

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

PRINTED: 06/17/2011  
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 06/06/2011
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	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey was initiated on 05/31/11 and concluded on 06/06/11 investigating ARO#KY00016489 and ARO#KY00016521. ARO#KY00016521 was unsubstantiated with unrelated deficiencies cited. ARO#KY00016489 was substantiated with deficiency cited.</p> <p>Based on observation, interview, record review, Evacuation Plan review, and Grading Permit review, it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as is possible; and each resident received adequate supervision to prevent accidents. The facility failed to ensure the Evacuation Plan was updated to reflect necessary changes to fire exits related to construction. The facility failed to ensure all accessible exits had a safe path to a public way. The facility failed to ensure staff was trained and knowledgeable regarding which fire exits were appropriate for evacuation during construction and required monitoring to prevent accidents. On 12/28/10, the facility began construction by digging a 25 foot retention pond affecting the safe path to public way from the two south exits of the facility. On 05/29/11 a fire was identified in room 117; however, staff interviews revealed they would have evacuated the residents through the south exits as they did not have knowledge of any changes in the evacuation plan nor had they been instructed to monitor the exits to ensure the safety of all residents. The two south fire exits, one located nearest room 117 and near the Physical Therapy (PT) department led to an uneven rocky and dirt surface and the other exit, located near resident rooms 230 and 231, led to a ditch which was approximately twelve (12) feet</p>	F 000	<p>Please accept this response as Richmond Place Rehabilitation and Health Center's (hereinafter referred to as "RPRHC") plan of correction for the statement of deficiencies issued on June 17, 2011, which was identified by the Kentucky Cabinet for Health Services during an abbreviated/ partial extended survey conducted May 31, 2011 through June 6, 2011, involving CFR 483.25, CFR 483.70, and CFR 483.75. RPRHC is committed to compliance with applicable legal and regulatory standards. Likewise, RPRHC recognizes and respects the important role federal and state agencies play in ensuring compliance with such standards. RPRHC respectfully submits this Plan of Correction as required by applicable law. However, the completion and submission of this Plan of Correction does not constitute an admission of any of the alleged non-compliance (and/or any underlying act or failure to act which is or maybe alleged to have caused the alleged non-compliance) identified by the Kentucky Cabinet for Health and Family Services Office of Inspector General or waive or release any defenses that RPRHC may have with respect to the alleged non-compliance and/or any underlying act or failure to act that may be directly or indirectly related thereto, both now or hereafter acquired.</p> <p>The facility alleges that effective July 1, 2011, the facility environment is as free of accident hazards as possible, and that each supervision to prevent accidents. All evacuation exits have a safe path to a public way. The emergency evacuation plan has been updated to eliminate one exit door due to construction. Associates have been educated regarding use of exits during construction to provide routes for safe evacuation. The facility is being maintained to protect the health and safety of residents, associates and the public.</p> <p>The following actions were taken to remove the alleged deficient practice for the residents and associates who were identified during the survey, as well as all residents and associates who could have been affected:</p>	

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

TITLE

(X6) DATE

*[Signature]* Administrator 7/16/11

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 60 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 000	Continued From page 1 deep. Both south fire exit doors remained accessible to all staff, residents and visitors with no staff supervising the two (2) exit doors despite the facility's knowledge there was not a safe path to a public way due to construction. These two south fire exits were the nearest exit, per the facility's evacuation plan, for fifty-five (55) of the facility's eight-four (84) residents. Immediate Jeopardy was identified on 06/02/11, was determined to exist on 12/28/10 and is ongoing.  Deficiencies cited were CFR 483.25 Quality of Care, F-323 at a S/S of a "K"; 483.70, F-454 at a S/S of a "K"; CFR 483.75, F-490 and F-520 at a S/S of a "K". Substandard Quality of Care was identified at CFR 483.25, F-323.	F 000	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 plan were reviewed. 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.	
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 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.  The findings include:	F 281	281 2. How will the facility identify other residents having the potential to be affected by the same deficient practice?  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	

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F 281	<p>Continued From page 2</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 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</p>	F 281	<p>charge nurse/CNA 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 was 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 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</p>	

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 1<sup>st</sup>, 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 F281 by 7/1/11.

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F 281	Continued From page 3 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.  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.	F 281			
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F-323 Supervision to Prevent Accidents  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.		

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F 323	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, Evacuation Plan review, and Grading Permit review, it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as is possible; and each resident received adequate supervision to prevent accidents. The facility failed to ensure the Evacuation Plan was updated to reflect necessary changes to fire exits related to construction. The facility failed to ensure all accessible exits had a safe path to a public way. The facility failed to ensure staff was trained and knowledgeable regarding which fire exits were appropriate for evacuation during construction and required monitoring to prevent accidents. On 12/28/10, the facility began construction by digging a 25 foot retention pond affecting the safe path to public way from the two south exits of the facility. On 05/29/11 a fire was identified in room 117; however, staff interviews revealed they would have evacuated the residents through the south exits as they did not have knowledge of any changes in the evacuation plan nor had they been instructed to monitor the exits to ensure the safety of all residents. The two south fire exits, one located nearest room 117 and near the Physical Therapy (PT) department led to an uneven rocky and dirt surface and the other exit, located near resident rooms 230 and 231, led to a ditch which was approximately twelve (12) feet deep. Both south fire exit doors remained accessible to all staff, residents and visitors with no staff supervising the two (2) exit doors despite the facility's knowledge there was not a safe path to a public way due to construction. These two south fire exits were the nearest exit, per the	F 323	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.  1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?  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		

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F 323	<p>Continued From page 5</p> <p>facility's evacuation plan, for fifty-five (55) of the facility's eight-four (84) residents.</p> <p>Based on the above findings, it was determined the facility's failure to have an effective system in place to supervise two accessible fire exits to ensure residents had a safe path for exit to a public way this failure is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy and Substandard Quality of Care was identified on 06/02/11 and was determined to exist on 12/28/10. (Refer to K38 Life Safety Code)</p> <p>The findings include:</p> <p>Review of the facility's Safety and Disaster Preparedness Introduction, Fire Safety and Evacuation Plan In Case of Fire (used for employee In-service), not dated, revealed staff were to remove residents to the nearest fire exit or beyond the nearest fire wall. The plan detailed two south fire exits. One south fire exit was located near the Physical Therapy (PT) department and was designated as the nearest exit for sixteen (16) residents of the facility. The other exit was located near resident rooms 230 and 231 and was designated as the nearest exit for thirty-nine (39) residents.</p> <p>Interview, on 06/02/11 at 10:00 AM with the Construction Superintendent, revealed construction began on 12/28/10 which affected the two (2) south exits of the nursing facility. Review of the Grading Permit revealed the local government granted the grading permit on 12/28/10. Continued interview, on 06/07/11 at</p>	F 323	<p>that lead to the construction site and secondly, initiate an immediate fire watch.</p> <p>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 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.</p> <p>On June 1, 2011 immediately following sealing the exits and</p>	

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F 323	<p>Continued From page 6</p> <p>3:30 PM with the Construction Superintendent, revealed a twenty-five (25) foot deep hole was dug outside the south exit door nearest to resident rooms 230 and 231 on 12/28/10. He further indicated he was unaware of exit discharge needing to lead to a public way.</p> <p>Review of the facility's Evacuallon plan revealed there was no evidence the facility had changed the evacuation plan related to the construction which began 12/28/10.</p> <p>Per Interview with Registered Nurse (RN) #1, on 06/01/11 at 12:10 PM, a fire was identified in room 117 on 05/29/11. The RN stated if evacuation were necessary, staff would have taken residents out the two (2) south exits detailing the exits were near the PT department and rooms 230 and 231.</p> <p>Observation, on 05/31/11 at 2:00 PM, revealed the south fire exit located near the PT department led to an uneven rocky and dirt surface. Further observation revealed the south fire exit located nearest to resident rooms 230 and 231 led to a ditch, which was approximately twelve (12) feet deep within eight (8) feet from the exit door.</p> <p>Observation, on 05/31/11 3:15 PM, revealed both exit doors remained accessible to all staff, residents, and visitors.</p> <p>Observation, on 06/01/11 at 2:00 PM, revealed no staff was supervising the exit door nearest PT or the exit door nearest resident rooms 230 and 231. Continued observations, at 3:00 PM and 4:00 PM, revealed no staff was supervising the two (2) exits. Observations, on 06/02/11 at 9:00 AM, 11:00 AM and 2:00 PM, revealed no staff</p>	F 323	<p>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</p>	

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F 323	<p>Continued From page 7</p> <p>was supervising the exit door nearest PT or the exit door nearest resident rooms 230 and 231.</p> <p>Interview with SRNA #2, on 06/03/11 at 5:38 PM, revealed she had received no training to monitor doors related to residents accessing and exiting, in case of an emergency. Interview with SRNA #2, on 06/01/11 at 6:36 PM, revealed if the fire on 05/29/11 had become a situation in which evacuation of residents was required, staff would have used the exits nearest the PT department and resident rooms 230 and 231. Interview with Licensed Practical Nurse (LPN) #3, on 06/1/11 at 6:53 PM, revealed if residents from the South unit had to be evacuated they would evacuate through the exit door nearest to the South Nurse's station which is nearest to resident rooms 230 and 231.</p> <p>Interview with the Administrator, on 06/03/11 at 7:00 PM, revealed the precautions taken to ensure the two (2) exits in the back of the facility were not used included the wander guard system, signs which stated it was a construction area do not use and key pads which had a code that no one except maintenance knew the code to operate. However, interview with SRNA #11, on 06/06/11 at 5:35 PM, revealed he had observed two (2) residents, Resident #3 and #6, attempt to exit the building through the front door by pushing down on the panic bar which caused the door to alarm. The facility Social Services Director identified eight (8) residents requiring supervision due to cognitive deficits, lack of safety awareness, risk for elopement and who the facility had applied wander guard bracelets to assist in supervision. Continued interview with the Administrator revealed he acknowledged that despite the wander guard alarming system being</p>	F 323	<p>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.</p> <p>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 returning to work by the staff development coordinator, social services director, RN weekend supervisor, administrator, or director of nursing.</p>	

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 1<sup>st</sup>, 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 9<sup>th</sup> 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.

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 returning to work.

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 be 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  
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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 06/06/2011
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 323	Continued From page 8 installed on these doors, both doors would unlock and open if the doors' panic bars had been engaged for fifteen (15) seconds.	F 323			
F 387 SS=D	The facility was unable to provide documented evidence they had developed and implemented an emergency evacuation plan specific to address the two (2) south exits involved in construction. Furthermore, there was no evidence the facility had trained staff regarding the appropriate, safe use of these two (2) exits or monitoring of the exits due to construction.  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.	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		

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F 387	<p>Continued From page 9 The findings include:</p> <p>1. Record review revealed the facility admitted Resident #5 on 12/17/09 with diagnoses which included Senile Dementia with behaviors, Muscle Weakness, Fracture of the Humerus, Alzheimer's Disease and Psychosis.</p> <p>Review of Resident #5's medical record on 06/06/11 revealed the last documented Physician's visit was 03/14/11.</p> <p>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.</p> <p>Review of Resident #6's medical record revealed the last documented Physician's visit was 03/07/11.</p> <p>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.</p> <p>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</p>	F 387	<p>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.</p> <p>3. What systemic changes will be made to ensure that the deficient practice will not recur?</p> <p>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</p>	

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;**

F387 was corrected by 7/1/11 All processes as stated above provide evidence to show all corrective action was completed by 7/1/11.

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F 387	Continued From page 10	F 387		
F 441 SS=E	<p>facility's policy.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441</p> <p>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.</p> <p>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.</p> <p>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 are not maintained. However other residents were</p>	

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F 441	Continued From page 11  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.  The findings include:  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.	F 441	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.  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 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 and was 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 F441 by 7/1/11.

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F 441	Continued From page 12	F 441			
F 454 SS=K	<p>2. Observation of per-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, and with the same gloves performed pericare of the vaginal area.</p> <p>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.</p> <p>483.70 LIFE SAFETY FROM FIRE</p> <p>The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, emergency evacuation plan review and Grading Permit review, it was determined the facility failed ensure compliance with the 2000 Edition of the Life Safety Code of the national Fire Protection Associate and failed to ensure all emergency fire exits accessible to staff, residents, and visitors had a safe path to a public way in the event of an emergency. On 12/28/10, construction began by digging a 25 foot retention pond which affected the safe path to the public way from the two south exits of the facility. On 05/29/11 a fire was identified in room 117. The two south exits were designated, per the facility's emergency evacuation plan, as the nearest exit for Fifty-five (55) of the facility's eighty-four (84) residents of the facility; however, the south exit located near</p>	F 454	<p><b>F-454 Physical Environment</b> <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.</p> <p>1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</p>		

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F 454	<p>Continued From page 13</p> <p>the Physical Therapy (PT) Department led to an uneven rocky and dirt surface and the south exit located near resident rooms 230 and 231 led to a ditch, which was approximately twelve (12) foot deep and eight (8) feet wide.</p> <p>Based on the above findings, It was determined the facility's failure to provide a safe path to a public way from accessible fire exits has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 06/02/11 and was determined to exist on 12/28/10. (Refer to LSC K38, CMS 2667L Event ID 1VJJ21)</p> <p>The findings include:</p> <p>Review of the facility's Safety and Disaster Preparedness Introduction, Fire Safety and Evacuation Plan In Case of Fire (used for staff inservice), not dated, revealed staff was to evacuate residents to the nearest fire exit or beyond the nearest fire wall. The plan detailed two south fire exits. One exit, located near resident rooms 230 and 231, was designated as the nearest exit for thirty-nine (39) residents. The other south fire exit, located near the PT department, was designated as the nearest exit for sixteen (16) residents of the facility.</p> <p>Interview, on 06/02/11 at 10:00 AM with the Construction Superintendent, revealed construction began on 12/28/10 which affected the nursing facility's two (2) south exits. Review of the Grading Permit revealed authorization to begin construction was received by the local government on 12/28/10. He further indicated he</p>	F 454	<p>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.</p> <p>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</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
F 454	<p>Continued From page 14</p> <p>was unaware of exit discharge needing to lead to a public way.</p> <p>Observation, on 05/31/11 at 2:00 PM, revealed the fire exit located nearest to the PT department led to an uneven rocky and dirt surface. The fire exit located near resident rooms 230 and 231 led to a ditch, which was approximately twelve (12) feet deep within eight (8) feet from the exit door. Observation, on 05/31/11 3:15 PM, revealed both exit doors remained accessible to all staff, residents, and visitors.</p> <p>Interview with Registered Nurse (RN) #1, on 06/01/11 at 12:10 PM, stated if the fire which occurred on 05/29/11 required resident evacuation then they would have evacuated through the emergency exit nearest resident rooms 230 and 231 or the door nearest the PT department.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #2, on 06/01/11 at 6:36 PM, revealed if the fire on 05/29/11 had become a situation in which evacuation of residents was required staff would have used the exits nearest the PT department and resident rooms 230 and 231.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 06/1/11 at 6:53 PM, revealed if residents from the South unit had to be evacuated they would evacuate through the exit door near the South Nurse's station which is nearest to resident rooms 230 and 231.</p> <p>The facility was unable to provide documented evidence they ensured all accessible fire exits had a safe path leading to a public way and had</p>	F 454	<p>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 prior to returning to work.</p> <p>As part of the evacuation route education the new and current evacuation plan was posted on June 2, 2011 by the</p>	

social service director and the weekend supervisor on each hall indicating the appropriate emergency exit to use for each resident hall (Appendix 1). 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 prior to returning to work.

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 Appendix 3). On June 1<sup>st</sup>, an

in-service with all members of the Angel round manager assignment (Appendix 4) 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 (Appendix 4). 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 9<sup>th</sup> 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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F 454	Continued From page 15 developed and implemented an emergency evacuation plan which addressed the two (2) south exits involved in construction.	F 454	<b>F-490 Administration</b> 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.  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 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		
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  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.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to be administered in a manner which enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being of each resident, related to provision of care in accordance with acceptable Standards of Practice. The facility administration failed to ensure compliance with Life Safety Code requirements and failed to ensure the residents' environment remained as free of accident hazards as is possible and each resident receives adequate supervision to prevent accidents. On 12/28/10, the facility had construction begin which affected the two south fire exit doors. The facility failed to ensure the south fire exit doors had a safe path to a public way; one exit led to a 12 foot deep retention pond and the other exit had an uneven rocky dirt surface. Both exit doors were accessible to residents, staff, and visitors with no monitoring or supervision of the exit doors. These two south fire exits were the nearest exit, per the facility's evacuation plan, for fifty-five (55)	F 490			

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F 490	<p>Continued From page 16 of the facility's eight-four (84) residents.</p> <p>Based on the above findings it was determined the facility's failure to have an effective system in place to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently had caused was was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care was identified on 06/02/11 and determined to exist on 12/28/10 and is ongoing.</p> <p>The findings include:</p> <p>Review of the facility's Safety and Disaster Preparedness Introduction, Fire Safety and Evacuation Plan in Case of Fire (used for employee in-service), not dated, revealed staff was to remove residents to the nearest fire exit or beyond the nearest fire wall.</p> <p>Observation, on 05/31/11 at 2:00 PM, revealed the south fire exit located nearest to the Physical Therapy (PT) Department led to an uneven rocky and dirt surface and the exit located nearest to resident rooms 230 and 231 led to a ditch, which was approximately twelve (12) feet deep. Observations revealed both exit doors remained accessible to all staff, residents and visitors. There were no staff observed supervising the two (2) exit doors despite the facility's knowledge there was not a safe path to a public way due to construction. (Refer to F-323 and F-454 and to LSC K38, CMS 2567L Event ID 1VJJ21)</p> <p>There was no evidence Administration had evaluated and/or revised the evacuation plan related to the south fire exits having no safe path</p>	F 490	<p>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</p>	

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F 490	<p>Continued From page 17</p> <p>to a public way and no evident the facility trained staff on any necessary changes identified to ensure unsafe exits were not utilized. The Administrator did consult with the Construction Superintendent who told him the exits were okay, even after the State Building Inspector on 04/07/11 had stated the exits needed to be clear and accessible to residents, staff, and visitors. (Refer to F-323 and F-518).</p> <p>Interview with the Administrator, on 06/01/11 at 4:25 PM, revealed the Quality Assurance Committee meeting was held on 05/11/11 in which a new fire education and plan developed by the corporate office had been discussed; however, the facility was unable to provide evidence of action taken to address the south fire exits being unsafe for exit in the event of an emergency requiring evacuation nor to ensure monitoring of the doors as they remained accessible despite the unsafe path due to construction. (Refer to F-520).</p> <p>Interview on 06/02/2011 at 11:30 AM with the facility Administrator revealed when asked why he did not ensure the south exits were accessible to a public way he stated the Construction Superintendent had told him the exits were okay. This was confirmed by the Construction Superintendent on 06/02/2011 at 10:00 AM who also revealed that he was unaware that these exits required a safe path to a public way. Continued interview with the Administrator, on 06/06/11 at 4:25 PM, revealed no problems had previously been identified with the fire safety and evacuation plan; however, the State Building Inspector on 04/07/11 had stated the exits needed to be clear and accessible to residents,</p>	F 490	<p>beginning on June 1, 2011 and was completed June 30, 2011.</p> <p>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.</p> <p>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,</p>	

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.

**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 F490 by 7/1/11.

# SURVEY FORM COVER SHEET

**FACILITY NAME:** Pathways inc. Hillcrest Hall    **FACILITY ADDRESS:** 209 Davis Road

Mount Sterling, Kentucky  
40353

**ADMINISTRATOR:** Todd Trumbore    **PHONE:** (859) 498-6574

**LEVEL OF CARE:** AODE/ RES    **DATE OF SURVEY:** July 13, 2011

**DAYS AND HOURS OF OPERATION:**

LICENSURE	CERTIFICATION	ARO#
X		

DEFICIENCIES? YES (LIST TAGS)	NO X



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F 490	Continued From page 18 staff, and visitors. He further stated he felt the precautions taken by the facility were appropriate to keep Individuals from exiting the two (2) back exit doors despite the observations of the exit doors during the survey revealed no staff were monitoring the exits which remained accessible to all staff, residents, and visitors.	F 490		
F 518 SS=K	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 observations, interview, in-service record review, review of the facility's Fire Safety and Evacuation Plan, it was determined the facility failed to update their emergency evacuation plan related to ongoing construction and failed to train all employees in emergency procedures related to safety and evacuations. The facility failed to ensure staff was knowledgeable and competent regarding the facility's fire procedures. On 12/28/10, construction began outside two south fire exits which affected the safe path to a public way. The facility failed to update the emergency evacuation plan related to the south exits and failed to provide training to staff to regarding using the south exits as a means of evacuation during the construction phase. Additionally, on 05/29/11 a fire was identified in room 117. Facility staff failed to follow the fire procedures.	F 518	<b>F-518 Employee Training for Emergencies</b> 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 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,	

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F 518	<p>Continued From page 19</p> <p>Based on the above findings it was determined the facility's failure to have update the emergency evacuation plan and failed to have an effective system in place to ensure employees were adequately trained in emergency procedures related to fire, which has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 06/02/11 and was determined to exist on 12/28/10.</p> <p>The findings include:</p> <p>1. Review of the facility's Evacuation Plan in the Case of Fire revealed staff was to evacuate residents to the nearest fire exit or beyond the nearest fire wall. The plan detailed two south fire exits: one located near the Physical Therapy (PT) Department which was detailed as the nearest exit for sixteen (16) residents and one located near rooms 230 and 231 which was detailed as the nearest exit for thirty-nine (39) residents.</p> <p>Interview with the Construction Superintendent, on 06/02/11 at 10:00 AM, revealed they began construction on 12/28/10 by digging a 25 foot retention pond which affected the safe path leading to a public way from the two south exits.</p> <p>Review of the Evacuation Plan revealed no documented evidence the facility had changed the plan to address the south fire exit doors. Additionally, there was no documented evidence that the facility had provided in-service training regarding the fire exits and any change in the Evacuation Plan after construction began.</p> <p>On 05/31/11 at 2:40 PM, observation revealed the</p>	F 518	<p>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</p>	

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F 518	<p>Continued From page 20</p> <p>south fire exit located by the Physical Therapy (PT) department led to an uneven rocky and dirt surface and the south fire exit located near resident rooms 230 and 231 led to a ditch, which was approximately twelve (12) feet deep within eight (8) feet from the exit door. Observation, on 05/31/11 3:15 PM, revealed both south fire exit doors remained accessible to all staff, residents, and visitors.</p> <p>Registered Nurse (RN) #1 interview, on 06/01/11 at 12:10 PM, revealed if there had been a situation in which residents needed to be evacuated they would have evacuated through the emergency exit nearest resident rooms 230 and 231 or the door nearest the PT department. Interview with SRNA #2, on 06/01/11 at 6:36 PM, revealed if this they had to evacuate residents staff would have used the exits nearest the PT department and resident rooms 230 and 231. Interview with Licensed Practical Nurse (LPN) #3, on 06/1/11 at 6:53 PM, revealed if residents from the South unit had to be evacuated, they would evacuate through the exit door nearest to the South Nurses Station which is nearest to resident rooms 230 and 231.</p> <p>Interview with the Administrator, on 06/03/11 at 7:00 PM, revealed the facility took the following precautions related to construction and the two (2) south exit doors: a sign was posted on the doors stating it was a construction area do not use, the south exit doors had a wander guard alarming system, both doors had a key pad that only the maintenance knew the code. The Administrator indicated the sign posted on the doors was the only addition after construction began. The Administrator acknowledged that</p>	F 518	<p>social service director beginning on June 1, 2011 and was completed June 30, 2011.</p> <p>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.</p> <p>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</p>	

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F 518	<p>Continued From page 21</p> <p>both south exit doors would unlock and open if the doors' panic bars had been engaged for fifteen (15) seconds. The facility was unable to provide documented evidence they had developed and implemented an emergency evacuation plan specific to address the two (2) south exits affected by the construction. Furthermore, there was no evidence the facility had trained staff regarding the appropriate, safe use of these two (2) south exits due to construction.</p> <p>2. Review of the facility's "Fire Safety and Evacuation Plan In Case of Fire," not dated, revealed the steps to be taken upon the discovery of a fire included; "remove any resident in immediate danger; pull the nearest fire alarm if it has not been activated and make certain that 911 or the Fire/Police department has been called, which should be done by the North Station Charge Nurse....".</p> <p>Interview with Registered Nurse (RN) #1, on 06/01/11 at 12:10 PM, revealed staff heard a fire alarm sounding on 05/29/11 and proceeded to check in resident rooms. RN #1 revealed she was the first staff person to room 117 and noted a fire next to the head of Resident #1's bed. She further indicated she ran to get the fire extinguisher after locating where the fire was and by the time she returned to the room a State Registered Nursing Assistant (SRNA) had put the fire out with wet towels. She indicated after the fire was extinguished the resident was removed from the room because of the smoke. She further stated the fire alarm was not pulled and they should have pulled the fire alarm. Interview with SRNA #1, on 06/01/11 at 7:35 PM, revealed</p>	F 518	<p>service director and the weekend supervisor on each hall indicating the appropriate emergency exit to use for each resident hall (Appendix 1).</p> <p>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.</p> <p>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</p>	

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F 518	<p>Continued From page 22</p> <p>she entered the room after RN #1, saw the fire and went to get wet towels from the resident's bathroom, placed the towels on the fire which was on a pillow on an activities bag on the floor near the head of the bed. She stated no one pulled the fire alarm. She indicated the resident was removed from the room after the fire was extinguished.</p> <p>Interview on 06/01/11 at 12:15 PM with Licensed Practical Nurse (LPN) # 1 revealed she was present and working on the South Unit on the day the fire occurred. She indicated RN #1, SRNA #1 and #2 and herself went to locate which room the alarm was coming from and RN #1 was the first to Resident #1's room, room 117 which RN #1 then yelled fire and went to get the fire extinguisher. She further stated SRNA #1 entered the room and SRNA #2, LPN #3 and herself proceeded to shut other residents' doors to their rooms. She indicated when they got back to room 117 SRNA #1 had smothered the fire out with wet towels and then SRNA #1 and RN #1 transferred the resident to a Broda chair to remove him/her from the smokey room, to the front lobby. She stated no one pulled the fire alarm.</p> <p>Interview with RN #2, on 06/01/11 at 6:30 PM, revealed she was present in the facility the day the fire happened on the South Unit; however, she was working on the North Unit. She indicated the staff from the back yelled down the hall to her to let her know there was a fire and she called the Fire Department. Interview with SRNA #2 on 06/01/11 at 6:36 PM revealed she was working on 05/29/11 at the time when the fire took place. She stated she was instructed to tell</p>	F 518	<p>associates are trained appropriately on safe evacuation procedures, safe exits and monitoring of exits to prevent unsafe egress.</p> <p>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</p> <p>A comprehensive test was developed to test associate</p>		

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F 518	<p>Continued From page 23</p> <p>the North Nurses Station and call 911. She said she ran towards the North Nurses Station and was met halfway down the hall by a Nurse whom she told about the fire. She then stated she ran back to the South Nurses Station to call 911. She further indicated no one pulled the fire alarm.</p> <p>Interview with the Administrator, on 06/01/11 at 12:10 PM, revealed the facility trained employees related to fire and emergency procedures using the Life Safety Code requirements. He further stated an In-service was provided upon hire "Safety and Disaster Preparedness Introduction, Fire Safety and Evacuation Plan in Case of Fire," and the Fire Department came to the facility to demonstrate the use of fire extinguishers and alarms every six (6) months. He further indicated the last In-services done by the Fire Department were in June 2010 and December 2010. However interview, on 06/06/11 at 7:46 AM, with SRNA #13 revealed she had worked at the facility for nine (9) months and had never been a part of a fire drill or had any training with the Fire Department. Interview, on 06/06/11 at 7:55 AM, with SRNA #14 revealed she had worked at the facility for two (2) years and had never received training from the Fire Department. Interview with SRNA #10, on 06/08/11 at 5:25 PM, revealed she had worked at the facility for two (2) and a half years and had never received training with the Fire Department. Interview with SRNA #11, on 06/06/11 at 5:35 PM, revealed he had worked at the facility for one (1) year and had not received training from the Fire Department. Interview with SRNA #12, on 06/06/11 at 5:45 PM, revealed she had worked at the facility for just over one (1) year for. She further stated she had never had training with the Fire Department and she did not</p>	F 518	<p>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. Associates are 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.</p> <p>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</p>		

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?

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 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. 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. 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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F 518	Continued From page 24 think anyone had. Interview with RN #2, on 06/01/11 at 6:30 PM, revealed she had received no prior training related to fire emergencies and had started working on 4/03/11. Interview with SRNA #2, on 06/01/11 at 6:36 PM, revealed she had not had fire emergency training even though she had been working at the facility for three (3) months. While review of the staff in-service records revealed the facility provided orientation training related to Safety and Disaster Preparedness Introduction, Fire Safety and Evacuation Plan In Case of Fire, there was no evidence the facility ensured staff competence related to fire safety and evacuation plans.  Continued Interview with the Administrator on 06/01/11 revealed the facility completed the required drills and then in-serviced staff if problems with staff response were identified; however, interviews with staff who responded to the fire on 05/29/11 revealed they did not follow the facility's policy for response to a fire. Furthermore, the facility could provide no documented evidence that they tested the staff's competence of the training to ensure appropriate action would be taken in the event of a fire.	F 518		
F 520 SS-K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  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.  The quality assessment and assurance	F 520	<b>F-520 Quality Assessment and Assurance</b>  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	

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F 520	<p>Continued From page 25</p> <p>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> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, Emergency Plan review, and Grading Permit review, it was determined the facility failed to ensure the quality assessment and assurance committee (QA) was effective in identifying and correcting quality issues with the potential for negatively affecting residents. The facility's quality assurance committee failed to ensure the resident environment remained as free of accident hazards as is possible; and each resident receives adequate supervision to prevent accidents. The facility failed to identify two (2) emergency exit doors (south), which led to construction areas, did not have a safe path to a public way and failed to identify the accessibility for residents to use the exits. These failures prevented the facility from implementing effective measures to ensure appropriate supervision of the two exit doors or to prevent accessibility while</p>	F 520	<p>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> <p>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.</p>		

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F 520	<p>Continued From page 26</p> <p>having an unsafe path to a public way during construction despite having a committee meeting on 05/11/11 which discussed a new fire education and plan. Furthermore, the facility failed to ensure staff was trained regarding emergency evacuation procedures related to the two south fire exits affected by the construction and failed to train staff related to supervision of the accessible exits. These two south fire exits were the nearest exit, per the facility's evacuation plan, for fifty-five (55) of the facility's eight-four (84) residents.</p> <p>Based on the above findings it was determined the facility failed to have an effective system to identify quality of care issues to ensure residents received quality of care to ensure the resident environment remained as free of accident hazards as is possible; and each resident receives adequate supervision to prevent accidents, which was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 06/02/11 and was determined to exist on 12/28/10.</p> <p>The findings include:</p> <p>Review of the facility's emergency evacuation plan revealed staff was to evacuate residents to the nearest exit. On 12/28/10, per interview with the Construction Superintendent and review of the Grading Permit revealed construction began by digging a retention pond varying in size from twenty-five (25) foot hole to a twelve (12) deep foot deep ditch which was eight (8) feet wide. This construction affected the two (2) south fire exit doors. On 05/31/11 at 2:00 PM, observation revealed the fire exit located near the Physical</p>	F 520	<p>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.</p> <p>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</p>		

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F 520	<p>Continued From page 27</p> <p>Therapy department led to an uneven rocky and dirt surface. The exit located nearest to resident rooms 230 and 231 led to a ditch, which was approximately twelve (12) feet deep. There was no evidence that the facility had implemented a change in the emergency evacuation plan or provided training to staff related to the accessibility, appropriate use of the exits and the need for monitoring the exits after the construction began on 12/28/10.</p> <p>Interview with the Administrator, on 06/01/11 at 4:25 PM, revealed the a Quality Assurance Committee meeting was held on 05/11/11 in which a new fire education and plan developed by the corporate office had been discussed. While the facility's committee met, the facility could provide no evidence of action taken to ensure the safety of residents in having a safe path to a public way for the two south exits, or ensuring monitoring of the south exit doors while the exit doors were accessible to all residents, staff, and visitors.</p> <p>Interview with the Administrator on 06/03/11 at 7:00 PM revealed the precautions taken to ensure the two (2) exits in the back of the facility were not used included the wander guard system, signs which stated it was a construction area do not use and key pads which had a code that no one except maintenance knew the code to operate. The only new addition was the sign after the construction began. Further Interview with the Administrator, on 06/07/11 at 4:25 PM, revealed no problems had previously been identified with the fire safety and evacuation plan and he felt the precautions taken were appropriate to keep individuals from exiting the two (2) back exit</p>	F 520	<p>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.</p> <p>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</p>		

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F 520	<p>Continued From page 28</p> <p>doors. However, SRNA #11 interview, on 06/06/11 at 5:35 PM, revealed he had observed two (2) residents, Resident #3 and #6, attempt to exit the building through the front door by pushing down on the panic bar which caused the door to alarm. The facility Social Services Director identified eight (8) residents requiring supervision due to cognitive deficits, lack of safety awareness, risk for elopement and who the facility had applied wander guard bracelets to assist in supervision. The Administrator further acknowledged both doors would unlock and open if the doors' panic bars had been engaged for fifteen (15) seconds.</p> <p>Observation, on 06/01/11 at 2:00 PM, at 3:00 PM and 4:00 PM and on 06/02/11 at 9:00 AM, 11:00 AM and 2:00 PM, revealed no staff was supervising the exit door nearest PT or the exit door nearest resident rooms 230 and 231. Interviews with SRNA #2, on 06/01/11 at 6:36 PM, and Licensed Practical Nurse (LPN) #3, on 06/1/11 at 6:53 PM, revealed these staff would have used the south fire exits to evacuate residents should an event have required evacuation. Further Interview with SRNA #2 revealed she had received no training to monitor doors related to residents accessing and exiting, in case of an emergency.</p> <p>The facility was unable to provide documented evidence the quality assurance committee identified quality concerns related to the two south fire exits and took action to secure a safe path to a public way and monitoring the fire exits while the exits paths were affected by the construction. Furthermore, the facility quality</p>	F 520	<p>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 1<sup>st</sup>, 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</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	
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F 520	Continued From page 29 assurance committee was unable to provide evidence that they had identified the need for training of staff regarding the fire exits to ensure staff was trained regarding the appropriate, safe use of these two (2) exits or monitoring of the exits due to construction.	F 520	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 be 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 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. 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, starting 6/28/11, to review competencies and data collected from all systemic changes for any recommendations necessary and will continue to meet until the corrective actions have been 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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K 000	INITIAL COMMENTS  42 CFR 483.70(a)  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.  An abbreviated Life Safety Code Survey investigating ARO#00016496 was initiated on 05/31/11 and concluded on 06/06/11. ARO#00016496 was substantiated with deficiencies cited. The Highest scope and severity cited was a "K". K-Tag #38 was cited due to two (2) exits that were not useable due to outside construction. This deficiency has been identified as Immediate Jeopardy beginning 12/28/10 and is ongoing. K-Tag #48 was cited due to staff not following the facility's emergency response policy and procedures manual scope and severity cited was an "F".	K 000			
K 038	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038			

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>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an exit access from the building that could be kept clean and provide a hard surface during all weather conditions that would be readily accessible at all times. Also the facility failed to ensure exits in the area undergoing construction were inspected daily for compliance with 7.1.10.1 of National Fire Protection Association 101. The deficient practice affected two (2) of two (2) smoke compartments, fifty-five (55) residents, nine(9) staff and visitors.</p> <p>The facility is licensed for ninety (90) beds with a census of eighty-five (85) the day of survey. On 05/29/2011 at 4:00 AM a fire occurred in resident room#117. Staff interviews on evacuation procedures revealed they were to evacuate out the southeast and southwest exits. The facility failed to notify Staff that the exits could not be used and no alternate evacuation plan/routes were created and or implemented.</p> <p>The facility's failure to ensure safe exit access from the building created a condition that was likely to cause serious injury, harm, impairment, or death.</p> <p>Immediate Jeopardy was identified on 06/02/11 and it was determined to exist on 12/28/10 and is ongoing.</p>	K 038			

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K 038	Continued From page 2  The findings include:  Observation on 05/31/11 at 2:00 PM revealed the southeast and southwest exits were not useable due to the exits discharging into an ongoing construction zone. There was no hard surface to a public way from either exit. Approximately eight (8) feet from the southeast exit door there was an open ditch eight (8) feet wide by twelve (12) feet deep. The southwest exit dropped down about eight (8) to ten (10) inches on to an uneven surface. The uneven surface was made up of large rock and dirt. In the event of fire or other emergency the existing conditions at the southwest exit would prohibit evacuation of residents by wheeled devices and ambulatory residents would be at extreme risk of falls even with assistance. The southeast and southwest exit doors were equipped with delayed egress and keypads and the doors were operational at the time of inspection. Evacuation routes found posted in corridors revealed the pull stations and fire extinguishers were not accurately identified. This was confirmed by the Administrator during the exit interview.  Interview with the facility Administrator and Construction Superintendent, on 06/02/11 at 10:00 AM, revealed that they were not aware that emergency exits require a hard surface path of travel to a public way.  Interview on 06/02/11 at 08:30 AM with the State Building Inspector revealed that he was at the facility on 04/07/11 for a preliminary inspection of the new building and advised the	K 038			

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K 038	<p>Continued From page 3</p> <p>Construction Superintendent to keep exit discharges clear at all times.</p> <p>Interview on 06/02/11 at 10:00 AM with the Construction Superintendent revealed that construction of the new building at the rear of existing facility began on 12/28/10 . He stated that construction of a (25 X 25) foot retention pond began that day approximately ten (10) feet away from the southeast exit door. He also stated that he was unaware of the hard surface requirement to the public way and that the project is expected to be completed sometime in August, 2011.</p> <p>Interview on 06/02/11 at 11:30 AM with the facility Administrator revealed the Construction Superintendent told him the exits were okay. This was confirmed by interview with the Construction Superintendent on 06/02/11 at 10:00 AM.</p> <p>Interview on 06/01/11 at 2:00 PM with State Registered Nursing Assistant (SRNA) "A" revealed that in the event of fire or need to evacuate she would use the southeast or southwest exits or whichever exit is the closest. She also stated that she was not aware that the rear exits could not be used.</p> <p>Interview on 06/01/11 at 2:15 PM with State Registered Nursing Assistant (SRNA) "B" revealed she would use closest exit in the event of fire or need to evacuate and was not aware the southeast and southwest exits could not be used.</p> <p>Interview on 06/03/11 at 12:10 PM with Registered Nurse (RN) #1 revealed that if the fire in room # 117 on 05/29/11 had been a situation</p>	K 038		

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K 038	<p>Continued From page 4</p> <p>that required residents to be evacuated she would have used the southeast and southwest exits.</p> <p>Interview on 06/01/11 at 12:13 PM with Licensed Practical Nurse (LPN) #1 revealed if evacuation was needed the morning of the fire(05/29/11) she would have used the southeast exit.</p> <p>Actual NFPA Standard: NFPA 101, 7.5.1.1. Exit access shall be arranged that exits are readily accessible at all times.</p> <p>Actual NFPA Standard: NFPA 101, 7.1.10.1. The means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in the case of fire or emergency.</p> <p>Actual NFPA Standard: NFPA 101, A.7.1.10.1*. A proper means of egress allows unobstructed travel at all times. Any type of barrier including, but not limited to, the accumulations of snow and ice in those climates subject to such accumulations is an impediment to free movement in the means of egress.</p> <p>Actual NFPA Standard: NFPA 101, 7.7.1. Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.</p> <p>NFPA 101, 19.7.9.2 The means of egress in any area undergoing construction, Repair or improvements shall be inspected daily for Compliance with of 7.1.10.1 and shall also</p>	K 038			

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K 038	Continued From page 5 comply with NFPA 241, Standard for Safeguarding Construction, Alteration, and Demolition Operations.	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: 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. NFPA 101 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 where 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.	K 048			

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K 048	Continued From page 6  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 (used for employee orientation) that employees are trained to utilize the R.A.C.E. procedure in the event of fire.  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.  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.  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	K 048			

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K 048	<p>Continued From page 7</p> <p>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 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</p>	K 048			

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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 048	<p>Continued From page 8</p> <p>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.</p> <p>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 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</p>	K 048			

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K 048	<p>Continued From page 9</p> <p>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 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</p>	K 048			

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K 048	Continued From page 10 of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and 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	K 048			

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

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K 048	Continued From page 11 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			