STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An abbreviated standard survey (KY31616) and a COVID-19 focused infection control survey was initiated on 04/30/2020 and concluded on 05/21/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. However, the complaint was substantiated and Immediate Jeopardy was identified. The total census was 70.

Record review and staff interviews revealed on 04/14/2020 staff assessed Resident #1's left foot to be cold and mottled (blotchy, red-purplish marbling of skin), with purple bruising across the top of the foot extending to the first and second toes. Staff also assessed the resident to have a weak pulse and a prolonged capillary refill in the extremity. On 04/16/2020, Resident #1's physician ordered a Venous Doppler Ultrasound (a test to check the circulation of veins) of the resident's left lower extremity, and on 04/17/2020, at approximately 7:00 PM, the facility received the results of the Venous Doppler Ultrasound, which showed no abnormal findings. However, on 04/17/2020, staff documented the resident's extremity was cold to touch from the resident's knee to his/her toes; there was discoloration across the top of his/her left foot extending to all toes, and a faint pedal pulse and pitting edema in the foot; and the resident complained of pain to the extremity upon movement. The staff failed to notify the physician of the worsening circulatory assessment of the resident's left foot. Interviews with staff and record review revealed Resident

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

#1's left foot/leg continued to show a decline. However, the facility failed to notify the resident's physician of the decline. On 04/24/2020, staff assessed that Resident #1's left foot was cold, mottled, had no pulse and had developed necrotic (dead tissue) areas. In addition, staff were unable to feel a pulse at the resident's left knee or in his/her feet. The physician was notified and Resident #1 was transferred to the hospital. Upon arrival at the hospital, Resident #1 was diagnosed with a distal occlusion of the left superficial femoral artery (the artery that supplies blood to the leg). On 04/25/2020, Resident #1's left lower extremity was amputated (surgically removed) above the left knee.

Immediate Jeopardy was identified on 05/06/2020 and was determined to exist on 04/14/2020 at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657), and 42 CFR 483.25 Quality of Care (F684). The facility was notified of the Immediate Jeopardy on 05/06/2020. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F684). An extended survey was conducted on 05/20-21/2020. Deficient practice was also identified at F697 at "G" level, and F842 at "D" level.

An acceptable Allegation of Compliance was received on 05/13/2020, which alleged removal of Immediate Jeopardy on 05/13/2020. The State Survey Agency determined the Immediate Jeopardy was removed on 05/13/2020 as alleged, prior to exit on 05/21/2020, which lowered the scope and severity to "D" level at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657), and 42 CFR 483.25 Quality of Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 (F684), while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3	F 580		

(e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to immediately inform the physician and the responsible party when a significant change in condition occurred for one (1) of three (3) sampled residents (Resident #1). Resident #1's physician was notified on 04/08/2020 that the resident had developed a red area to the top of the left foot. The facility made subsequent physician notifications when the resident was having pain to the foot on 04/10/2020; when the resident was unable to bear weight on 04/13/2020; and, on 04/16/2020, when the resident's capillary refill (time taken for color to return normal after pressure has been applied. A prolonged capillary refill time may indicate decreased peripheral perfusion or peripheral artery disease) was abnormal and the left lower extremity was discolored. However, staff also documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

beginning 04/14/2020, that the resident had thready pulses (pulse that is not easily felt and commonly rapid) and the left foot was cold and mottled (mottling is blotchy, red-purplish marbling of the skin which can be a symptom of a serious underlying condition, such as vascular disease). However, there was no documented evidence the physician was made aware. Further review of Resident #1's medical record revealed the resident's foot/leg continued to decline; however, the resident's physician was not notified. On 04/24/2020 at approximately 4:00 AM, the resident had no pulses at the knee or foot, and the left, lower leg was cold and mottled. Interview with the resident's daughter revealed she was not aware that the resident's foot was injured until the resident's roommate told her of the injury through a window on 04/10/2020. She further stated she was not aware how serious the resident's condition was until she saw the resident after the resident was transferred to the hospital.

Resident #1 was transferred to a local hospital on 04/24/2020 and diagnosed with Critical Lower Limb Ischemia (restricted blood supply to tissue) with "Occlusion of the mid left superficial femoral artery distally (artery that supplies blood to the leg was blocked)."

Resident #1 was then transferred to a larger medical center where the resident's left leg was amputated (surgically removed) above his/her knee on 04/25/2020 related to "Profound ischemia (restricted blood flow) and cadaveric (corpse like) left lower extremity."

The facility's failure to notify the resident's physician of a change in condition and need to alter treatment has caused or is likely to cause

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5	F 580		

serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/06/2020, and was determined to exist on 04/14/2020 at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657), and 42 CFR 483.25 Quality of Care (F684). The facility was notified of the Immediate Jeopardy on 05/06/2020. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F684).

An acceptable Allegation of Compliance was received on 05/13/2020, which alleged removal of Immediate Jeopardy on 05/13/2020. The State Survey Agency determined the Immediate Jeopardy was removed on 05/13/2020 as alleged, prior to exit on 05/21/2020, which lowered the scope and severity to "D" level at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657), and 42 CFR 483.25 Quality of Care (F684), while the facility monitors the effectiveness of systemic changes and quality assurance activities.

The findings include:

Interview with the Administrator on 05/05/2020 at 5:40 PM revealed if residents experienced a change in condition, she expected staff to reassess the resident, and if the change in condition continued, staff should notify the resident's physician.

However, review of the facility's policy titled "Change in a Resident's Condition or Status", last revised November 2016, revealed the facility would promptly notify the resident, his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6	F 580		

physician and a resident representative based on the resident's cognition, of changes in the resident's medical/mental condition and or status. The policy defined a "significant change" of condition as a decline or improvement in a resident's status that would not normally resolve itself without intervention by staff or by standard disease-related clinical interventions being implemented (is not "self-limiting"). The policy also stated a significant change was something that impacted more than one area of the resident's health status, and required interdisciplinary review and/or revision to the care plan.

Review of Resident #1's medical record revealed the facility admitted the resident on 01/23/2020 with diagnoses that included Alzheimer's disease and Muscle Weakness. Review of Resident #1's Admission Minimum Data Set Assessment (MDS) dated 01/29/2020, revealed the facility assessed Resident #1 to be cognitively impaired with a Brief Interview for Mental Status (BIMS) score of five (5). Further review revealed the facility assessed the resident to require extensive assistance of two (2) staff members with toileting, transfers, and bed mobility; and, he/she could ambulate (walk) with the assistance of one person. According to the MDS, Resident #1 had no venous or arterial ulcers (wounds on the leg or ankle caused by poor circulation), and no other ulcers, wounds, or skin problems of the foot.

Review of Nurses' Notes revealed on 04/08/2020 at 5:10 PM, Resident #1's left foot was slightly red and tender to touch. Review of a "Skin Ulcer/Injury Form" for Resident #1, revealed on 04/08/2020 at 5:00 PM, the resident's physician was notified of a red spot on the top of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7	F 580		

#1's left foot.

Continued review of Nurse's Notes revealed on 04/10/2020 at 1:53 PM, staff documented that Resident #1's left foot was swollen, red, a small bruise was noted to the top of the left foot and to the left great toe, and the resident had pain. According to the documentation, the resident's physician was contacted to request scheduled pain medication because Resident #1 was not alert enough to ask for pain medication, until the resident's "pain is out of control."

Interview with Resident #1's daughter on 05/18/2020 at 10:00 AM revealed the facility did not notify her of the resident's injury/pain. She stated she was not aware of any change in the resident's condition until she visited the resident's window on 04/10/2020 and was informed by the resident's roommate that the resident had injured his/her foot (the daughter was unable to visit inside the facility due to COVID-19 restrictions). She stated she called the facility and spoke with the facility's Social Worker, who told her that she checked on the resident and the injury was not a "big deal."

Further review of the Nurse's Notes revealed on 04/13/2020 at 4:13 PM, a nurse documented that therapy notified nursing staff that Resident #1 would not bear weight to the left lower extremity. According to the Note, the resident's physician was notified and an order for an x-ray of the left lower extremity was obtained.

Review of Resident #1's x-ray report revealed the left foot x-ray was completed on 04/13/2020 and showed that the resident had diffuse osteopenia (low bone mineral density), mild osteoarthritic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8	F 580		

(joint disease) changes, and a small posterior heel spur (a foot condition created by calcium deposits). No acute fracture or dislocation was identified.

Further review of Resident #1's Nurse's Notes revealed on 04/14/2020 at 4:07 AM, Registered Nurse (RN) #1 documented that the resident's left foot was" now cold, mottled, (his/her) pulses were thready", and the resident's capillary refill was abnormal. However, there was no documented evidence the resident's physician was notified when the change in the resident's condition was identified.

Interview with RN #1 on 05/05/2020 at 8:15 AM revealed that she did not notify Resident #1's physician that the resident's foot had become cold and mottled with thready pulses. She stated the resident's x-ray results had returned with no acute findings during her shift, so she reported the change in the resident's condition to the oncoming shift. According to the RN, Resident #1's physician "may not answer the phone at night, or say this could have waited."

Review of Resident #1's Nurse's Notes dated 04/16/2020, at 8:36 PM, two (2) days later, revealed Licensed Practical Nurse (LPN) #2 documented that Resident #1's left lower extremity was discolored, and his/her capillary refill was "slow." According to the Note, the resident's physician was notified and an order for a Venous Doppler ultrasound (a test to check the circulation/check for clots in the large veins in the legs) was obtained.

Interview with LPN #2 on 05/04/2020 at 4:50 PM confirmed that she only informed Resident #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9	F 580		

physician that the resident's left lower extremity and foot "in general" was discolored and his/her capillary refill was slow. Further interview revealed LPN #2 did not notify the resident's physician of the thready pulses.

Further review of Resident #1's Nurse's Notes for 04/17/2020 at 4:51 PM, revealed LPN #1 documented the resident's left leg had become cold to touch from the knee down to the toes, discoloration was observed from his/her shin to the toes, the left foot was swollen, and the resident's pedal pulses were faint. The Nurse's Note stated the Venous Doppler study had been completed and they were awaiting the results. Further review revealed there was no documented evidence that the resident's physician was notified that the coldness and discoloration had worsened and was affecting the resident's leg.

Interview with LPN #1 on 05/04/2020 at 3:50 PM confirmed that on 04/17/2020, Resident #1's pedal pulses were faint, and the resident's left leg was discolored from the shin to his/her toes. However, the LPN stated she did not inform the resident's physician, but stated that looking back, she should have notified the physician.

Review of Resident #1's Venous Doppler study/test results revealed the test was conducted on 04/17/2020 and no abnormal findings were indicated. Review of Nurse's Notes revealed the physician was notified of the test results on 04/17/2020 at 7:06 PM.

Continued review of Resident #1's Nurse's Notes revealed on 04/18/2020, 04/19/2020, 04/21/2020 and 04/23/2020, LPN #1 and RN #1 continued to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 10	F 580		

document that the resident's left foot and/or left extremity was cool to touch and was discolored. However, there was no documented evidence that the resident's physician was made aware that the resident's foot had become "cool."

Review of LPN #1's documentation for 04/23/2020 at 1:35 PM, revealed the LPN documented that Resident #1's "Left lower extremity continues to be cool to touch, with discoloration noted from toes to knee." The LPN also documented "pitting edema" was also observed to the resident's left lower foot and leg and the resident's pedal pulses were positive.

Continued interview with LPN #1 on 05/04/2020 at 3:50 PM, with RN #1 on 05/05/2020 at 8:15 AM, revealed they never notified Resident #1's physician that the resident's foot/leg was cold, nor that the resident's leg had become discolored from the knee to the toes. LPN #1 stated she should have notified Resident #1's physician when she identified the change in the resident's condition. The LPN stated, "We could have done other" diagnostic tests, got the resident "out sooner," and a different outcome could have occurred for the resident. RN #1 stated "looking back" she would have been more persistent with notifying the resident's physician about the resident's leg/foot after the Venous Doppler study. RN #1 stated, "My gut was telling me something was wrong." However, she stated she did not notify Resident #1's physician when she assessed the resident's leg to be cold and mottled with thready pulses.

Interview with the Director of Nursing (DON) on 05/05/2020 at 5:00 PM revealed Monday through Friday the facility held an Interdisciplinary Team

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 11	F 580		

(IDT) meeting to ensure physicians were notified timely when a change in a resident's condition was identified. She stated the team reviewed resident medical records, which included Nurse's Notes, in attempts to ensure physician notification occurred as required. The DON stated the facility conducted an investigation related to care/treatment, which included physician notification for Resident #1, and no concerns were identified.

Continued review of Resident #1's Nurse's Notes revealed on 04/24/2020 at 8:35 AM, RN #1 documented that the "bruises" that had "appeared" on 04/08/2020 to the ventral side of foot were now dry necrotic areas. The resident's toes; lateral, ventral, and plantar surfaces of the foot; and the heel were deep purple with black areas. The left knee had a red/purple area covering most of the proximal aspect of the patella (knee), and was cool and tender to touch. The RN also documented that the resident had pain, no palpable pedal pulses nor popliteal pulses (pulses in the foot and knee), and the skin between the knee and foot was cold and mottling. According to the Nurse's Note, the resident's physician's office was contacted and a staff member at the physician's office was going to have the physician make a "tele call" to view the resident's foot when the physician arrived at the office.

Continued interview with RN #1 on 05/05/2020 at 8:15 AM, revealed she cared for Resident #1 on 04/24/2020 and at approximately 4:00 AM, she identified that the resident's foot/leg had worsened. She stated the resident had necrotic (dead tissue) to the toes, purple/black areas to the lateral/ventral aspects of his/her foot, and to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12	F 580		

his/her heel; and had a new red/purple area covering most of the proximal aspect (front center) of his/her knee. In addition, the RN stated that she was unable to obtain pulses to Resident #1's left foot or behind his/her knee. According to the RN, she paged the resident's physician at approximately 6:30 AM on 04/24/2020 in an attempt to notify him of the change in the resident's condition; however, the physician did not return the call at that time. She stated she waited until the physician's office opened at approximately 8:00 AM and called the physician's office; however, office staff stated the physician was at the hospital. RN #1 stated she completed her shift documentation and went to the physician's office at approximately 9:00 AM and notified the physician of the change in Resident #1's condition. RN #1 stated the physician directed his office staff to contact the hospital of the need for Resident #1 to be directly admitted to the hospital for further evaluation and treatment.

Interview with Physician #1 on 05/05/2020 at 12:50 PM revealed staff informed him that Resident #1 complained of pain and that he/she had a small bruise and swelling to his/her left leg. However, staff did not inform him that Resident #1's pulses were thready in his/her left foot, or that the resident's leg/foot was cold to touch until 04/24/2020 at approximately 9:15 AM (unable to recall exact time) when RN #1(she attempted to page the physician at approximately 6:30 AM and when he returned call to the facility, time unknown, the nurse had already left the facility) however, the RN came to his office and showed him photographs of the resident's leg/foot. The physician stated staff were required to inform him when changes in a resident's condition occurred,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 13	F 580		

and if staff would have informed him of the ongoing changes in the resident's condition, after the Venous Doppler ultrasound was conducted on 04/17/2020, he would have ordered an Arterial Doppler study and the resident could have potentially had a different outcome.

Review of Resident #1's medical record from Hospital #1 revealed he/she arrived to the hospital at approximately 12:30 PM. After diagnostic tests were completed at 3:43 PM on 04/24/2020, Resident #1's diagnoses included Critical lower limb ischemia (restricted blood supply) and "Occlusion of the mid left superficial femoral artery distally" (blockage in the femoral artery, which is located in the groin). Resident #1 was later transferred to a larger medical center (Hospital #2) for further care/treatment on 04/24/2020.

Review of Resident #1's medical record from Hospital #2 revealed the resident's left leg was amputated (surgically removed) above his/her knee on 04/25/2020 related to "Profound ischemia (restricted blood flow) and cadaveric (corpse like) left lower extremity."

Continued interview with Resident #1's Daughter on 05/18/2020 at 10:00 AM revealed after she learned of the resident's injury on 04/10/2020, the facility notified her several times about testing that was being conducted. However, she stated the facility did not relay how bad the resident's condition was and, she had not been able to visit to see the resident because of visitation restrictions due to COVID-19. She stated she was not aware how bad the resident's leg was until she saw the resident on 04/24/2020 after the resident had been taken to the hospital. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14	F 580		

stated when she saw the resident's leg it was "mottled" and the resident's toes were black. She stated the resident's leg had "gotten progressively worse" since the amputation on 04/25/2020, had since required another surgery to remove "more of that leg." Resident #1's Daughter stated the resident was 91 years old, and should not be spending the last part of his/her "life like this." The daughter stated the facility "... should have gotten [the resident] help sooner, before it went that far and got that bad."

***The facility implemented the following actions to remove Immediate Jeopardy effective 05/13/2020:

1. Resident #1 no longer resides at the facility.

2. The facility held an ad hoc QAPI (Quality Assurance and Performance Improvement) committee meeting on 05/07/2020 to review the Immediate Jeopardy findings and discuss the development of the action items to be completed.

3. Members of the clinical leadership team conducted head-to-toe skin inspections on 05/08/2020, which included checking pedal pulses and capillary refill for all residents. No new circulatory concerns were identified.

4. On 05/08/2020, the Director of Nursing (DON) selected a sample of three (3) completed skin inspection forms from each hall (15 in total), as a second review. The DON identified no concerns.

5. Beginning on 05/12/2020, the DON, Unit Manager, Wound Nurse, and/or Nurse Supervisor will assess five (5) residents per unit daily to assess circulatory changes, capillary refill, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 15	F 580		

pedal pulses, comparing to the documented baseline from 05/07/2020. Staff completing the assessments will immediately address any concerns. The monitoring will continue until the facility meets regulatory compliance. The QAPI team will review the results at least weekly to track the facility's progress toward regulatory compliance.

6. The Minimum Data Set (MDS) Coordinator provided education to the Education Training Director (ETD) regarding updating resident care plans when a resident's change in condition occurs. The ETD then provided this education to all licensed nurses by 05/08/2020. Each nurse was required to verbalize the process to update the care plan in the Electronic Medical Record to ensure competency.

7. The Director of Nursing and ETD educated all licensed nurses on physician notification, change in condition and Medical Director Notification on 05/07/2020 through 05/09/2020. The education also included documentation requirements for physician notifications in the medical record. Resident skin inspections to include, but not limited to, circulatory indicators of capillary refill, pedal pulses, and vital signs. Any new/undocumented skin impairments or signs/symptoms of circulatory problems require immediate physician notification and documentation in the medical record in the nursing progress notes. In addition, staff will update care plans with the new interventions related to a change in a resident's status.

8. On 05/07/2020 through 05/08/2020, all licensed nurses were required to complete a post-test to verify training competency related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 16	F 580		

physician notification, change in condition and Medical Director Notification. The nurses were required to receive a score of 100% before resuming duties. Licensed nurses on leave will be required to have this education and pass a posttest prior to returning to work. Any newly hired licensed nurse will receive this education/testing from the ETD and/or DON prior to assuming duties.

9. On 05/08/2020 the Director of Nursing, MDS Coordinator, Wound Nurse, and Nurse Managers completed a review of the last thirty days of Interdisciplinary Team (IDT) notes and physician's orders to ensure staff had made physician notification in any change of resident condition. The review included ensuring staff had updated resident care plans to reflect the change of condition and any associated interventions. The Director of Nursing, MDS Coordinator, Wound Nurse, and Nurse Managers identified no concerns.

10. On 05/08/2020, the Director of Nursing, Unit Manager and/or Weekend Supervisor, initiated an on-going audit of the prior 24- hour nursing notes and physician's orders to ensure the identification of any resident circulatory concerns, physician notification, and care plan updates. Nursing leadership will address any concerns when discovered.

11. On 05/08/2020, the QAPI team held a second ad hoc meeting to review the initial skin/circulatory audits, physician notifications and care plan updates, as well as the status of the licensed nurse's education initiated on 05/07/2020. The Administrator reviewed the results with the Medical Director on 05/08/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 17	F 580		

***The State Survey Agency verified the facility implemented the following actions to remove Immediate Jeopardy on 05/13/2020, as alleged:

1. Review of the medical record revealed the facility transferred Resident #1 to the hospital on 04/24/2020 and the resident did not return to the facility.

2. A review of QAPI Committee meeting minutes dated 05/07/2020 revealed the committee reviewed the Immediate Jeopardy notifications and the action plans for facility compliance. Review of the meeting sign in sheet dated 05/07/2020, revealed the facility's department heads attended. Interviews, conducted on 05/21/2020, with the Administrator, Medical Director, Director of Nursing (DON), the Unit Managers, and the Minimum Data Set (MDS) Coordinator revealed the facility had conducted a QAPI meeting on 05/07/2020 to discuss the immediate jeopardy and to initiate the development of a plan of action for compliance.

3. A review of skin assessments conducted from 05/06/2020 through 05/08/2020 revealed all residents had a head to toe skin assessment performed to include evaluation of pedal pulses and capillary refill. Review of skin assessments completed for Resident #4, Resident #5, Resident #6 and Resident #7 revealed the assessments were completed with no concerns identified. Observation of skin assessments for Resident #6 and Resident #7 conducted on 05/20/2020, included evaluation of pedal pulses and capillary refill with no concerns identified. Interviews with the DON, Unit Manager #1, and Unit Manager #2 on 05/21/2020 revealed all residents' skin, pedal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 18	F 580		

pulses, and capillary refill status was assessed by 05/08/2020.

4. A review of skin assessment audits completed by the DON on 05/08/2020 revealed the DON had audited a sample of fifteen (15) completed skin assessments with no issues identified. Review of the May 2020 skin assessments completed for Resident #4, Resident #5, Resident #6, and Resident #7 revealed no concerns with the completion or accuracy of the assessments. Interview with the DON on 05/21/2020 at 2:38 PM revealed she had conducted audits of the skin assessments performed on 05/08/2020, of three (3) residents from each hallway with no new issues or changes of condition found.

5. A review of daily audits completed from 05/12/2020 through 05/20/2020 by the DON, Unit Managers, Wound Nurse, and the Weekend Supervisor revealed five (5) residents from each unit were assessed daily for circulatory changes, capillary refill, and pedal pulses. The assessments were compared with assessments completed on 05/08/2020 with no concerns identified. Interviews with the DON, Unit Manager #1, Unit Manager #2, the Wound Nurse, and the Weekend supervisor conducted on 05/21/2020 revealed they were assessing a sample of residents daily on each unit for circulatory concerns to ensure any changes in a resident's condition was identified.

6. A review of an in service education sign in sheet dated 05/07/2020 revealed the MDS Nurse had educated the EDT on updating resident care plans when a change in condition occurred. Interview with the MDS Nurse on 05/21/2020 at 1:42 PM revealed she had trained the EDT on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 19	F 580		

requirement to update the plan of care when a resident had a change of condition. Interview with the EDT Nurse on 05/21/2020 at 1:57 PM, revealed the MDS Nurse had educated her on updating resident care plans on 05/07/2020. The EDT stated she educated all licensed nurses except employees who were on leave regarding the requirement by 05/08/2020. Further interview with the EDT revealed employees who were on leave could not work until the training was completed. Review of employee in-service education sign in sheets revealed all licensed employees were educated on updating resident care plans when a change in condition occurred on 05/08/2020 by the EDT Nurse. Interviews conducted with LPN #3, LPN #4, Unit Manager #1, Unit Manager #2, and the Weekend Supervisor on 05/21/2020 revealed they received education on 05/08/2020 by the EDT on updating care plans when a resident had a change of condition.

7. A review of Education Sign in Sheets dated 05/07/2020 through 05/09/2020 revealed all nurses were educated by the DON and EDT on physician notification, change of condition, Medical Director Notification if the physician could not be reached and documentation requirements for physician notifications in the medical record. The education referenced resident skin inspections, circulatory indicators of capillary refill, pedal pulses, and vital signs. Any new/undocumented skin impairments or signs/symptoms of circulatory problems required immediate physician notification and documentation in the medical record and updating the plan of care with the new interventions related to a change in resident's status. Interviews with the DON at 2:38 PM and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 20	F 580		

the EDT Nurse at 1:57 PM on 05/21/2020, revealed they had in serviced all nursing staff from 05/07/2020 through 05/08/2020 regarding physician notification, change of condition, conducting assessments for circulatory issues, updating the plan of care and documenting in the medical record. Interviews on 05/21/2020 conducted with LPN #3, LPN #4, Unit Manager #1, Unit Manager #2, the MDS Nurse and the Weekend Supervisor revealed the EDT and the DON had in serviced them related to the process for physician notification of change of condition, conducting skin assessments to identify circulatory concerns, updating the resident's plan of care and documenting in the resident's medical record.

8. A review of post-tests completed by licensed nursing staff on 05/07/2020 and 05/08/2020 revealed all nursing staff had completed a post-test with a satisfactory score. Interviews with LPN #1, LPN #2, Unit Manager #1, Unit Manager #2, the MDS Nurse, and the Weekend supervisor on 05/21/2020 revealed they completed a post-test after the education provided by the EDT and the DON on 05/07/2020 or 05/08/2020.

9. Review of the past thirty days Progress Notes and Physician Order audits completed by the DON, MDS Coordinator, Wound Nurse and Nurse Managers on 05/08/2020, revealed no concerns with notification of change of condition and resident care plans being updated accordingly. Observations conducted on 05/20/20 for Resident #4, Resident #5, Resident #6, and Resident #7 revealed no concerns with change of condition. Record reviews conducted for Resident #4, Resident #5, Resident #6, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 21	F 580		

Resident #7's May 2020 Nurse's Notes, physicians orders, skin assessments, and the plan of care revealed no concerns with change of condition, updating the plan of care or physician notification. Interviews with the DON, Unit Manager #1, and Unit Manager #2, on 05/21/2020 revealed they had reviewed thirty days of progress notes, physician orders, and residents' care plans to ensure changes of condition had been identified, physicians were notified, and the resident's care plan was updated with new interventions on 05/08/2020 with no issues identified.

10. A review of daily nursing note audits and physician's orders completed from 05/08/2020 through 05/20/20 by the DON, Unit Managers, and the Weekend Supervisor revealed nursing notes and physicians orders were reviewed daily for any concerns with resident changes in condition, circulatory status, and validating the care plan had been updated with new interventions. A review of the medical records for Resident #4, Resident #5, Resident #6, and Resident #7 to include May 2020 Progress Notes, Physicians Orders, and the Plan of Care revealed no concerns with physician notification of change of condition or with updates to the plan of care for the residents. Interviews with the DON, Unit Manager #1, Unit Manager #2 and the Weekend Supervisor on 05/21/2020 revealed they had reviewed the previous twenty-four hour nursing notes and physician's orders daily to ensure physician notification and that care plans were updated to reflect any change in resident condition.

11. A review of the QAPI Committee meeting minutes dated 05/08/2020 revealed the QAPI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 22 Committee reviewed audit findings of skin assessments, physician notifications, care plan updates, and the status of licensed nurse's education initiated on 05/07/2020. A review of QAPI Committee Meeting Minutes for 05/12/2020 and 05/19/2020 revealed the QAPI Committee was meeting weekly to review audit findings and to monitor the facility's plan of action. An interview with the Medical Director on 05/21/2020 at 2:49 PM reveled the Medical Director attended the QAPI meeting on 05/07/2020 by phone to review the Immediate Jeopardy Notification and the Plan of Action. Further interview with the Medical Director revealed she attended the QAPI meeting on 05/08/2020 in person to review the facility's audits and education progress. The Medical Director stated staff would contact her within thirty minutes if they were not able to reach a resident's physician when the resident had a change of condition. The Medical Director stated she had been attending weekly QAPI meetings to monitor the facility's compliance. An interview with the Administrator on 05/21/2020 at 3:05 PM revealed she had been monitoring the QAPI process for compliance daily by conducting the morning meetings to ensure daily audits were completed and any identified concerns were addressed. In addition, the Administrator had conducted weekly QAPI Meetings for continued review of audit findings and monitoring the facility's compliance and Immediate Jeopardy removal.	F 580		
F 657 SS=J	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 23 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Resident Assessment Instrument (RAI) Manual, it was determined the facility failed to ensure one (1) of three (3) resident's care plans (Resident #1) was reviewed and/or revised when a significant change in condition occurred. On 04/08/2020, Resident #1 developed a red, tender area to the top of his/her left foot; and, on 04/10/2020, the resident developed bruising and pain to the foot that required scheduled pain	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24	F 657		

medication for "pain is out of control." The facility revised the resident's care plan on 04/10/2020 with an intervention to administer pain medication as ordered and on 04/14/2020 to monitor the bruising. However, the facility failed to revise the resident's care plan with individualized, measurable interventions that could evaluate the care plan's effectiveness as required by the RAI Manual. In addition, the facility failed to revise the resident's care plan with interventions to address the resident's care when the resident's foot/leg became cold, mottled (mottling is blotchy, red-purplish marbling of the skin can be a symptom of a serious underlying condition, such as vascular disease), with thready pulses (pulse is not easily felt and commonly rapid) on 04/14/2020; nor when the resident's pain was not managed with medication that was prescribed on 04/10/2020.

On 04/24/2020, at approximately 4:00 AM, Resident #1's left foot was cold and mottled with necrotic (dead) tissue to the resident's foot and the resident had no pulses at the left knee or left foot. Resident #1 was transferred to a local hospital on 04/24/2020, where the resident was diagnosed with Critical Lower Limb Ischemia (restricted blood supply to tissue) and "Occlusion of the mid left superficial femoral artery distally." The resident was then transferred to a large medical center where Resident #1's left leg was amputated (surgically removed) above his/her knee on 04/25/2020 related to "Profound ischemia (restricted blood flow) and cadaveric (corpse like) left lower extremity."

The facility's failure to revise resident care plans when a significant change in condition occurred has caused or is likely to cause serious injury,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 25	F 657		

harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/06/2020, and was determined to exist on 04/14/2020 at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657), and 42 CFR 483.25 Quality of Care (F684). The facility was notified of the Immediate Jeopardy on 05/06/2020. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F684).

An acceptable Allegation of Compliance was received on 05/13/2020, which alleged removal of Immediate Jeopardy on 05/13/2020. The State Survey Agency determined the Immediate Jeopardy was removed on 05/13/2020, prior to exit on 05/21/2020, which lowered the scope and severity to "D" level at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657), and 42 CFR 483.25 Quality of Care (F684), while the facility monitors the effectiveness of systemic changes and quality assurance -activities.

The findings include:

Email correspondence with the Administrator on 05/05/2020 at 10:14 AM revealed the facility did not have a care plan policy. The Administrator stated the facility followed the Resident Assessment Instrument (RAI) Manual for care plans.

Review of the RAI Manual, Section 4.7, revealed the care plan must include measurable objectives and timeframes, and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 26	F 657		

and psychosocial well-being.

Further review of the RAI, Section JO100 Pain Management, revealed planning for care must utilize identification of pain management interventions, review the effectiveness of pain management, and revise the plan if goals are not met. The Manual further revealed that residents would need a comprehensive, individualized management regimen. Review of Section M, Skin Conditions, revealed planning for care of skin changes should be accounted for in the interdisciplinary care plan. According to the RAI Manual, the care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident was receiving.

Review of Resident #1's medical record revealed the facility admitted the resident on 01/23/2020, with diagnoses that included Alzheimer's Disease and Muscle Weakness. Review of Resident #1's Admission Minimum Data Set Assessment (MDS) dated 01/29/2020, revealed the resident required extensive assistance of two (2) staff members with transfers/toileting, personal hygiene, and bed mobility; and could ambulate (walk) with the assistance of one person. According to the MDS, Resident #1 had no venous or arterial ulcers (wounds on the leg or ankle caused by poor circulation), and no other ulcers, wounds, or skin problems of the foot. The MDS also indicated Resident #1 had no pain and was not on a scheduled pain medication regimen during the assessment period.

Review of Resident #1's care plan also revealed he/she had problems of hypertension, incontinence of urine/bowels, and limited mobility on 01/31/2020 and the care plan stated the goals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 27	F 657		

for the resident were to be free of signs/symptoms of cardiac distress (shortness of breath, complaints of chest pain and abnormal vital signs, etc.) and maintain intact skin integrity. Interventions implemented on Resident #1's care plan dated 01/31/2020, included that staff were to assess and report redness, rashes, bruises, abrasions, or skin breakdown. The care plan also indicated staff were to monitor for edema and elevate the resident's legs, as needed; and turn and reposition the resident every two (2) hours and as needed.

Review of Resident #1's Nurse's Notes revealed at 5:10 PM on 04/08/2020, the resident's left foot was slightly red and tender to touch. On 04/10/2020, at 1:53 PM, the resident's left foot was swollen, red, a small bruise was observed to the left great toe and the top of the resident's left foot, and the resident complained of pain.

Review of Resident #1's care plan revealed the facility revised the care plan on 04/10/2020 to include the resident's left leg and foot pain concern and an intervention was added three (3) days later on 04/13/2020 that stated "meds [medications] per orders see mars [Medication Administration Record]." The care plan did not address an individualized pain management regimen for Resident #1 as required by the RAI Manual, nor did the care plan facilitate review of the effectiveness of the pain management.

Further review of Resident #1's medical record revealed on 04/13/2020, three (3) days after the bruising was identified to the resident's foot, the facility revised the resident's Medication Administration Record (MAR) to include the requirement for staff to monitor bruising to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 28	F 657		

resident's left foot for signs/symptoms of worsening/healing. Further review revealed this was discontinued on 04/14/2020 when "non-drug treatment" monitoring of the bruise twice daily was added. Staff documented each shift from 04/14/2020 through 04/23/2020 that the bruise was monitored. However, further review of Resident #1's care plan revealed no documented evidence that the facility revised the resident's care plan when the resident developed bruising, redness, or swelling to the left foot/toe with time-frames and a description of the services that were required to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for Resident #1 as required by the RAI Manual.

Further review of Resident #1's Nurse's Notes revealed on 04/14/2020 at 4:07 AM, the resident's left foot was cold, mottled, pulses were thready, and capillary refill (time for color to return to normal after pressure has been applied. A prolonged capillary refill time may indicate decreased peripheral perfusion or peripheral artery disease) was abnormal. Continued review of Resident #1's care plan revealed the facility revised the care plan on 04/14/2020 and directed staff to "monitor discolorations to left foot until resolved." However, the care plan did not address the resident's foot being cold and/or mottled, nor did it address the resident's pulses being thready. Subsequently, the care plan did not include measurable objectives with established timeframes; specific interventions; items needing additional assessment, testing, and review/notification of the physician; nor, items that may require additional monitoring.

Continued review of the Nurse's Notes revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 29	F 657		

the circulation to Resident #1's foot/leg continued to worsen. On 04/17/2020 and 04/21/2020, staff documented that the resident's left leg/foot was cool/cold, had discoloration/bruising, and/or had faint/thready pulses. In addition, review of the resident's Physical Therapy Notes for 04/17/2020 and 04/21/2020 revealed the resident had decreased weight bearing and was unable to bear weight to the left foot/leg by 04/23/2020. Again, the resident's care plan was not revised with timeframes and a description of the services that were required to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

Review of Resident #1's Nurse's Notes dated 04/24/2020 at 8:35 AM, revealed the resident's foot had developed necrotic (dead tissue) and/or black areas to the foot, toes, and heel. The left knee had a red/purple area covering most of the knee and was cool and tender to touch. The nurse also documented that the resident had pain, no palpable pedal pulses nor popliteal pulses (pulses in the foot and knee), and the skin between the knee and foot was cold and mottling.

Review of Resident #1's medical record from Hospital #1 revealed he/she arrived at the hospital on 04/24/2020 at approximately 12:30 PM. Further review revealed after diagnostic tests were completed and with the results at 3:43 PM on 04/24/2020, it was determined the resident had a Critical lower limb ischemia (restricted blood supply to tissue) and "Occlusion of the mid left superficial femoral artery distally." The resident was transferred to a larger medical center (Hospital #2) for further evaluation/treatment on 04/24/2020, where the resident's left leg was amputated (surgically

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 30	F 657		

removed) above his/her knee on 04/25/2020 related to "Profound ischemia (restricted blood flow) and cadaveric (corpse like) left lower extremity."

Interview with Licensed Practical Nurse (LPN) #1 at 3:50 PM on 05/04/2020 revealed she assessed Resident #1 on 04/17/2020 and determined that Resident #1's pedal pulses were faint, and his/her left leg was discolored from the shin to the toes. According to LPN #1 nursing staff did not review/revise the care plans, to include developing interventions to address the resident's concerns/problems.

Interview with Registered Nurse (RN) #1 at 8:15 AM on 05/05/2020 revealed she assessed Resident #1 on 04/14/2020 and 04/21/2020, and determined that the resident's foot/leg was cold, mottled, and the resident's pulses were thready. However, according to RN #1, she did not review/revise the resident's care plan when she identified changes in the resident's condition because she was not responsible to review/revise care plans at the facility.

Interview with the MDS Nurse on 05/05/2020 at 1:45 PM revealed care plans were reviewed/revised during a morning meeting Monday through Friday. The MDS Nurse stated that during the meetings, she reviewed new physician's orders, and the Director of Nursing (DON) reviewed the Nurse's Notes to ensure any changes in a resident's condition "gets to the care plan." The MDS Nurse stated if she had been aware of the ongoing change in Resident #1's condition, she would have revised the resident's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 31	F 657		

Interview with the DON on 05/05/2020 at 5:00 PM revealed residents' care plans were reviewed/revised during the Interdisciplinary Team (IDT) Meeting held Monday through Friday. The DON stated that she and other members of the IDT reviewed documentation to ensure care plans were reviewed/revised when changes in a resident's condition occurred. The DON stated she did not recall reviewing nursing documentation related to Resident #1's ongoing change in condition, which included the notes that the resident's left foot/leg was cold and mottled and his/her pulses were thready. However, according to the DON, the assessment findings would not "trigger" a care plan revision for Resident #1 because it was not a "permanent change" for the resident.

Interview with the Administrator on 05/05/2020 at 5:40 PM revealed she did not attend IDT Meetings regularly. She stated she had no process to ensure resident care plans were reviewed/revised as required.

***The facility implemented the following actions to remove Immediate Jeopardy effective 05/13/2020:

1. Resident #1 no longer resides at the facility.

2. The facility held an ad hoc QAPI (Quality Assurance and Performance Improvement) committee meeting on 05/07/2020 to review the Immediate Jeopardy findings and discuss the development of the action items to be completed.

3. Members of the clinical leadership team conducted head-to-toe skin inspections on 05/08/2020, which included checking pedal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 32	F 657		

pulses and capillary refill for all residents. No new circulatory concerns were identified.

4. On 05/08/2020, the Director of Nursing (DON) selected a sample of three (3) completed skin inspection forms from each hall (15 in total), as a second review. The DON identified no concerns.

5. Beginning on 05/12/2020, the DON, Unit Manager, Wound Nurse, and/or Nurse Supervisor will assess five (5) residents per unit daily to assess circulatory changes, capillary refill, and pedal pulses, comparing to the documented baseline from 05/07/2020. Staff completing the assessments will immediately address any concerns. The monitoring will continue until the facility meets regulatory compliance. The QAPI team will review the results at least weekly to track the facility's progress toward regulatory compliance.

6. The Minimum Data Set (MDS) Coordinator provided education to the Education Training Director (ETD) regarding updating resident care plans when a resident's change in condition occurs. The ETD then provided this education to all licensed nurses by 05/08/2020. Each nurse was required to verbalize the process to update the care plan in the Electronic Medical Record to ensure competency.

7. The Director of Nursing and ETD educated all licensed nurses on physician notification, change in condition and Medical Director Notification on 05/07/2020 through 05/09/2020. The education also included documentation requirements for physician notifications in the medical record. Resident skin inspections to include, but not limited to, circulatory indicators of capillary refill,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 33	F 657		

pedal pulses, and vital signs. Any new/undocumented skin impairments or signs/symptoms of circulatory problems require immediate physician notification and documentation in the medical record in the nursing progress notes. In addition, staff will update care plans with the new interventions related to a change in a resident's status.

8. On 05/07/2020 through 05/08/2020, all licensed nurses were required to complete a post-test to verify training competency related to physician notification, change in condition and Medical Director Notification. The nurses were required to receive a score of 100% before resuming duties. Licensed nurses on leave will be required to have this education and pass a posttest prior to returning to work. Any newly hired licensed nurse will receive this education/testing from the ETD and/or DON prior to assuming duties.

9. On 05/08/2020 the Director of Nursing, MDS Coordinator, Wound Nurse, and Nurse Managers completed a review of the last thirty days of Interdisciplinary Team (IDT) notes and physician's orders to ensure staff had made physician notification in any change of resident condition. The review included ensuring staff had updated resident care plans to reflect the change of condition and any associated interventions. The Director of Nursing, MDS Coordinator, Wound Nurse, and Nurse Managers identified no concerns.

10. On 05/08/2020, the Director of Nursing, Unit Manager and/or Weekend Supervisor, initiated an on-going audit of the prior 24- hour nursing notes and physician's orders to ensure the identification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 34	F 657		

of any resident circulatory concerns, physician notification, and care plan updates. Nursing leadership will address any concerns when discovered.

11. On 05/08/2020, the QAPI team held a second ad hoc meeting to review the initial skin/circulatory audits, physician notifications and care plan updates, as well as the status of the licensed nurse's education initiated on 05/07/2020. The Administrator reviewed the results with the Medical Director on 05/08/2020.

***The State Survey Agency verified the facility implemented the following actions to remove Immediate Jeopardy on 05/13/2020, as alleged:

1. Review of the medical record revealed the facility transferred Resident #1 to the hospital on 04/24/2020 and the resident did not return to the facility.

2. A review of QAPI Committee meeting minutes dated 05/07/2020 revealed the committee reviewed the Immediate Jeopardy notifications and the action plans for facility compliance. Review of the meeting sign in sheet dated 05/07/2020, revealed the facility's department heads attended. Interviews, conducted on 05/21/2020, with the Administrator, Medical Director, Director of Nursing (DON), the Unit Managers, and the Minimum Data Set (MDS) Coordinator revealed the facility had conducted a QAPI meeting on 05/07/2020 to discuss the immediate jeopardy and to initiate the development of a plan of action for compliance.

3. A review of skin assessments conducted from 05/06/2020 through 05/08/2020 revealed all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 35	F 657		

residents had a head to toe skin assessment performed to include evaluation of pedal pulses and capillary refill. Review of skin assessments completed for Resident #4, Resident #5, Resident #6 and Resident #7 revealed the assessments were completed with no concerns identified. Observation of skin assessments for Resident #6 and Resident #7 conducted on 05/20/2020, included evaluation of pedal pulses and capillary refill with no concerns identified. Interviews with the DON, Unit Manager #1, and Unit Manager #2 on 05/21/2020 revealed all residents' skin, pedal pulses, and capillary refill status was assessed by 05/08/2020.

4. A review of skin assessment audits completed by the DON on 05/08/2020 revealed the DON had audited a sample of fifteen (15) completed skin assessments with no issues identified. Review of the May 2020 skin assessments completed for Resident #4, Resident #5, Resident #6, and Resident #7 revealed no concerns with the completion or accuracy of the assessments. Interview with the DON on 05/21/2020 at 2:38 PM revealed she had conducted audits of the skin assessments performed on 05/08/2020, of three (3) residents from each hallway with no new issues or changes of condition found.

5. A review of daily audits completed from 05/12/2020 through 05/20/2020 by the DON, Unit Managers, Wound Nurse, and the Weekend Supervisor revealed five (5) residents from each unit were assessed daily for circulatory changes, capillary refill, and pedal pulses. The assessments were compared with assessments completed on 05/08/2020 with no concerns identified. Interviews with the DON, Unit Manager #1, Unit Manager #2, the Wound Nurse, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 36	F 657		

Weekend supervisor conducted on 05/21/2020 revealed they were assessing a sample of residents daily on each unit for circulatory concerns to ensure any changes in a resident's condition was identified.

6. A review of an in service education sign in sheet dated 05/07/2020 revealed the MDS Nurse had educated the EDT on updating resident care plans when a change in condition occurred. Interview with the MDS Nurse on 05/21/2020 at 1:42 PM revealed she had trained the EDT on the requirement to update the plan of care when a resident had a change of condition. Interview with the EDT Nurse on 05/21/2020 at 1:57 PM, revealed the MDS Nurse had educated her on updating resident care plans on 05/07/2020. The EDT stated she educated all licensed nurses except employees who were on leave regarding the requirement by 05/08/2020. Further interview with the EDT revealed employees who were on leave could not work until the training was completed. Review of employee in-service education sign in sheets revealed all licensed employees were educated on updating resident care plans when a change in condition occurred on 05/08/2020 by the EDT Nurse. Interviews conducted with LPN #3, LPN #4, Unit Manager #1, Unit Manager #2, and the Weekend Supervisor on 05/21/2020 revealed they received education on 05/08/2020 by the EDT on updating care plans when a resident had a change of condition.

7. A review of Education Sign in Sheets dated 05/07/2020 through 05/09/2020 revealed all nurses were educated by the DON and EDT on physician notification, change of condition, Medical Director Notification if the physician could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 37	F 657		

not be reached and documentation requirements for physician notifications in the medical record. The education referenced resident skin inspections, circulatory indicators of capillary refill, pedal pulses, and vital signs. Any new/undocumented skin impairments or signs/symptoms of circulatory problems required immediate physician notification and documentation in the medical record and updating the plan of care with the new interventions related to a change in resident's status. Interviews with the DON at 2:38 PM and the EDT Nurse at 1:57 PM on 05/21/2020, revealed they had in serviced all nursing staff from 05/07/2020 through 05/08/2020 regarding physician notification, change of condition, conducting assessments for circulatory issues, updating the plan of care and documenting in the medical record. Interviews on 05/21/2020 conducted with LPN #3, LPN #4, Unit Manager #1, Unit Manager #2, the MDS Nurse and the Weekend Supervisor revealed the EDT and the DON had in serviced them related to the process for physician notification of change of condition, conducting skin assessments to identify circulatory concerns, updating the resident's plan of care and documenting in the resident's medical record.

8. A review of post-tests completed by licensed nursing staff on 05/07/2020 and 05/08/2020 revealed all nursing staff had completed a post-test with a satisfactory score. Interviews with LPN #1, LPN #2, Unit Manager #1, Unit Manager #2, the MDS Nurse, and the Weekend supervisor on 05/21/2020 revealed they completed a post-test after the education provided by the EDT and the DON on 05/07/2020 or 05/08/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 38	F 657		

9. Review of the past thirty days Progress Notes and Physician Order audits completed by the DON, MDS Coordinator, Wound Nurse and Nurse Managers on 05/08/2020, revealed no concerns with notification of change of condition and resident care plans being updated accordingly. Observations conducted on 05/20/20 for Resident #4, Resident #5, Resident #6, and Resident #7 revealed no concerns with change of condition. Record reviews conducted for Resident #4, Resident #5, Resident #6, and Resident #7's May 2020 Nurse's Notes, physicians orders, skin assessments, and the plan of care revealed no concerns with change of condition, updating the plan of care or physician notification. Interviews with the DON, Unit Manager #1, and Unit Manager #2, on 05/21/2020 revealed they had reviewed thirty days of progress notes, physician orders, and residents' care plans to ensure changes of condition had been identified, physicians were notified, and the resident's care plan was updated with new interventions on 05/08/2020 with no issues identified.

10. A review of daily nursing note audits and physician's orders completed from 05/08/2020 through 05/20/20 by the DON, Unit Managers, and the Weekend Supervisor revealed nursing notes and physicians orders were reviewed daily for any concerns with resident changes in condition, circulatory status, and validating the care plan had been updated with new interventions. A review of the medical records for Resident #4, Resident #5, Resident #6, and Resident #7 to include May 2020 Progress Notes, Physicians Orders, and the Plan of Care revealed no concerns with physician notification of change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 39	F 657		

of condition or with updates to the plan of care for the residents. Interviews with the DON, Unit Manager #1, Unit Manager #2 and the Weekend Supervisor on 05/21/2020 revealed they had reviewed the previous twenty-four hour nursing notes and physician's orders daily to ensure physician notification and that care plans were updated to reflect any change in resident condition.

11. A review of the QAPI Committee meeting minutes dated 05/08/2020 revealed the QAPI Committee reviewed audit findings of skin assessments, physician notifications, care plan updates, and the status of licensed nurse's education initiated on 05/07/2020. A review of QAPI Committee Meeting Minutes for 05/12/2020 and 05/19/2020 revealed the QAPI Committee was meeting weekly to review audit findings and to monitor the facility's plan of action. An interview with the Medical Director on 05/21/2020 at 2:49 PM reveled the Medical Director attended the QAPI meeting on 05/07/2020 by phone to review the Immediate Jeopardy Notification and the Plan of Action. Further interview with the Medical Director revealed she attended the QAPI meeting on 05/08/2020 in person to review the facility's audits and education progress. The Medical Director stated staff would contact her within thirty minutes if they were not able to reach a resident's physician when the resident had a change of condition. The Medical Director stated she had been attending weekly QAPI meetings to monitor the facility's compliance. An interview with the Administrator on 05/21/2020 at 3:05 PM revealed she had been monitoring the QAPI process for compliance daily by conducting the morning meetings to ensure daily audits were completed and any identified concerns were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 40 addressed. In addition, the Administrator had conducted weekly QAPI Meetings for continued review of audit findings and monitoring the facility's compliance and Immediate Jeopardy removal.	F 657		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the "Merck Manual" (medical information resource manual), it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1) received necessary care and treatment in accordance with professional standards. On 04/08/2020, Resident #1 developed a small, red area on the top of his/her left foot which progressively declined until 04/24/2020, when the resident's foot and leg were cold, mottled (Mottling is blotchy, red-purplish marbling of the skin can be a symptom of a	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 41	F 684		

serious underlying condition, such as vascular disease), had necrotic (dead) tissue and staff could not palpate a pulse in the resident's foot or at the knee. Although staff notified Resident #1's physician on several occasions from 04/08/2020 through 04/17/2020, regarding the resident's left extremity, the staff failed to recognize, identify, and act upon clinical indications that the resident's circulatory status was continuing to decline from 04/08/2020 through 04/23/2020. Subsequently, the facility took no action to contact the resident's physician and/or ensure further diagnostic testing was conducted. On 04/24/2020, Resident #1 was transferred to the hospital and diagnosed with Critical Lower Limb Ischemia (restricted blood supply to tissue) with an "Occlusion of the mid left superficial femoral artery distally" (artery in the groin area was blocked). Continued review of hospital records revealed on 04/25/2020, Resident #1's left leg was surgically removed above the left knee due to "Profound ischemia (restricted blood flow) and cadaveric (corpse like) left lower extremity."

The facility's failure to ensure residents received care and treatment has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/06/2020, and was determined to exist on 04/14/2020 at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657), and 42 CFR 483.25 Quality of Care (F684). The facility was notified of the Immediate Jeopardy on 05/06/2020. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F684).

An acceptable Allegation of Compliance was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 42	F 684		

received on 05/13/2020, which alleged removal of Immediate Jeopardy on 05/13/2020. The State Survey Agency determined the Immediate Jeopardy was removed on 05/13/2020, as alleged, prior to exit on 05/21/2020, which lowered the scope and severity to "D" level at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657), and 42 CFR 483.25 Quality of Care (F684), while the facility monitors the effectiveness of systemic changes and quality assurance activities.

The findings include:

Interview with the Administrator on 04/30/2020 at 1:00 PM revealed the facility had no policy related to Nursing Assessment. Email correspondence with the Administrator on 05/05/2020 also revealed the facility had no policy related to Professional Standards of Practice. However, interview with the Administrator on 05/05/2020 at 5:40 PM, revealed if a resident experienced a change in condition, she expected staff to reassess the resident, and if the change in condition continued, staff should notify the resident's physician.

According to the Merck Manual, modified July 2019, symptoms of occlusive peripheral arterial disease varied; however, when an artery narrows, the part of the body it supplies may not receive enough blood resulting in ischemia (lack of blood flow/oxygen). Ischemia is a severe condition that can cause tissue damage and loss of limbs. This condition will not improve on its own and requires appropriate medical attention. In the limbs, early symptoms of ischemia may include claudication (pain, burning, or cramping in the muscles with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 43	F 684		

exercise that goes away with rest). This can progress over time to critical limb threatening ischemia, the reduction of blood flow to the affected extremity that results in severe pain or tissue loss. If the tissue of the limb has been affected, a non-healing sore or even gangrene may occur and the skin turns black; this requires immediate attention.

Further review of the Merck Manual revealed when the blood supply is severely reduced, the foot may be cold, and special equipment may be needed to detect pulses in the foot. As the artery is narrowed further, a person may develop sores that do not easily heal, typically on the toes or heel and occasionally on the lower leg, especially after an injury.

Continued review of the Merck Manual revealed sudden, complete blockage of an artery in a leg or an arm may cause severe pain, coldness, and numbness in the affected limb. The person's leg or arm is either pale or bluish (cyanotic). No pulse can be felt below the blockage. The sudden, drastic decrease in blood flow to the limb is a medical emergency. The absence of blood flow can quickly result in loss of sensation in or paralysis of a limb. If blood flow is absent for too long, tissue may die, and the limb may need to be amputated.

Review of Resident #1's medical record revealed the facility admitted the resident on 01/23/2020 with diagnoses that included Alzheimer's Disease and Muscle Weakness. Review of Resident #1's Admission Minimum Data Set Assessment (MDS) dated 01/29/2020, revealed the resident required extensive assistance of two (2) staff members with transfers/toileting, personal hygiene, and bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 44	F 684		

mobility. Further review revealed the resident could ambulate (walk) with the assistance of one person. The MDS also revealed Resident #1 was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of five (5). According to the MDS, Resident #1 had no venous or arterial ulcers (wounds on the leg or ankle caused by poor circulation); and no other ulcers, wounds, or skin problems of the foot.

Review of a "Skin Ulcer/Injury Form" for Resident #1, revealed on 04/08/2020 at 5:00 PM, the resident's physician was notified because a red spot was observed on the top of Resident #1's left foot. According to the documentation, the resident told staff that he/she "bumped" his/her foot.

Review of Nurse's Notes revealed on 04/10/2020, at 1:53 PM staff documented that Resident #1's left foot was "now" swollen, red, a small bruise was noted to the top of the left foot and left great toe, and the resident complained of pain. Staff documented that the resident's physician was contacted to request scheduled pain medication because Resident #1 was not "alert enough to ask" for pain medication, until his/her "pain is out of control." Resident #1's medical record also revealed on 04/10/2020 at 2:24 PM that therapy staff would be asked to screen the resident.

Review of Resident #1's Therapy Notes revealed Physical Therapy evaluated the resident on 04/13/2020 and noted that the resident complained of pain with weight bearing to the left foot/ankle. Continued review of the Nurse's Notes revealed on 04/13/2020 at 4:13 PM, therapy staff reported to nursing that Resident #1 would not bear weight to the left lower extremity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 45	F 684		

and the resident's physician was notified. An order for an x-ray of the left lower extremity was obtained; and, the x-ray report revealed the resident had no acute fracture or dislocation.

Further review of Resident #1's Nurse's Notes revealed the next day, on 04/14/2020 at 4:07 AM, Registered Nurse (RN) #1 documented that the resident's left foot was cold, mottled, pulses were thready (pulse is not easily felt and commonly rapid), and the resident's capillary refill was abnormal (time taken for color to return normal after pressure has been applied. A prolonged capillary refill time may indicate decreased peripheral perfusion or peripheral artery disease). There was no documented evidence that the facility identified this as an acute change in the resident's condition; subsequently, no action was taken to address the resident's circulatory compromise to the resident's foot.

Continued review of the Nurse's Notes for Resident #1, revealed on 04/15/2020, staff documented the resident's bruises had improved, and that the resident had pedal pulses and no pain. However, review of the resident's Physical Therapy Notes for 04/15/2020 revealed the resident was only able to take one step with a rolling walker "with significant complaints of left foot pain."

Further review of Resident #1's Nurse's Notes revealed on 04/16/2020, at 8:36 PM, Resident #1's left lower extremity was discolored and capillary refill was "slow". According to the Note, the resident's physician was notified and an order for a Venous Doppler (a test to check the circulation/check for clots in the large veins in the legs) was obtained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 46	F 684		

Continued review of the Nurse's Notes revealed on 04/17/2020 at 4:51 PM, Resident #1's left leg had become cold to the touch from the resident's knee to the toes, had discoloration from the shin to the toes, the left foot was swollen, had bruising to the top of the foot and the top of all toes, and the resident's pedal pulses were faint. In addition, despite being on scheduled pain medication, the Note also stated that the resident continued to voice pain with movement of his/her left leg/foot. According to the Note, a Doppler study had been completed and the facility was awaiting the results. In addition, Resident #1's Physical Therapy Notes also indicated on 04/17/2020 that the resident "continues to have pain in left foot/ankle" and was "unable to bear weight" on his/her left lower extremity "due to pain". The Notes stated an ultrasound had been ordered and staff were awaiting results of the test. Again, there was no documented evidence the facility identified this acute change in the resident's condition and no action was taken to address the worsening condition of the resident's foot/leg.

Review of Resident #1's Venous Doppler test results revealed the test was conducted on 04/17/2020 and no abnormal findings were indicated. Review of Nurse's Notes dated 04/17/2020 at 7:06 PM, revealed the physician was notified of the results of the test.

However, continued review of Resident #1's Nurse's Notes revealed on 04/18/2020, 04/19/2020, and 04/20/2020, staff continued to document that the resident's left foot/left extremity continued to be cool to touch and was discolored. In addition, the resident's Physical Therapy (PT)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 47	F 684		

Notes revealed that the resident had difficulty bearing weight to the left lower extremity on 04/20/2020. Further review revealed there was no documented evidence that staff took any action to ensure Resident #1 received care and treatment to address the signs/symptoms of decreased blood flow to his/her foot and leg.

On 04/21/2020 at 2:08 AM, staff documented that Resident #1's feet were cold despite wearing socks, his/her feet were mottling, pulses were thready, capillary refill was abnormal, and had bruising to the left foot and to the great and second toe. In addition, PT Notes for 04/21/2020 revealed the resident had decreased weight bearing because of pain in the left foot, the notes also indicated, "X-ray and Doppler were negative."

Further review of Resident #1's medical record revealed there was no documented assessment of the resident's foot/leg on 04/22/2020.

On 04/23/2020 at 1:35 PM, review of Nurse's Notes revealed that Resident #1's left lower extremity continued to be cool to touch with discoloration from the knee to the toes, pitting edema to the foot and lower leg, and pulses were noted in the resident's foot. In addition, Resident #1's Physical Therapy Notes for 04/23/2020 revealed the resident continued to bear weight on his/her right lower extremity only, and the therapist documented "short wave diathermy is contraindicated due to possible blood flow impairment and cognitive deficits." Again, no action was taken to address Resident #1's circulatory compromise to the left leg/foot.

Review of Nurse's Notes revealed on 04/24/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 48	F 684		

at 8:35 AM, RN #1 documented that the "bruises" that had "appeared" on 04/08/2020 to the ventral side of Resident #1's foot had become dry, necrotic areas. In addition, the resident's toes, lateral, ventral, and plantar surfaces of the foot, and the heel were deep purple with black areas. The left knee had a red/purple area covering most of the proximal aspect of the patella (knee), and was cool and tender to touch. The RN also documented that the resident had pain, no palpable pedal pulses nor popliteal pulses (pulses in the foot and knee), and the skin between the knee and foot was cold and mottling. According to the Nurse's Note, the resident's physician's office was contacted and a staff member at the physician's office was going to have the physician make a "tele call" (tele medicine/video) to view the resident's foot when the physician arrived at the office.

Continued review of Resident #1's medical record revealed staff documented on 04/24/2020 at 1:10 PM that the resident was transferred to the hospital.

Review of Resident #1's Emergency Medical Services (EMS) transportation sheet revealed EMS was notified of the need to transport the resident to the hospital on 04/24/2020 at 11:53 AM. Continued review of the EMS sheet revealed the resident arrived at the hospital for evaluation and treatment at 12:30 PM on 04/24/2020.

Review of Resident #1's medical record from Hospital #1 revealed the resident was diagnosed with Critical Lower Limb Ischemia (restricted blood supply to tissue) and "Occlusion of the mid left superficial femoral artery distally" (the artery in the left groin area was blocked). Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 49	F 684		

was transferred to a larger medical center (Hospital #2) for further care/treatment on 04/24/2020.

Review of Resident #1's medical record from Hospital #2 revealed Resident #1's left leg was amputated (surgically removed) above his/her knee on 04/25/2020 related to "Profound ischemia (restricted blood flow) and cadaveric (corpse like) left lower extremity."

Interview with State Registered Nurse Aide (SRNA) #4 on 05/03/2020 at 2:40 PM revealed she frequently cared for Resident #1 and nursing staff had told her that an ultrasound had been completed on the resident's leg and was normal. However, according to SRNA #4, the discoloration and area to the resident's foot "just kept getting worse." The SRNA stated the resident would be "moaning and complaining of pain whether we moved (him/her) or not." SRNA #1 stated she reported to nursing staff the changes she observed to the resident's leg and foot; however, she stated, "It continually got progressively worse."

Interview with SRNA #2 on 05/03/2020 at 6:35 PM revealed she frequently cared for Resident #1 and had observed "bruising" to the resident's left foot around 04/09/2020. SRNA #2 stated she was on leave from work, and when she returned the week of April 15, 2020 (unable to recall the exact date), the resident's left leg was "purple" in appearance and the resident moaned with pain when staff moved his/her leg. SRNA #2 stated she reported the changes in the resident's leg to nursing staff, who stated they were aware of the change in Resident #1's condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 50	F 684		

Interview with SRNA #3 on 05/04/2020 at 12:20 PM revealed she also frequently provided care for Resident #1. She stated around the time the facility received the Venous Doppler results (approximately 04/17/2020) bruising was observed to Resident #1's big toe on his/her left foot. She stated "days later" the "bruising" started going up the resident's leg. SRNA #3 also stated Resident #1's left leg was "colder" to touch than the right leg and remained that way for approximately two (2) weeks before he/she went to the hospital. In addition, SRNA #3 stated the resident "just hurt, period." She stated, "Anything to do with that leg from the time the bruising started, hurt." The SRNA also stated she reported the changes in the resident's condition to facility nurses, including LPN #1.

Interview with SRNA #1 on 05/02/2020 at 6:00 PM revealed Resident #1 "had a lot of pain" to the left foot. He stated the last few times he cared for the resident, the resident required more assistance with bed mobility "because of the pain." He further stated that he cared for Resident #1 during the night shift (7 PM-7 AM) on 04/23-24/2020. SRNA #1 stated the resident's leg "was cold and looked bad" during his shift. He stated the facility nurses were aware and were also concerned. SRNA #1 stated he observed them (the nurses) "Googling" information on their phones regarding the resident's leg. He stated the nurses "thought it was dry gangrene." The SRNA was unable to recall exactly what time the change in the resident's leg was observed, but stated, "It was early morning," on 04/24/2020.

Interview with the Physical Therapist on 05/04/2020 at 2:30 PM revealed Resident #1's left foot was "really painful" and the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 51	F 684		

"didn't want to put weight on it." He stated he notified Nursing of the resident's complaints of pain and inability to bear weight. In addition, the Therapist stated Resident #1's left leg was "cooler to touch" than his/her right leg; however, he did not assess the resident's pulses in his/her lower extremities.

Interview with LPN #1 at 3:50 PM on 05/04/2020 revealed she documented Resident #1's assessment findings on 04/17/2020 and observed that the resident's pedal pulses were faint, and his/her left leg was discolored from the shin to the resident's toes. LPN #1 acknowledged the resident's leg never improved after the diagnostic test results were negative for a venous blood flow problem on 04/17/2020. She acknowledged that nursing assessments should guide care. LPN #1 stated the resident's physician should have been notified so other diagnostic tests could have been conducted. LPN #1 stated that contacting the physician when the resident did not improve could have made a difference in the outcome for the resident, especially since his/her concern was later determined to be arterial.

Interview with RN #1 at 8:15 AM on 05/05/2020 revealed she assessed Resident #1 on 04/14/2020 and 04/21/2020. RN #1 stated, "Looking back, I would have been more persistent with physician notification after the Doppler results." She stated, "My gut was telling me something was wrong." On 04/24/2020 at approximately 4:00 AM, the RN stated she observed dry, necrotic (dead) tissue to the resident's toes, lateral/ventral aspects of his/her foot, and his/her heel. RN #1 stated the resident's left knee also had a red/purple area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 52	F 684		

covering most of the proximal aspect (front center) of his/her knee, and she was unable to obtain pulses to Resident #1's left foot or behind his/her knee.

Further interview with RN #1 revealed she paged the resident's physician at approximately 6:30 AM on 04/24/2020 to notify him of the change in the resident's condition; however, the physician did not return the call at that time. She stated she waited until the physician's office was open, around 8:00 AM, and notified office staff; however, she was informed the physician was at the hospital. According to the RN, she was not able to document the resident's assessment until 8:35 AM on 04/24/2020. RN #1 stated once she completed resident documentation, and was able to leave the facility, she went to the physician's office (around 9:00 AM approximately five [5] hours after the assessment of the decline in the resident's condition) and notified Resident #1's physician of the change in his/her condition. RN #1 stated the physician directed his office staff to arrange for Resident #1 to be directly admitted to the hospital for further evaluation and treatment. RN #1 stated that although it was the facility's practice to notify the physician at the time a change in condition was identified to have occurred, she had been unsuccessful in contacting Resident #1's physician prior to going to the physician's office.

Interview with the Director of Nursing (DON) on 05/05/2020 at 5:00 PM revealed residents' condition was monitored daily, Monday-Friday, during an Interdisciplinary Team (IDT) meeting. The DON stated nursing documentation, twenty-four (24) report sheets, laboratory results, and physician orders were monitored during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 53	F 684		

meeting to ensure changes had been addressed. However, the DON stated she did not recall identifying that Resident #1 had an ongoing change in condition, nor any documentation that indicated the resident's foot/leg was cold/mottled or his/her pulses were thready. The DON stated she was notified of the resident's change in condition the morning of 04/24/2020 when she arrived at the facility.

Interview with LPN #2 on 05/20/2020 at 1:15 PM revealed staff had not been trained on signs/symptoms of vascular or arterial issues "until this happened to this resident" in reference to Resident #1.

Email correspondence with the Administrator on 05/06/2020 at 1:59 PM revealed the facility had provided no education related to the signs and/or symptoms of arterial ulcers to direct care nursing staff.

Interview with Physician #1 on 05/05/2020 at 12:50 PM revealed staff had not informed him that Resident #1's pulses were thready in his/her left foot, or that the resident's leg/foot was cold to touch until 04/24/2020. He stated staff were required to notify him when changes in a resident's condition occurred. However, the physician confirmed he received no calls from the facility related to Resident #1's condition, after he was notified of the normal Venous Doppler results on 04/17/2020. He stated if staff had informed him of the ongoing change in the resident's condition, after the Venous Doppler ultrasound was conducted, he would have ordered an Arterial Doppler and Resident #1 could have potentially had a different outcome.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 54	F 684		

Interview with Physician #2 on 05/14/2020 at 4:00 PM revealed he evaluated Resident #1 on 04/24/2020 at Hospital #1. He stated when he evaluated the resident his thought was that the resident "could have had blockages for a while." Physician #2 stated lower extremities being cool to touch and thready pulses were "definitely a sign that was when the problem started" for Resident #1. He also stated those assessment findings were "telltale signs" that something was wrong and he would expect licensed nurses to inform a physician of those findings when they were identified.

Interview with Physician #3 on 05/18/2020 at 11:10 AM revealed he evaluated Resident #1 at Hospital #2. He stated he conducted the surgical removal of the resident's left lower extremity above the knee on 04/25/2020, because the resident's leg had been without blood supply. Physician #3 stated Resident #1 also had "full thick necrosis on multiple areas of" the foot and toes. He stated the resident appeared to have "two weeks' worth of ischemia" before the resident got to the hospital and stated, "It definitely didn't just happen."

***The facility implemented the following actions to remove Immediate Jeopardy effective 05/13/2020:

1. Resident #1 no longer resides at the facility.

2. The facility held an ad hoc QAPI (Quality Assurance and Performance Improvement) committee meeting on 05/07/2020 to review the Immediate Jeopardy findings and discuss the development of the action items to be completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 55	F 684		

3. Members of the clinical leadership team conducted head-to-toe skin inspections on 05/08/2020, which included checking pedal pulses and capillary refill for all residents. No new circulatory concerns were identified.

4. On 05/08/2020, the Director of Nursing (DON) selected a sample of three (3) completed skin inspection forms from each hall (15 in total), as a second review. The DON identified no concerns.

5. Beginning on 05/12/2020, the DON, Unit Manager, Wound Nurse, and/or Nurse Supervisor will assess five (5) residents per unit daily to assess circulatory changes, capillary refill, and pedal pulses, comparing to the documented baseline from 05/07/2020. Staff completing the assessments will immediately address any concerns. The monitoring will continue until the facility meets regulatory compliance. The QAPI team will review the results at least weekly to track the facility's progress toward regulatory compliance.

6. The Minimum Data Set (MDS) Coordinator provided education to the Education Training Director (ETD) regarding updating resident care plans when a resident's change in condition occurs. The ETD then provided this education to all licensed nurses by 05/08/2020. Each nurse was required to verbalize the process to update the care plan in the Electronic Medical Record to ensure competency.

7. The Director of Nursing and ETD educated all licensed nurses on physician notification, change in condition and Medical Director Notification on 05/07/2020 through 05/09/2020. The education also included documentation requirements for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 56	F 684		

physician notifications in the medical record. Resident skin inspections to include, but not limited to, circulatory indicators of capillary refill, pedal pulses, and vital signs. Any new/undocumented skin impairments or signs/symptoms of circulatory problems require immediate physician notification and documentation in the medical record in the nursing progress notes. In addition, staff will update care plans with the new interventions related to a change in a resident's status.

8. On 05/07/2020 through 05/08/2020, all licensed nurses were required to complete a post-test to verify training competency related to physician notification, change in condition and Medical Director Notification. The nurses were required to receive a score of 100% before resuming duties. Licensed nurses on leave will be required to have this education and pass a posttest prior to returning to work. Any newly hired licensed nurse will receive this education/testing from the ETD and/or DON prior to assuming duties.

9. On 05/08/2020 the Director of Nursing, MDS Coordinator, Wound Nurse, and Nurse Managers completed a review of the last thirty days of Interdisciplinary Team (IDT) notes and physician's orders to ensure staff had made physician notification in any change of resident condition. The review included ensuring staff had updated resident care plans to reflect the change of condition and any associated interventions. The Director of Nursing, MDS Coordinator, Wound Nurse, and Nurse Managers identified no concerns.

10. On 05/08/2020, the Director of Nursing, Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 57	F 684		

Manager and/or Weekend Supervisor, initiated an on-going audit of the prior 24- hour nursing notes and physician's orders to ensure the identification of any resident circulatory concerns, physician notification, and care plan updates. Nursing leadership will address any concerns when discovered.

11. On 05/08/2020, the QAPI team held a second ad hoc meeting to review the initial skin/circulatory audits, physician notifications and care plan updates, as well as the status of the licensed nurse's education initiated on 05/07/2020. The Administrator reviewed the results with the Medical Director on 05/08/2020.

***The State Survey Agency verified the facility implemented the following actions to remove Immediate Jeopardy on 05/13/2020, as alleged:

1. Review of the medical record revealed the facility transferred Resident #1 to the hospital on 04/24/2020 and the resident did not return to the facility.

2. A review of QAPI Committee meeting minutes dated 05/07/2020 revealed the committee reviewed the Immediate Jeopardy notifications and the action plans for facility compliance. Review of the meeting sign in sheet dated 05/07/2020, revealed the facility's department heads attended. Interviews, conducted on 05/21/2020, with the Administrator, Medical Director, Director of Nursing (DON), the Unit Managers, and the Minimum Data Set (MDS) Coordinator revealed the facility had conducted a QAPI meeting on 05/07/2020 to discuss the immediate jeopardy and to initiate the development of a plan of action for compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 58	F 684		

3. A review of skin assessments conducted from 05/06/2020 through 05/08/2020 revealed all residents had a head to toe skin assessment performed to include evaluation of pedal pulses and capillary refill. Review of skin assessments completed for Resident #4, Resident #5, Resident #6 and Resident #7 revealed the assessments were completed with no concerns identified. Observation of skin assessments for Resident #6 and Resident #7 conducted on 05/20/2020, included evaluation of pedal pulses and capillary refill with no concerns identified. Interviews with the DON, Unit Manager #1, and Unit Manager #2 on 05/21/2020 revealed all residents' skin, pedal pulses, and capillary refill status was assessed by 05/08/2020.

4. A review of skin assessment audits completed by the DON on 05/08/2020 revealed the DON had audited a sample of fifteen (15) completed skin assessments with no issues identified. Review of the May 2020 skin assessments completed for Resident #4, Resident #5, Resident #6, and Resident #7 revealed no concerns with the completion or accuracy of the assessments. Interview with the DON on 05/21/2020 at 2:38 PM revealed she had conducted audits of the skin assessments performed on 05/08/2020, of three (3) residents from each hallway with no new issues or changes of condition found.

5. A review of daily audits completed from 05/12/2020 through 05/20/2020 by the DON, Unit Managers, Wound Nurse, and the Weekend Supervisor revealed five (5) residents from each unit were assessed daily for circulatory changes, capillary refill, and pedal pulses. The assessments were compared with assessments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 59	F 684		

completed on 05/08/2020 with no concerns identified. Interviews with the DON, Unit Manager #1, Unit Manager #2, the Wound Nurse, and the Weekend supervisor conducted on 05/21/2020 revealed they were assessing a sample of residents daily on each unit for circulatory concerns to ensure any changes in a resident's condition was identified.

6. A review of an in service education sign in sheet dated 05/07/2020 revealed the MDS Nurse had educated the EDT on updating resident care plans when a change in condition occurred. Interview with the MDS Nurse on 05/21/2020 at 1:42 PM revealed she had trained the EDT on the requirement to update the plan of care when a resident had a change of condition. Interview with the EDT Nurse on 05/21/2020 at 1:57 PM, revealed the MDS Nurse had educated her on updating resident care plans on 05/07/2020. The EDT stated she educated all licensed nurses except employees who were on leave regarding the requirement by 05/08/2020. Further interview with the EDT revealed employees who were on leave could not work until the training was completed. Review of employee in-service education sign in sheets revealed all licensed employees were educated on updating resident care plans when a change in condition occurred on 05/08/2020 by the EDT Nurse. Interviews conducted with LPN #3, LPN #4, Unit Manager #1, Unit Manager #2, and the Weekend Supervisor on 05/21/2020 revealed they received education on 05/08/2020 by the EDT on updating care plans when a resident had a change of condition.

7. A review of Education Sign in Sheets dated 05/07/2020 through 05/09/2020 revealed all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 60	F 684		

nurses were educated by the DON and EDT on physician notification, change of condition, Medical Director Notification if the physician could not be reached and documentation requirements for physician notifications in the medical record. The education referenced resident skin inspections, circulatory indicators of capillary refill, pedal pulses, and vital signs. Any new/undocumented skin impairments or signs/symptoms of circulatory problems required immediate physician notification and documentation in the medical record and updating the plan of care with the new interventions related to a change in resident's status. Interviews with the DON at 2:38 PM and the EDT Nurse at 1:57 PM on 05/21/2020, revealed they had in serviced all nursing staff from 05/07/2020 through 05/08/2020 regarding physician notification, change of condition, conducting assessments for circulatory issues, updating the plan of care and documenting in the medical record. Interviews on 05/21/2020 conducted with LPN #3, LPN #4, Unit Manager #1, Unit Manager #2, the MDS Nurse and the Weekend Supervisor revealed the EDT and the DON had in serviced them related to the process for physician notification of change of condition, conducting skin assessments to identify circulatory concerns, updating the resident's plan of care and documenting in the resident's medical record.

8. A review of post-tests completed by licensed nursing staff on 05/07/2020 and 05/08/2020 revealed all nursing staff had completed a post-test with a satisfactory score. Interviews with LPN #1, LPN #2, Unit Manager #1, Unit Manager #2, the MDS Nurse, and the Weekend supervisor on 05/21/2020 revealed they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 61	F 684		

completed a post-test after the education provided by the EDT and the DON on 05/07/2020 or 05/08/2020.

9. Review of the past thirty days Progress Notes and Physician Order audits completed by the DON, MDS Coordinator, Wound Nurse and Nurse Managers on 05/08/2020, revealed no concerns with notification of change of condition and resident care plans being updated accordingly. Observations conducted on 05/20/20 for Resident #4, Resident #5, Resident #6, and Resident #7 revealed no concerns with change of condition. Record reviews conducted for Resident #4, Resident #5, Resident #6, and Resident #7's May 2020 Nurse's Notes, physicians orders, skin assessments, and the plan of care revealed no concerns with change of condition, updating the plan of care or physician notification. Interviews with the DON, Unit Manager #1, and Unit Manager #2, on 05/21/2020 revealed they had reviewed thirty days of progress notes, physician orders, and residents' care plans to ensure changes of condition had been identified, physicians were notified, and the resident's care plan was updated with new interventions on 05/08/2020 with no issues identified.

10. A review of daily nursing note audits and physician's orders completed from 05/08/2020 through 05/20/20 by the DON, Unit Managers, and the Weekend Supervisor revealed nursing notes and physicians orders were reviewed daily for any concerns with resident changes in condition, circulatory status, and validating the care plan had been updated with new interventions. A review of the medical records for Resident #4, Resident #5, Resident #6, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 62	F 684		

Resident #7 to include May 2020 Progress Notes, Physicians Orders, and the Plan of Care revealed no concerns with physician notification of change of condition or with updates to the plan of care for the residents. Interviews with the DON, Unit Manager #1, Unit Manager #2 and the Weekend Supervisor on 05/21/2020 revealed they had reviewed the previous twenty-four hour nursing notes and physician's orders daily to ensure physician notification and that care plans were updated to reflect any change in resident condition.

11. A review of the QAPI Committee meeting minutes dated 05/08/2020 revealed the QAPI Committee reviewed audit findings of skin assessments, physician notifications, care plan updates, and the status of licensed nurse's education initiated on 05/07/2020. A review of QAPI Committee Meeting Minutes for 05/12/2020 and 05/19/2020 revealed the QAPI Committee was meeting weekly to review audit findings and to monitor the facility's plan of action. An interview with the Medical Director on 05/21/2020 at 2:49 PM reveled the Medical Director attended the QAPI meeting on 05/07/2020 by phone to review the Immediate Jeopardy Notification and the Plan of Action. Further interview with the Medical Director revealed she attended the QAPI meeting on 05/08/2020 in person to review the facility's audits and education progress. The Medical Director stated staff would contact her within thirty minutes if they were not able to reach a resident's physician when the resident had a change of condition. The Medical Director stated she had been attending weekly QAPI meetings to monitor the facility's compliance. An interview with the Administrator on 05/21/2020 at 3:05 PM revealed she had been monitoring the QAPI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 63 process for compliance daily by conducting the morning meetings to ensure daily audits were completed and any identified concerns were addressed. In addition, the Administrator had conducted weekly QAPI Meetings for continued review of audit findings and monitoring the facility's compliance and Immediate Jeopardy removal.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure pain management was provided to residents who required such services, consistent with professional standards of practice for one (1) of three (3) sampled residents (Resident #1). Review of Resident #1's Nursing Notes dated 04/08/2020, revealed the resident complained of pain in his/her left foot. The Nurses Notes indicated Tylenol (pain medication) was administered to the resident however, review of the Medication Administration Record (MAR) revealed no documented evidence the medication was given. Continued review of Resident #1's Nursing Notes revealed on 04/10/2020, Resident #1's physician ordered scheduled Tylenol and Diclofenac (anti-inflammatory medication) be administered. However, medical record review	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 64	F 697		

and staff interviews revealed the resident continued to complain of pain until 04/24/2020, when the facility transferred the resident to the hospital. Resident #1 was diagnosed with an occlusion of the mid left superficial femoral artery distally, and underwent surgical removal of the limb on 04/25/2020. There was no documented evidence the facility re-assessed the resident's pain or attempted to manage the resident's ongoing complaints of pain when the ordered medication was not effective.

The findings include:

Review of the facility's policy "Pain Management Process," dated October 2015, revealed the facility's goal was to ensure all residents received appropriate pain relief measures to ensure a resident's pain does not affect their ability to function within their designated goals. The policy also stated the facility would meet the resident's goals for pain control by the use of medications and alternative methods to reduce pain. In addition, the policy stated necessary intervention, evaluation, and re-evaluation would be a standard of care practice for licensed nurses.

Review of Resident #1's medical record revealed the facility admitted the resident on 01/23/2020 with diagnoses that included Alzheimer's Disease and Muscle Weakness.

Review of Resident #1's Admission Minimum Data Set (MDS) assessment dated 01/29/2020, revealed the staff assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5) indicating the resident was cognitively impaired and required extensive assistance of two (2) staff members with transfers, toileting and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 65	F 697		

bed mobility. In addition, staff assessed Resident #1 to have no pain and was not on a scheduled pain medication regimen.

Review of a Skin Ulcer/Injury Form dated 04/08/2020 at 5:00 PM, revealed staff assessed Resident #1 to have a red area on top of the left foot, caused by the resident "bumping" his/her foot. Review of Resident #1's Nursing Notes dated 04/08/2020 at 5:10 PM, revealed the resident's left foot was slightly red, tender to touch, and the resident complained of pain to the area. The nurse documented in the nursing notes that she administered Tylenol 650 mg (milligrams) to Resident #1 which the resident had ordered on an "as needed" basis. However, review of Resident #1's MARS for 04/08/2020 revealed no documented evidence the nurse administered the medication to Resident #1. Interview with Licensed Practical Nurse (LPN) #3 on 05/20/2020 at 1:50 PM, revealed the LPN stated she administered the resident's Tylenol on 04/08/2020 as indicated in her nurses notes. However, she stated the system has a "glitch" in it and sometimes it will remove documentation that "as needed" medication had been administered.

Interview with Resident #1's Daughter on 04/30/2020 at 4:15 PM revealed she went to the facility to visit Resident #1 through the window on 04/10/2020. She stated while at the window, Resident #1's roommate (unsampled Resident #8) yelled through the window and asked her if she was aware that Resident #1's leg was "hurt" and that Resident #1 had been "yelling out in pain." The daughter stated that was the first time she had heard about a problem with the resident's lower extremity; she stated the facility had not notified her of any concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 66	F 697		

An interview with Unsampled Resident #8, whom the facility assessed to have a BIMS' score of fourteen (14), indicating the resident was cognitively intact, was conducted on 04/30/2020 at approximately 11:30 AM. The roommate was unaware of what had happened to Resident #1's leg, but stated, "I just know it hurt (him/her) really bad." The roommate stated Resident #1 "yelled out and moaned in pain, but I couldn't help (him/her)". Unsampled Resident #8 stated he/she was glad to see Resident #1's Daughter at the window so "I could try and get help" for Resident #1.

Review of Nursing Notes dated 04/10/2020 at 1:53 PM, revealed Resident #1 was complaining of pain to the left foot/leg. Further review of the Nursing Note revealed staff contacted Resident #1's physician of the assessment and the resident's complaints of pain. Further review revealed the staff requested a scheduled pain medication be ordered, due to the resident's cognitive status and not being alert enough to request pain medication until the "pain is out of control". Continued review of Resident #1's Nursing Notes, revealed the resident's physician called the facility on 04/10/2020 at 3:38 PM and ordered the resident to receive scheduled Tylenol (pain reliever) 650 milligrams (mg) three times a day at 7 AM, 1 PM and 7 PM and Diclofenac (nonsteroidal anti-inflammatory medication) 75 mg twice a day at 7 AM and 7 PM. In addition, review of Resident #1's MAR revealed the resident also had a previous order for Tylenol 650 mg four times daily as needed, with the maximum dose of Tylenol not to exceed 3000 mg from all sources daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 67	F 697		

Continued review of Resident #1's Medication Administration Record revealed from 04/09/2020 through 04/24/2020 Resident #1 complained of pain on 04/09/2020, 04/10/2020, 04/11/2020, 04/13/2020, 04/17/2020, 04/18/2020, 04/19/2020, 04/20/2020, 04/23/2020, and 04/24/2020, despite receiving the scheduled Tylenol and Diclofenac. In addition, the MARS revealed Resident #1 was administered "as needed" Tylenol, in addition to the scheduled Tylenol and Diclofenac on 04/10/2020 at 1:56 PM and 10:20 PM, on 04/16/2020 at 7:23 PM and on 04/22/2020 at 10:45 PM. However, there was no documented evidence found to indicate that the facility ever re-evaluated the resident's on-going pain or notified the physician to obtain a more effective pain management regimen.

Review of Physical Therapy Notes for Resident #1, dated 04/14/2020, revealed therapy staff documented Resident #1 complained of pain when attempting to bear weight; and, on 04/15/2020, the resident had "significant complaints of left foot pain." On 04/17/2020, the Therapy Notes stated that Resident #1 remained unable to bear weight on the left extremity due to pain.

Interview with the Physical Therapist on 05/04/2020 at 2:30 PM, revealed the therapist described Resident #1's lower extremity to be "really painful." The therapist stated he notified nursing of the resident's "visible signs of pain."

Interview with State Registered Nurse Aide (SRNA) #1 on 05/02/2020 at 6:00 PM revealed he cared for Resident #1 during the night shift on 04/23/2020. SRNA #1 stated Resident #1 would exhibit "facial grimace and had a lot of pain."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 68	F 697		

SRNA #1 stated the "last few times" he had cared for Resident #1, the resident required the assistance of two (2) staff due to the amount of pain the resident was experiencing.

Interview with SRNA #4 on 05/03/2020 at 2:40 PM revealed Resident #1 would be "moaning" and complain of pain whether care was being provided or not. The SRNA stated, she reported the resident's complaints of pain to the nurses.

Interview with SRNA #2 on 05/03/2020 at 6:35 PM and SRNA #5 on 05/04/2020 at 1:00 PM, revealed both staff stated Resident #1 "moaned" when the left lower extremity was moved. The staff stated they notified the nursing staff of the resident's complaints of pain when care was provided.

Interview with SRNA #3 on 05/04/2020 at 12:20 PM revealed she frequently cared for Resident #1 and stated the resident "just hurt, period." SRNA #3 stated "anything to do with that leg from the time the bruising started" caused Resident #1 to be in pain.

Interview with Registered Nurse (RN) #1 at 8:15 AM on 05/05/2020 revealed she was assigned to care for Resident #1 on 04/24/2020. RN #1 stated when she touched the resident's left lower extremity, the resident "was yelping" in pain. RN #1 stated the resident's leg "only hurt if you touched or moved it."

Interview with Licensed Practical Nurse (LPN) #2 on 05/20/2020 at 1:15 PM revealed if a resident complained of pain their pain level should be assessed and documented on the MAR and later re-evaluated to ensure that the measures taken

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 69	F 697		

were effective to relieve the resident's pain.

Interview with LPN #3 on 05/20/2020 at 1:50 PM revealed if a resident complained of pain staff were required to re-evaluate the pain after administering medication or a pain relieving intervention to evaluate effectiveness. However, LPN #3 stated even though staff had informed her that Resident #1 had complained of pain, (unsure of specific dates) she failed to conduct a pain assessment for the resident as required.

Interview with Unit Manager (UM) #1 on 05/21/2020 at 12:38 PM revealed staff were required to conduct pain assessments for facility residents once a shift. The UM also stated when Resident #1 voiced complaints of pain, staff should have assessed the resident's pain and documented a follow up assessment to ensure interventions to manage the pain were effective.

Interview with the DON on 05/05/2020 at 5:00 PM revealed she expected staff to assess a resident's complaints of pain when voiced and to assess the effectiveness of pain medication that was ordered to ensure its effectiveness. The DON also stated she was not made aware that Resident #1 had ongoing complaints of pain from 04/10/2020 through 04/24/2020.

Interview with Physician #1 on 05/05/2020 at 12:50 PM revealed staff had not informed him that Resident #1 had ongoing complaints of pain after he ordered Tylenol and Diclofenac to be administered routinely on 04/10/2020. The Physician stated staff should have informed him of Resident #1's ongoing complaints of pain.

Review of Hospital records for Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 70 revealed the resident arrived to the hospital on 04/24/2020 at 12:30 PM and diagnostic tests performed revealed the resident had a "critical lower limb schema (restricted blood supply to tissue) and occlusion of the mid left superficial femoral artery distally." Subsequently, on 04/25/2020, Resident #1 underwent amputation of the left lower extremity.	F 697		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 71	F 842		

(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 72	F 842		

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to maintain accurate medical records in accordance with professional standards of practice for one (1) of three (3) sampled residents (Resident #1). Interviews with staff, review of Resident #1's medical record, and review of Resident #1's weekly skin assessments revealed staff had assessed and documented in the Nurse's Notes from 04/08/2020 through 04/23/2020 that Resident #1's left lower extremity was discolored, edematous, bruised, and developed mottling (marbled purple appearance of the skin due to abnormal circulation). However, review of skin assessments completed by nursing staff on 04/09/2020, 04/16/2020, and 04/23/2020, revealed the assessments stated no abnormal findings were identified.

The findings include:

Review of the facility's policy "Skin Care Guideline," dated April 2019, revealed the purpose of the policy was to provide a system for evaluation of skin in order to identify risk and implement individual interventions to address risk factors and a process for providing care when interruptions occur in skin integrity. The policy also stated a licensed nurse would complete a weekly skin assessment of residents and document the findings in the medical record.

Review of Resident #1's medical record revealed the facility admitted the resident on 01/23/2020 with diagnoses that included Alzheimer's Disease and Muscle Weakness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 73	F 842		

Review of Resident #1's Admission Minimum Data Set (MDS) assessment dated 01/29/2020 revealed the facility assessed the resident to require extensive assistance of two (2) staff members for bed mobility, transfers, and toileting. The facility also assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5), indicating the resident was cognitively impaired.

Review of Resident #1's Nurse's Notes dated 04/08/2020 at 5:10 PM, revealed the resident's left foot was slightly red and tender to touch. However, on 04/09/2020 at 7:00 AM, staff completed a skin assessment for Resident #1 and documented no abnormalities.

Further review of Resident #1's Nurse's Notes revealed on 04/10/2020, at 1:53 PM staff documented the resident's left foot was swollen, red, and bruising extended from the left great toe across the top of the resident's foot. On 04/14/2020 at 4:07 AM staff documented the resident's left foot was cold and mottled (blotchy, red-purplish marbling of skin). On 04/15/2020 at 3:39 PM, staff documented that bruising remained to the resident's left foot. However, review of a skin assessment completed for Resident #1 on 04/16/2020 at 7:00 AM, revealed no abnormal findings were documented on the resident's skin assessment.

Continued review of Resident #1's Nurse's Notes revealed on 04/17/2020 at 4:51 PM, the resident's left leg was cold to touch from the knee to the toes and discoloration was present from the shin to the toes, and the left foot was swollen. On 04/18/2020 at 3:34 PM, staff documented the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 74	F 842		

resident's left foot was discolored, cool to touch, and had pitting edema present. On 04/19/2020 at 4:21 AM, 04/20/2020 at 3:45 AM, 04/21/2020 at 2:08 AM, and 04/23/2020 at 1:35 PM, staff documented the resident's left foot remained discolored, cool to touch, and was edematous. However, review of Resident #1's skin assessment completed on 04/23/2020 at 7:00 AM revealed staff had documented no abnormalities.

Interview with Licensed Practical Nurse (LPN) #1 on 05/04/2020 at 3:50 PM revealed she had documented Resident #1's skin assessments on 04/09/2020 and 04/23/2020. LPN #1 stated the discolorations and abnormalities to the resident's left lower extremity were ongoing and present when she completed the skin assessments on 04/09/2020 and 04/23/2020, but she had not documented them on the resident's skin assessment.

Interview with LPN #2 on 05/20/2020 at 1:15 PM revealed she conducted Resident #1's skin assessment on 04/16/2020. She stated she recalled the resident had skin discolorations to the left lower extremity and the resident's capillary refill was abnormal on that date. She stated she should have included her assessment findings on the skin assessment form, to ensure the resident's medical record was accurate as required.

Interview with the Director of Nursing (DON) on 05/05/2020 at 5:00 PM revealed she expected staff to accurately conduct and document the findings of resident skin assessments in the medical record.

Interview with the Administrator on 05/05/2020 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 75 5:40 PM, revealed she expected staff to document skin assessments accurately in the resident's medical record. The Administrator also stated the facility did not have a process in place to ensure staff were accurately documenting resident skin assessments in the medical record.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. BUILDING _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	**131 MEADOWLARK DRIVE RICHMOND, KY 40475**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was initiated on 04/30/2020 and concluded on 05/21/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100454	A. BUILDING: _____ B. WING _____	C 05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION CENTER	131 MEADOWLARK DRIVE RICHMOND, KY 40475

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A complaint investigation (KY31616) and a COVID-19 focused infection control survey was initiated on 04/30/2020 and concluded on 05/21/2020. The complaint was substantiated and Immediate Jeopardy was identified pursuant to 42 CFR 483.25. The corresponding State violation of imminent danger was cited as a Type A Citation on 05/11/2020. An amended Type A Citation was issued on 05/28/2020. No deficient practice was identified related to the infection control survey.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE