin integrity related to decreased mobility and a History of a Stage II Pressure Area to the Left Hip. The interventions included weekly skin assessments, and encourage resident from lying on left side. Review of the Weekly Skin Assessments revealed there was no documented evidence of skin assessments completed from 08/22/10 until 09/04/10 (eighteen (18) days) and from 09/04/10 until 09/25/10 (twenty-one (21) days). 5. Review of Resident #20's medical record revealed diagnoses which included Dementia and Parkinson's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/23/10 revealed the facility assessed the resident as having short term memory problems, and requiring extensive assistance with bed mobility, ambulation, transfers. Further review of the MDS revealed the facility assessed the resident as having incontinence of bladder. Review of the Resident Assessment Protocol Summary (RAPS) dated 01/14/10 revealed the resident required staff assistance with mobility due to Osteoarthritis and Parkinson's Disease. Further review of the RAPS revealed the risks of decreased mobility included skin breakdown. Review of the Comprehensive Plan of Care dated	F 282			

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F 282	Continued From page 8 01/14/10 revealed the resident had the potential for impaired skin integrity related to decreased mobility and incontinence of bladder. The interventions included weekly skin assessments. Review of the Weekly Skin Assessments revealed there was no documented evidence of skin assessments completed from 08/30/10 until 09/13/10 (fourteen (14) days later). 6. Review of Resident #8's clinical record revealed diagnoses which include Pernicious Anemia, Difficulty Walking, and Muscle Weakness - General. A review of Resident #8's current Plan of Care dated 12/16/09 included an intervention of weekly skin assessments. Resident #8's Skin assessments were reviewed for the months of 08/10, 09/10, and 10/10. There was no documented evidence skin assessments were provided for the week of 08/01/10 to 08/07/10, as well as 08/15/10 to 08/21/10, 08/22/10 to 08/28/10, 08/29/10 to 09/04/10, and 09/05/10 to 09/11/10. Also, the record had no documented evidence an assessment was completed for the week of 09/28/10 to 10/02/10, per the Plan of Care. 7. Review of Resident #10's clinical record revealed diagnoses which included Fractured Humerus, Muscle Weakness, and Osteoporosis. A review of Resident #10's current Plan of Care included an intervention for weekly skin assessments. Resident #10's skin assessments were reviewed for the months of 08/10, 09/10, and 10/10. Per the review there was no documented evidence skin assessments were provided, per the Plan of Care, the first three weeks in 08/10, as well as for the week of 09/05/10 to 09/11/10	F 282			

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F 282	Continued From page 9 8. Review of Resident #17's clinical record revealed diagnoses which included Type II Diabetes Mellitus without Complication, Muscle Weakness - Generalized, and Difficulty in Walking. A review of Resident #17's Plan of Care included an intervention for weekly skin assessments to be provided. Review of Resident #17's skin assessments revealed no documented evidence the resident was provided skin assessments, per the Plan of Care, for the weeks of 08/08/10 to 08/14/10. 9. Review of Resident #12's medical record revealed diagnoses which included Diabetes Mellitus, Left Hip Fracture, Humerus Fracture and Ankle Fracture. Review of the Annual Minimum Data Set (MDS) Assessment dated 08/17/10 revealed the resident required limited assistance with bed mobility, transfers and ambulation. Review of the Resident Assessment Protocol Summary (RAPS) dated 08/17/10 revealed the resident required staff assistance with mobility related to the diagnosis of a history of a Left Hip Fracture, Humerus Fracture and Ankle Fracture; Osteoporosis and Left Shoulder Pain, and incontinence of bowel and bladder. Further review of the RAP revealed complications could include skin breakdown. Review of the Comprehensive Plan of Care dated 08/27/10 revealed the resident had the potential for impaired skin integrity related to decreased mobility, incontinence of bowel and bladder, and a diagnosis of Diabetes Mellitus. The interventions included performing skin assessments once a week.	F 282			

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F 282	<p>Continued From page 10</p> <p>Review of the Weekly Skin Assessment revealed a skin assessment was completed on 08/03/10. However, there was no documented evidence the resident was provided a skin assessment until 08/17/10, fourteen (14) days after the assessment on 08/03/10.</p> <p>10. Review of the Clinical Record revealed Resident #11 was admitted on 07/21/10 with diagnoses which included Hypertension, Osteoporosis, Dementia and Depression. Review of the Admission MDS Assessment dated 07/29/10 revealed the facility assessed the resident as having no pressure ulcer at that time.</p> <p>Review of the Plan of Care dated 07/30/10 revealed Resident #11 was at risk for impaired skin integrity related to decreased mobility. Continued review revealed an intervention to perform a complete skin assessment and record weekly.</p> <p>Review of the Weekly Skin Assessments revealed skin assessments were completed five (5) times during a 10-week period, on 07/25/10, 08/08/10, 08/29/10, 09/19/10 and 10/02/10.</p> <p>No skin assessment was observed during the survey due to the resident's agitation and combativeness with staff. In addition, the resident became upset with surveyor, yelling "get out, get out."</p> <p>11. Review of the closed Clinical Record revealed Resident #15 was admitted on 05/07/10 and discharged on 06/26/10. Diagnoses included Dementia, Urinary Tract Infection, and Clostridium Difficile Infection of the gastrointestinal tract.</p>	F 282			

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F 282	Continued From page 11 Review of the RAPS dated 05/19/10 revealed Resident #15 was assessed by the facility as being at risk for pressure ulcers due to decreased bed mobility, incontinence and bedfast state. Review of the Care Plan dated 05/19/10 revealed Resident #15 had the potential for impaired skin integrity related to decreased mobility and bowel and bladder incontinence with Clostridium Difficile infection. Interventions included the following: perform complete skin assessment weekly. Review of the Weekly Skin Assessments revealed no documented evidence a skin assessment was completed on Resident #15 for the two-week period between 05/11/10 and 05/25/10. Additionally, there was no evidence a skin assessment was provided from 05/27/10 to 06/06/10 (nine days). 12. Clinical Record review revealed Resident #4 was admitted on 05/10/10 with diagnoses which included Spinal Cord Compression with Paraplegia, Hypertension, and Depression. Review of the Annual MDS Assessment dated 05/18/10 revealed the facility assessed Resident #4 as having no pressure ulcers. Review of the RAPS of the same date revealed the resident was admitted with a red blanchable area on her coccyx. The resident was considered high risk for "unavoidable skin breakdown" due to immobility and disease process of the spinal cord compression. Review of the Quarterly MDS Assessment dated 08/10/10 revealed the area on the coccyx had progressed to a Stage IV pressure ulcer.	F 282		

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F 282	<p>Continued From page 12</p> <p>Review of the Care Plan dated 05/18/10, and updated 08/10/10, revealed interventions for both potential and actual "unavoidable" impairment in skin integrity. Continued review revealed the intervention to perform a complete skin assessment and document weekly.</p> <p>Review of the Weekly Skin Assessments revealed no documented evidence a skin assessment was completed for the two-week period between 09/20/10 and 10/04/10. Although weekly documented measurements of the ulcer on the coccyx were available, there was no evidence the resident was assessed, per the Care Plan, for the development of new ulcers.</p> <p>Review of Wound Evaluation Records revealed the ulcer had decreased from 2.0 cm x 0.8 cm on 08/13/10 to 1.2 cm x 0.2 cm on 10/7/10. Interview with the family of Resident #4 on 10/10/10 at 4:30 PM revealed they were very actively involved in the resident's care and care planning on a daily basis. Both the resident's spouse and daughter expressed being very pleased with the healing of the resident's ulcer thus far. As the resident's dressing was not due to be changed for three (3) days, and based on the family's satisfaction with the healing, the ulcer was not observed by the suryeyor.</p> <p>Interview with LPN #2 on 10/12/10 at 3:35 revealed all staged wounds should be measured every Thursday. She stated all residents should have a complete weekly skin assessment regardless of whether an open wound was present. Continued interview revealed the nurse thought someone monitored compliance regarding the timely completion of skin assessments, but she was not sure who had that</p>	F 282			

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F 282	Continued From page 13 responsibility. She further stated the Unit Coordinator had recently resigned her position and her replacement just began her duties "this week." Interview with the DON, on 10/13/10 at 5:55 PM, revealed she knew there was a problem getting new staff trained on all the documentation forms/skin assessments. Further interview revealed she felt recent high turnover in nursing staff led to a lack of consistency. The DON stated she believed the facility had good outcomes in the prevention and treatment of pressure ulcers, even though the skin assessments were not always completed timely.	F 282	F 314 1. The corrective action that took place for the resident found to have been affected by the deficient practice; A weekly skin assessment was completed by a licensed nurse on Resident #1 on 10/15/10. No skin breakdown was found that had not been previously identified and was receiving treatment. A wound measurement of the open area that had been previously identified was completed on 10/21/10 showing progression of healing. Wound measurements on 10/28/10 identified area as healed. The resident was discharged on 10/29/10. A weekly skin assessment was completed by a licensed nurse on Resident #2 on 10/10/10. No skin breakdown was identified.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure necessary services to promote healing, prevent infection, and prevent new sores from developing for two of twenty-one (21) sampled residents (Resident #1 and #2). Resident #1 and #2 were identified by the facility to be at risk for the development of skin breakdown. However,	F 314		

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F 314	Continued From page 14 the facility failed to ensure staff conducted weekly assessments of these residents' skin condition. The findings include: 1. Clinical Record review revealed Resident #1 was admitted on 07/13/10 with diagnoses which included Dementia and Parkinson's Disease. In addition, the resident had a history of Cerebral Vascular Accident (Stroke). The Admission MDS Assessment, dated 07/26/10, was reviewed and revealed the facility had assessed Resident #1 as having a Stage II pressure ulcer. Review of the RAPS revealed the presence of a Stage II ulcer. Continued review revealed the facility had identified that Resident #1 was at risk for further pressure ulcers related to impaired mobility and bowel and bladder incontinence. Review of the Comprehensive Plan of Care, dated 07/26/10, revealed the facility had noted an intervention regarding Resident #1 was to be provided a skin assessment on a weekly basis. Review of the Weekly Skin Assessments revealed no documented evidence Resident #1's skin was assessed between 09/04/10 and 09/19/10 or from 09/25/10 to 10/09/10 (periods of fifteen (15) days and fourteen (14) days, respectively), per the Comprehensive Plan of Care. Further review of the Comprehensive Plan of Care revealed the Stage II pressure ulcer was healed on 08/03/10. However, review of the Wound Evaluation Record revealed the area	F 314	2. How the facility addressed how it would identify if other resident's were affected by the deficient practice; Since all of the residents have the potential to be affected by this concern, an audit was completed on 10/14/10 of all weekly skin assessment status. All resident weekly skin assessments were updated by 10/15/10. Any residents identified, had a weekly skin assessment completed by 10/15/10. All identified interventions were implemented on individualized residents as appropriate. 3. The measures put into place or systemic change made to insure that the deficient practice will not recur; The skin assessment schedule was revised. An auditing tool was created to use to audit that residents had had their weekly skin	

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F 314	<p>Continued From page 15</p> <p>reopened on 08/14/10, was closed on 08/26/10, and reopened again on 09/11/10. Although the wound was evaluated on 09/11/10, there was no documented evidence a full skin assessment was done at that time, placing the resident at risk for additional unidentified pressure ulcers.</p> <p>CNA #8 was interviewed on 10/11/10 at 11:00 AM and revealed she was assigned to care for Resident #1 on 10/11/10. The aide stated the resident was able to toilet independently with assistance from the wheelchair to the toilet. CNA #8 stated she had not specifically looked at the coccyx area while the resident was toileting today (meaning 10/11/10), but thought the area was healed.</p> <p>LPN #4 was interviewed on 10/11/10 at 11:30 AM and stated she was responsible for the care of Resident #1 that day. LPN #4 stated Resident #'s skin assessments were due to be completed every Saturday, on day shift. This Nurse stated that the Nurse who was assigned to the resident on Saturdays was to complete the assessment. LPN #4 indicated she was unaware if Resident #1 had a pressure ulcer or not and suggested the surveyor "ask the aide."</p> <p>Further review of the Wound Evaluation Record, dated 09/28/10, revealed Resident #1 had an open area on the coccyx which measured 0.2 cm x 0.1 cm. Continued review revealed no documented evidence of the subsequent wound evaluation, due on 10/07/10.</p> <p>Interview with LPN #1 on 10/12/10 at 3:10 PM revealed she was assigned to care for Resident #1 on 10/07/10. She stated she was sure she had evaluated the ulcer but could not say why it</p>	F 314	<p>assessments completed which will be completed by the nurse managers or designee. Wound measurements sheets will also be reviewed at this time to assure they have been completed weekly. At the time of the weekly skin assessment, all appropriate interventions will be implemented on an individualized resident need. Weekly measurements of all residents who currently have open areas will be done by the Unit Manager or designee with a copy of these measurements given to the Director of Nursing. The Director of Nursing will keep a weekly log of residents who currently have pressure ulcers. The licensed nursing staff were re-inserviced by the Staff Development Director on the facility policy for completion of weekly skin assessments,</p>		

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F 314	<p>Continued From page 16</p> <p>was not documented. LPN #1 stated she recalled the area and it "looked like a scratch the last time she saw it." Continued interview revealed she believed if the skin on the coccyx had been an open area, she would have documented this. In addition, LPN #1 stated the facility had changed wound evaluation forms about that time and she thought she may have started to document on the old form (there was a date of 10/07 documented but no other information) and changed to the new form. However, the new form could not be located.</p> <p>Observation of the skin assessment completed by LPN #1 on 10/12/10 at 3:00 PM revealed an open area on the coccyx which measured 1.1 cm by 1.0 cm. The nurse described the open area as a Stage II ulcer.</p> <p>2. Review of Resident #2's clinical record revealed diagnoses which included Dementia, Malignant Ascites, and Chronic Lymphocytic Leukemia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/20/10 revealed the facility assessed the resident as having both short and long term memory loss, and as having a Stage I Pressure Ulcer.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 01/29/10 revealed the resident required staff assistance with mobility secondary to Malignant Ascites and Chronic Lymphocytic Leukemia. The RAPS further stated the risks and complications could include skin breakdown.</p> <p>Review of the Physician's Orders dated 10/10 revealed orders for Barrier Cream as needed, pressure redistribution mattress and a pressure</p>	F 314	<p>procedure to follow when an open area is identified, completion of the wound measurement sheet and facility protocol for weekly wound measurement of pressure ulcers which was completed by 11/4/10.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by; Completed auditing tools will be reviewed by the Quality Assurance Director or designee weekly x 4 weeks, monthly x 3 months, then, as needed, thereafter, to assist with compliance. Re-education or re-inservicing will be scheduled, as needed with the Staff Development Director. The Quality Assurance designee will audit the treatment sheets to assure that any residents that have an identified pressure area are having measurements</p>	

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F 314	Continued From page 17 relieving device in the wheelchair.	F 314	measurements documented on the	
F 315 SS=D	<p>Observation of the resident on 10/10/10 at 5:00 PM revealed the resident was in the bed lying on an air mattress.</p> <p>Review of the Comprehensive Plan of Care dated 02/01/10 revealed the resident had the potential for impaired skin integrity related to decreased mobility and a History of a Stage II Pressure Area to the Left Hip. The interventions included weekly skin assessments, and encourage resident from lying on the left side.</p> <p>Review of the Weekly Skin Assessments revealed there was no documented evidence of skin assessments completed from 08/22/10 until 09/04/10 (eighteen (18) days) and from 09/04/10 until 09/25/10 (twenty-one (21) days).</p> <p>Interview on 10/13/10 at 5:55 PM with the Director of Nursing revealed there had been a high turnover of staff recently and it was difficult getting everyone trained on all the forms/skin assessments. She stated there was a lack of consistency among all nursing staff.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p>	F 315	<p>wound measurement tool used by the facility on a weekly basis. This will be completed once (1) weekly for four (4), and then once (1) monthly for three (3) months and as needed, thereafter to assist with compliance. Monitored results will be reported and discussed by the director of nursing or designee monthly at the quality assurance meeting for review of compliance until the committee is confident that the systems are adequate.</p> <p>5. The date that the corrective action will be completed; 'ID Prefix Tag' F314</p>	11/16/10

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F 315	Continued From page 18	F 315	F 315		
	<p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents received appropriate care and services related to urinary incontinence for two of twenty-one (21) sampled residents (Resident #7 and #21).</p> <p>The findings include:</p> <p>1. Review of Resident #21's clinical record revealed the resident was admitted to the facility on 10/07/10 with diagnoses which included Right Sided Pontine Infarct. Further record review revealed there was no Minimum Data Set (MDS) Assessment due to the recent admission.</p> <p>Review of Resident #21's Interim Plan of Care revealed the resident was incontinent of bowel and bladder. The goal stated the resident would establish an individual bowel/ bladder routine. The interventions included monitoring incontinence, utilizing briefs, and incontinent care as needed.</p> <p>Interview on 10/13/10 at 4:20 PM with Resident #21's private sitter, revealed she arrived at 10:00 AM. She stated she performed incontinence care for the resident at 1:00 PM when she realized staff had not been in to check the resident for incontinence since she arrived. She stated the staff came in to check on the resident after she had performed the incontinence care and assisted the resident to physical therapy. Continued interview revealed the resident was</p>		<p>1. The corrective action that took place for the resident found to have been affected by the deficient practice; Based on the bladder assessment, pattern assessment, history and resident's risks, a comprehensive careplan was established for Resident #21 identifying care plan interventions for his incontinence. Resident #21 C.N.A. careplan was updated to reflect that he is on a check and change program. He has had a history of Urinary Tract Infections but has not had one since admitted to the facility. Nursing staff was re-educated on the correct procedure regarding performing perineal care on a male resident to prevent infection on which was completed on 11/4/10. It was identified that Resident #7 had an</p>		

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F 315	Continued From page 19 assisted back to bed after physical therapy and had not been checked for incontinence since 1:00 PM. Observation of peri-care on 10/13/10 at 4:30 PM, after surveyor intervention, revealed the resident's brief was saturated with urine. CNA #13 who was performing peri-care stated the resident's brief was "pretty wet". Further observation revealed the CNA wiped the resident's penis and scrotum with a wet wipe and failed to pull back the foreskin to cleanse the penis. After surveyor intervention, the CNA pulled back the foreskin of the penis and a large amount of secretions was noted on the shaft of the penis. Continued interview with CNA #13 immediately after the peri-care was performed, revealed she had just arrived on the unit at 4:30 PM and the CNA who was assigned to the resident on the previous shift must have "got caught up in showers". CNA #13 indicated there was not enough staff at times to ensure the incontinence care was completed every two hours. Phone interview was attempted with CNA #14 who was assigned to the resident on the previous shift; however, the CNA was unable to be reached. Interview on 10/13/10 at 4:50 PM with Licensed Practical Nurse (LPN) #8, revealed she was assigned to Resident #21 from 7:00 AM until 7:00 PM. She stated she was assigned to twenty or more residents and was unable to do frequent rounds; however, she checked the residents and the rooms when administering medications and treatments. Continued interview, revealed if the resident received incontinence care at 1:00 PM,	F 315	unsuccessful trial on a scheduled toileting program and was placed on a check and change program on 7/31/10. Nursing staff were re-educated on the incontinence plan for Resident #21 and Resident #7 and the facility's protocol regarding checking and changing residents per policy. The re-education was completed on 11/4/10 by the staff development coordinator. Licensed nursing staff will be responsible to monitor residents on a check and change program during their shift to assist with compliance that the facility's policy is being followed.	

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F 315	<p>Continued From page 20</p> <p>he/ she should have received Incontinence care again at 3:00 PM. Further Interview revealed the staff were aware the sitter was not responsible for performing the residents Incontinence care.</p> <p>2. Review of Resident #7's clinical record revealed diagnoses which included Dementia with Behavioral Disturbance, and Cerebral Vascular Accident. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/12/10 revealed the facility assessed the resident as having both short and long term memory loss, as requiring extensive assistance with transfers and hygiene, and as having Incontinence of bowel and bladder.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 03/17/10, revealed the resident required staff assistance for mobility and was at risk for Urinary Tract Infections, odor, and soiled clothing related to Incontinence of urine.</p> <p>Review of the Comprehensive Plan of Care dated 03/29/10 revealed the resident had an alteration in elimination secondary to Incontinence of bowel/bladder. The interventions included checking for Incontinence and performing Incontinence care if soiled or wet.</p> <p>Observation on 10/11/10 at 8:35 AM, 8:55 AM, 9:15 AM, 9:30 AM, 9:45 AM, 10:00 AM, and 10:20 AM revealed the resident was sitting in a high back wheelchair in the dayroom. Observation at 10:45 AM and 11:05 AM revealed the resident was in the dining room sitting in a wheelchair taking part in an exercise group activity. Observation at 1:15 PM and 1:20 PM revealed the resident was sitting in a wheelchair in the day room participating in an ice cream social.</p>	F 315	<p>2. How the facility addressed how it would identify if other resident's were affected by the deficient practice; Comprehensive care plans were reviewed by the nurse management team by 11/15/10 to determine if appropriate treatment and services to prevent urinary tract infections; restore bladder function, as possible; and, to ensure residents were not catheterized without a medical diagnosis. Appropriate interventions were implemented for individual residents' needs. C.N.A. careplans were reviewed and updated as needed, to assist with identifying residents' incontinent needs. Nursing staff were reeducated on the facility's protocol regarding checking and changing residents in a timely fashion, prevention of urinary tract infections and</p>	

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 C 10/13/2010
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 315	<p>Continued From page 21</p> <p>Observation on 10/11/10 at 1:30 PM revealed the resident was transferred from the wheelchair to the bed by two CNAs per the instructions of Registered Nurse #1 after surveyor intervention. Observation of peri-care performed by CNA #15 at that time, revealed the residents brief was saturated with urine.</p> <p>Interview on 10/11/10 at 1:45 PM with Certified Nursing Assistant (CNA) #15 who was assigned to the resident, revealed the resident had been up in the wheelchair since 7:00 AM. She stated, she had tolleted the resident sometime between 9:00 AM and 10:00 AM, and the resident should have been tolleted again at 12:00 noon. She further stated she was passing lunch trays from 12:15 PM until 12:30 PM, and asked the resident if she/he would like to be tolleted at 1:00 PM. Further interview revealed the resident refused to be tolleted at 1:00 PM and the resident had not been checked or changed since the resident had last received incontinence care between 9:00 AM and 10:00 AM.</p> <p>Interview on 10/13/10 at 7:16 PM with Licensed Practical Nurse (LPN) #8, revealed she was assigned to the resident on 10/11/10 on the day shift. She stated she usually asked the aids if they had completed the incontinence care and assisted the aides if needed. Continued interview revealed the CNAs were to check and change the residents every few hours. However, the LPN was unaware Resident #7 had not been checked and changed every two hours on 10/11/10.</p> <p>Interview on 10/13/10 at 11:15 AM with the Director of Nursing (DON) revealed the residents should be checked for the need for incontinence care every two hours.</p>	F 315	<p>measures to restore bladder function, as possible; and, to ensure residents were not catheterized without a medical diagnosis. Each licensed nurse and CNA had this information reviewed with them prior to 11/15/10 by the staff development coordinator or designee. Any nursing associate that had not been scheduled to work by 11/15/10 received the education via mail for their review. Licensed nursing staff will be responsible to monitor residents on a check and change program, scheduled toileting programs and catheter care during their shift to assist with compliance that the facility's policy is being followed. All residents could potentially be at risk for urinary tract infection if peri-care were performed incorrectly. Nursing staff</p>		

was educated on the correct procedure regarding performing perineal care on a male resident in order to prevent infection on which was completed by 11/4/10 by the staff development coordinator. C.N.A.s were instructed to notify charge nurses of residents that presented with signs or symptoms that could indicate a urinary tract infection. Licensed nursing staff will be responsible to monitor SRNA performance to assist with compliance that the facility's procedure is being followed.

3. The measures put into place or systemic change made to insure that the deficient practice will not recur; Residents will be assessed for bladder function on admission, pattern assessment completed and treatment and services appropriate to restore bladder functions, as

possible through the comprehensive care plan process. Charge nurses will implement interventions relating to acute changes of condition relating to urinary status and care plans will then be reviewed and updated by the Nurse Managers who will then validate that the interventions are occurring. Non-licensed nursing staff received inservicing relating to peri-care of residents, prevention of urinary tract infections, following the C.N.A. careplan relating to incontinence and the facility protocol for checking and changing residents in a timely fashion followed by competency check-offs with return demonstrations which were completed by 11/4/10 by the facility nurse managers. All new hires will have perineal care competency check-offs noted in their file.

Licensed nurses were re-educated on their responsibility relating to supervising C.N.A. performance relating to checking and changing residents which was completed on or before 11/4/10 by the staff development coordinator. Non-licensed staff will make rounds with the oncoming shift on their assignment. Licensed staff will make walking rounds on their unit with the oncoming shift to assist with compliance.

4. The facility plans to monitor its performance to ensure that solutions are sustained by; Each resident who has had an acute change of condition relating to urinary status will be reviewed weekly at the quality of care meeting. The director of nursing or designee will make observation rounds on a minimum of four (4) residents on a check and change program and for

appropriate treatment and services to prevent urinary tract infections; restore bladder function, as possible; and, to ensure residents were not catheterized without a medical diagnosis. Any discrepancies noted will be addressed with the responsible C.N.A at the time of the review. Staff development or designee will re-educate or re-educate, if needed. These observation rounds will be documented on a auditing tool developed by the facility three (3) times weekly for two (2) weeks, once (1) weekly for four (4) weeks and once monthly for three (3) months to assist with compliance. QA designee will track and trend results and report and discuss at the monthly Quality Assurance committee meeting for three (3) months or continue

thereafter until the
committee is confident
that the systems in place
are adequate.

5. The date that the
corrective action will be
completed; 'ID Prefix Tag'

11/16/10

F 315

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NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509	
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F 328 SS=D	483.26(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents received proper treatment and care for enteral fluids for one (1) of twenty-one (21) sampled residents (Resident #21). The findings include: Review of Resident #21's medical record revealed the resident was admitted to the facility on 10/07/10 with diagnoses which included Dysphagia and Status Post Gastrostomy Tube Placement. Further record review revealed there was no Minimum Data Set (MDS) Assessment due to the recent admission. Review of the Physician's Orders dated 10/11/10 revealed Orders for gastrostomy tube feedings of Jevity 1.5 at seventy-five milliliter's (75 ml's) per hour via pump for twenty-two (22) hours. Further review of the Physician's Orders dated 10/07/10 revealed orders to ensure the head of the bed	F 328	F 328 1. The corrective action that took place for the resident found to have been affected by the deficient practice; The head of the bed of Resident #21 was raised to a 30 degree angle and a marking was placed on the bed to identify where it should be kept at all times to prevent aspiration while the tube feeding is infusing. 2. How the facility addressed how it would identify if other resident's were affected by the deficient practice; Since all residents with tube feedings have the potential to be affected by the specific practice cited, all residents with tube feedings had the same type of marking made to their bed frame to allow staff to visualize the 30 degree head of the bed marking at all times. In addition to the tube	

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F 328	Continued From page 23 was elevated at thirty (30) degrees for tube feedings. Review of the Interim Plan of Care dated 10/07/10 revealed the resident had a feeding tube and the goal stated the resident would tolerate feeding without complications. The interventions included elevating the head of the bed 30 degrees during tube feedings. Observation on 10/13/10 at 4:20 PM revealed Certified Nursing Assistant (CNA) #13 lowered the resident's head of the bed to perform per-care while the tube feeding was infusing. When the surveyor questioned the CNA about the tube feeding infusing while the head of bed was flat, the CNA pushed the button on the tube feeding pump in order to place the tube feeding on hold. Interview on 10/13/10 at 4:40 PM with CNA #13 revealed she should have asked the nurse to place the tube feeding on hold prior to performing incontinence care. She further stated she should not have lowered the head of the bed with the tube feeding infusing. Interview on 10/13/10 at 4:50 PM with Licensed Practical Nurse (LPN) #6 revealed she was assigned to Resident #21 and the CNAs were not to operate the tube feeding pump, but were to ask her to stop the tube feedings or place the tube feedings on hold when needed. Interview on 10/13/10 at 5:10 PM with the Unit Manager of the 200 Hall where Resident #21 resided, revealed the nurse should be asked to stop the tube feeding prior to incontinence care and the head of the bed should not be lowered	F 328	feeding services the treatment and care was reviewed for all residents receiving special services by the nurse management team, which was completed by 11/15/10. Appropriate interventions were implemented for individual residents' needs. Nursing staff were given additional re education on care related to special services. Each licensed nurse and CNA had this information reviewed with them prior to 11/15/10 by the staff development coordinator or designee. Any nursing associate that had not been scheduled to work by 11/15/10 received the education via mail for their review. 3. The measures put into place or systemic change made to insure that the deficient practice will not recur; Charge nurses will implement care plan interventions relating to	

acute changes of condition of residents that have special services for individualized treatment and care. Care plans will then be reviewed and updated by the Nurse Manager who will then validate the treatment and care is occurring. To address tube feeding procedures specifically the nursing staff was re educated regarding the importance of keeping the head of the bed elevated at 30 degrees while the tube feeding is infusing to prevent the potential of aspiration. Each licensed nurse and CNA had this information reviewed with them prior to 11/5/10 by the staff development coordinator. Any nursing associate that had not been scheduled to work by 11/4/10 received the education via mail for their review. Non-licensed staff was instructed not to touch the tube- feeding pump. If

the pump was placed on Hold by the nurse, the resident 's head of the bed would be able to be lowered to safely give care, then, elevated to the bed frame marking and the pump restarted by the nurse. Charge nurses will validate that Head of Bed is elevated at 30 degrees during their shift and document this on each shift.

4. **The facility plans to monitor its performance to ensure that solutions are sustained by;**
A quality assurance audit tool was developed and implemented to specifically review care related to special services. Using the audit tool the director of nursing or designee will monitor that residents who are receiving special services are receiving proper treatment and care. The audit tool requires special attention to C.N.A's

giving care to a tube-feeding resident and keeping the head of the bed elevated to the appropriate degree while tube feedings are infusing. This monitoring tool will be completed three (3) times a week times two (2) weeks, once (1) weekly times four (4) weeks and once (1) monthly times three (3) months to assist with compliance. Re-education or re-in-servicing will be given by the Staff Development nurse or designee as indicated by these results. Monitoring results will be reported and discussed by the director of nursing at the monthly Quality Assurance committee meeting times three (3) months and thereafter until the committee is confident the systems related to monitoring of special care services are in place and adequate.

5. The date that the
corrective action will be
completed; 'ID Prefix Tag' 11/16/10
F328

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NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509	
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F 328	Continued From page 24 while tube feeding was infusing due to the risk of aspiration.	F 328	F 371	
F 371 SS=F	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure sanitary conditions in the kitchen. The Kitchen floor was visibly dirty and omelettes inside the refrigerator which was unlabeled and undated. The findings include: Observation during the initial tour of the kitchen on 10/10/10 at 10:15 AM revealed the kitchen floor was visibly dirty, unswept and sticky. Interview with the Assistant Kitchen Manager on 10/10/10 at 10:15 AM revealed there were only four (4) staff persons working in the kitchen and they did not mop the floor because they were rushed to finish breakfast and start lunch. Interview with the Kitchen Aide on 10/10/10 at 10:20 AM revealed the floor was not mopped	F 371	1) The corrective action that took place for the resident found to have been affected by the deficient practice; No residents were found to have been affected by the deficient practice. The kitchen floor was cleaned on 10/10/10 after it was identified. The omelet in the refrigerator was discarded immediately after it was identified as being stored in the refrigerator. 2) How the facility addressed how it would identify if other resident's were affected by the deficient practice; The Dietary Assistant manager a complete audit of the kitchen for sanitation rounds on 10/12/10 to ensure that no other sanitation concerns were identified. The Dietary Manager or designee reeducated all cooks and all dietary aides on 10/20/10 to ensure no residents would be affected by the deficient practice in the future. The reeducation included: cleaning/sanitizing, Food stored properly with date and label in the kitchen and no personal food items stored in the reach in	

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NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509		
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F 371	Continued From page 25 because there was not enough time or staff on the weekend. She said they usually mopped after breakfast, before they started preparing lunch. Further observation during initial tour of the kitchen on 10/10/10 at 10:25 AM revealed a plastic bag of omelettes inside the refrigerator which was unlabeled and undated. Interview with the Cook's Assistant on 10/10/10 at 10:25 AM revealed the omelettes were not to be in the refrigerator and she quickly removed them. Further interview on 10/13/10 at 4:00 PM with the same Cook's Assistant revealed the omelettes were taken off the tray line as leftovers and she put them in the refrigerator because she intended to take them home to her eat. Interview with the Dietary/Kitchen Manager on 10/13/10 at 5:00 PM revealed placing the unlabeled, undated bag of omelettes in the refrigerator to take home later was against her rules.	F 371	cooler and walk in cooler. A separate reeducation was conducted on 10/20/10 informing the staff of the requirement for maintaining a clean and sanitary floor immediately following each meal service. 3) The measures put into place or systemic change made to insure that the deficient practice will not recur; A schedule has been developed assigning specific associates floor cleaning responsibility for each meal for the entire month. The Assistant Dietary Manager or designee will conduct walking rounds five (5) days per week for four (4) weeks to identify any potential sanitation or infection control issues in the dietary department. The sanitation rounds will continue once (1) weekly for two (2) months and then monthly thereafter to insure compliance of potential sanitation or infection control issues in dietary.		

4) The facility plans to monitor its performance to ensure that solutions are sustained by; The Dietary Manager or designee will conduct an audit once (1) weekly to identify any potential sanitation and infection control issues for eight (8) weeks. After eight (8) weeks, the Dietary Manager or designee will conduct the same audit once every two (2) weeks for eight (8) weeks. After sixteen (16) weeks, the Dietary Manager or designee will conduct the audit once (1) monthly thereafter for compliance. The Dietary Manager or designee will in-service all dietary staff on sanitation and infection control measures quarterly thereafter for compliance.

5) The date that the corrective action will be completed; 'ID 11/16/10 prefix Tag' F 371.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185483	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2010
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NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
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K 000	INITIAL COMMENTS	K 000		
K 052 SS=F	<p>A Life Safety Code survey was initiated and completed on 10/11/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the fire alarm system was maintained according to NFPA standards. The deficiency affected all staff and residents.</p> <p>The findings include:</p> <p>Review of the facility's quarterly reports, related to smoke detectors, on 10/11/2010 at 1:44 PM, revealed the facility had no record of sensitivity</p>	K 052	<p>I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.</p> <p>K 052</p> <p>1. The corrective action that took place for the resident found to have been affected by the deficient practice; To ensure that each smoke</p>	

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NOV - 5 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 11/5/10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 052	Continued From page 1 testing for the smoke detectors. Sensitivity testing for smoke detectors must be conducted bi-annually to ensure smoke detectors are able to sense smoke during a fire. The observation was confirmed with the Maintenance Director. Interview on 10/11/2010 at 1:44 PM, with the Maintenance Director, revealed the last sensitivity test for the smoke detectors was conducted on 06/09/08. Reference: NFPA 72 (1999 edition) 7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:	K 052	detector is within its listed and marked sensitivity range the facility initiated the smoke detectors test for sensitivity on the day it was discovered 10/11/10 and this inspection was completed on 10/12/10. The facility utilized a licensed fire and safety company (EDI) to inspect the system. 2. How the facility addressed how it would identify if other resident's were affected by the deficient practice; The facility maintenance team leader and campus maintenance director reviewed other required testing timelines for the purpose of compliance of NFPA 101 life safety code standards to ensure no other testing requirements were out of compliance.	

3. **The measures put into place or systemic change made to insure that the deficient practice will not recur;**
The campus maintenance director will maintain records of the fire alarm system and audit compliance monthly on inspection reports to verify timely inspections occur. The facility maintenance team leader or designee will exit with any contractors who provide work in the facility. This exit will include an overview of the work provided and timeline requirements addressing the need for review for compliance with local, state and federal requirements.
4. **The facility plans to monitor its performance to ensure that solutions are sustained by;** The facility administrator or

designee will review LSC record keeping requirements as outlined in the NFPA 101 life Safety Code standards bi-annually. The Quality Assurance Committee will review for compliance annually to assist with compliance of this standard.

5. **The date that the corrective action will be completed; 'ID Prefix Tag' K 052**

11/4/10

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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	
K 052	Continued From page 2 (1) Calibrated test method (2) Manufacturer 's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced: Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. NFPA 101 LIFE SAFETY CODE STANDARD	K 052			
K 062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	K 062 1. The corrective action that took place for the resident found to have been affected by the deficient practice; The facility had received regular inspections of the automatic sprinkler systems as required, but had not been made aware that the calibration or replacement of sprinkler head gauges was required every (5) years		

by our contracted inspection company Brown Sprinkler. Once the facility became aware of the requirement the replacement of the gauges service was performed by Brown Sprinkler company on 10/25/10 .

2. **How the facility addressed how it would identify if other resident's were affected by the deficient practice;**The facility maintenance team leader and campus maintenance director reviewed other required testing timelines for the purpose of compliance of NFPA 101 life safety code standards to ensure no other testing requirements were out of compliance.
3. **The measures put into place or systemic change made to insure that the deficient practice will not recur;** The campus maintenance director

will maintain records of the sprinkler system and audit compliance monthly on inspection reports to verify timely inspections occur. The facility maintenance team leader or designee will exit with any contractors who provide work in the facility. This exit will include an overview of the work provided and timeline requirements addressing the need for review for compliance with local, state and federal requirements.

4. The facility plans to monitor its performance to ensure that solutions are sustained by; The facility administrator or designee will review LSC record keeping requirements as outlined in the NFPA 101 life Safety Code standards bi-annually. The Quality Assurance Committee will review for compliance annually to assist with

compliance of this
standard.

5. **The date that the
corrective action will
be completed; 'ID
Prefix Tag' K 062**

11/4/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186483	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2010
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
K 069	Continued From page 4	K 069	K 069 1. The corrective action that took place for the resident found to have been affected by the deficient practice; No resident were found to have been affected by the noted signage requirement. Fire Extinguisher Signage was immediately purchased and placed above the extinguisher on 10/11/10 by the maintenance team leader. The signage included information on proper use of extinguisher.	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire extinguishers had the proper signage according to NFPA standards. The deficiency affected eleven (11) staff in the Kitchen area. The findings include: Observation on 10/11/2010 at 9:30 AM, revealed the "K" type fire extinguisher in the Kitchen area did not have the proper signage. Extinguishers must have the proper signage in order for staff, located in the kitchen area, to be reminded of the proper use of the fire extinguisher. The observation was confirmed with the Maintenance Director. Interview on 10/11/2010 at 9:30 AM, with the Maintenance Director, revealed the K type fire extinguisher had never had any type of signage.			
K 072 SS=D	Reference: NFPA 96 (1998 edition) 7-2.1.1 A placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area. NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	2. How the facility addressed how it would identify if other resident's were affected by the deficient practice; Fire Extinguisher Signage was immediately purchased and placed above the extinguisher on 10/11/10 by the maintenance team leader. An inservice was conducted with all	

kitchen staff by the maintenance team leader and staff development coordinator on 11/4/10 as an effort to highlight the signage and its purpose.

- 3. The measures put into place or systemic change made to insure that the deficient practice will not recur;** The maintenance team leader will inspect for signage in this location during the monthly rounds of auditing fire extinguishers. The facility maintenance team leader or designee will exit with any contractors who provide work in the facility. This exit will include an overview of the work provided and discussion of signage requirements addressing the need for review for compliance with local, state and federal requirements.

4. **The facility plans to monitor its performance to ensure that solutions are sustained by; The facility administrator or designee will review LSC record keeping requirements as outlined in the NFPA 101 life Safety Code standards bi-annually, which will include appropriate signage in the community is maintained to remind staff of proper usage of fire extinguishers. The Quality Assurance Committee will review for compliance annually to assist with compliance of this standard.**
5. **The date that the corrective action will be completed; 'ID Prefix Tag' K 069**

11/4/10

DEPARTMENT OF HEALTH AND HUMAN 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 10/11/2010
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
K 072	Continued From page 5	K 072	K 072 1. The corrective action that took place for the resident found to have been affected by the deficient practice; The facility administrative staff assessed all equipment that was located in evacuation corridors. The equipment which was all portable and considered necessary for nursing staff to have access for efficient patient care needs was immediately removed from the hallways and placed in residents' living room areas. The facility, prior to the sited deficiency, provided the life safety code officer documented inservicing material, from two previous occasions, signed by facility employees with acknowledgment of the egress consideration.	
	<p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridors were free and clear of obstructions and available for instant use in an emergency, according to NFPA standards. The deficiency affected approximately twenty-four (24) residents.</p> <p>The findings include:</p> <p>Observation on 10/11/2010 at the 200 Hall Nurse's station at 1:12 PM, revealed three (3) medicine carts were unattended and not in use inside the corridor. Further observation on 10/11/2010 at 3:15 PM revealed the three (3) medicine carts were still unattended and not in use. Wheeled items such as medicine carts, linen carts, and patient lifts are not to be left unattended and unused in the corridors due to blocking the way of egress in an emergency. Wheeled items must be returned to the storage location after use. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/11/2010 at 3:15 PM, with 200 Hall Nurse, revealed the carts were last used at the 9:00 AM medication pass, and the three (3) medication carts had been there since the completion of the medication pass.</p> <p>Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185483	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2010
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NAME OF PROVIDER OR SUPPLIER RICHMOND PLACE REHABILITATION AND HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 073 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>No furnishings or decorations of highly flammable character are used: 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure decorations used in the facility were flame retardant, according to NFPA standards. The deficiency affected approximately twenty-four (24) residents.</p> <p>The findings include:</p> <p>Observation on 10/11/2010 at 1:30 PM, revealed decorations (wooden wreaths) on resident room doors located in the facility. The resident rooms were Room number 112, 116, 117, 118, 119, 121, 123, 222, 223, 224, and 225. Combustible decorations used in a health care facility must be flame retardant to prevent the spread of fire. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/11/2010 at 1:30 PM, with the Maintenance Director, reveals the facility does not treat decorations to make them flame retardant.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or</p>	K 073	<p>K 073</p> <p>1. The corrective action that took place for the resident found to have been affected by the deficient practice; No resident were found to have been affected by the noted non-flame retardant decorations in the building. Flame retardant chemicals were ordered on 10/11/10 and received on 10/13/10. All rooms indicated 112, 116, 117, 118, 119, 121, 123, 222, 223, 224, and 225 were all treated with flame retardant chemical.</p> <p>2. How the facility addressed how it would identify if other resident's were affected by the deficient practice; A flame retardant chemical was used on other decorations throughout the facility in an effort to address all non-flame retardant decorations. An</p>	

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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	
K 073	Continued From page 7 spread is not present.	K 073	<p>inservice was conducted with staff by the maintenance team leader and staff development coordinator which was completed on 11/4/10 as an effort to highlight the flame retardant requirement.</p> <p>3. The measures put into place or systemic change made to insure that the deficient practice will not recur; The maintenance team leader will inspect for for non-flame retardant decorations' during the monthly rounds of auditing fire extinguishers. Re-inservicing education will be provided and documented with each monthly fire drill from 11/4/10 forward.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by; The</p>		

facility administrator or designee will review the fire drill and LSC record keeping requirements as outlined in the NFPA 101 life Safety Code (2000 edition) standards bi-annually, The Quality Assurance Committee will review for compliance annually to assist with compliance of this standard.

5. The date that the corrective action will be completed; 'ID Prefix Tag' K 073

11/4/10