PRINTED: 06/05/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185262	B. WING _				C <b>21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL			STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		03/	21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 000	a COVID-19 focused initiated on 04/30/202 05/21/2020. The faci compliance with 42 C and has implemented Medicaid Services (C Disease Control and Precommended practic COVID-19. However substantiated and Imidentified. The total compliance with 42 C and has implemented for the foot extendition of the foot extremity of the Venous showed no abnormal 04/17/2020, staff doce extremity was cold to knee to his/her toes; the foot; and the resident of th	dard survey (KY31616) and infection control survey was to and concluded on lity was found to be in FR 483.80 Infection Control I the Centers for Medicare & MS) and Centers for Prevention (CDC) test to prepare for the complaint was mediate Jeopardy was tensus was 70.  affi interviews revealed on the seed Resident #1's left foot do (blotchy, red-purplish in purple bruising across the ing to the first and second tested the resident to have a longed capillary refill in the 2020, Resident #1's venous Doppler Ultrasound reculation of veins) of the extremity, and on 04/17/2020, in PM, the facility received the Doppler Ultrasound, which findings. However, on the umented the resident's touch from the resident's there was discoloration ther left foot extending to all all pulse and pitting edema in the complained of pain to the overent. The staff failed to the the worsening circulatory sident's left foot. Interviews review revealed Resident	F				AND DATE
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE			(X6) DATE

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

(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.

Facility ID: 100454

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185262	B. WING				C <b>21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL	LITATION CENTER		131	EET ADDRESS, CITY, STATE, ZIP CODE  MEADOWLARK DRIVE  HMOND, KY 40475	1 00	2172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	However, the facility physician of the decli assessed that Reside mottled, had no pulse necrotic (dead tissue were unable to feel a knee or in his/her fee notified and Residen hospital. Upon arriva was diagnosed with a superficial femoral arblood to the leg). Or left lower extremity weremoved) above the Immediate Jeopardy and was determined CFR 483.10 Resider 483.21 Comprehensi Plans (F657), and 42 (F684). The facility were Jeopardy on 05/06/2 Care was identified at Care (F684). An extron 05/20-21/2020. Didentified at F697 at 1 level.  An acceptable Allegar received on 05/13/20 Immediate Jeopardy Survey Agency deter Jeopardy was remove prior to exit on 05/21 scope and severity to Resident Rights (F58 Comprehensive Persident States of the deciver Persident Rights (F58 Comprehensive Persident Rights (F58 Comprehe	inued to show a decline.  failed to notify the resident's ine. On 04/24/2020, staff ent #1's left foot was cold, e and had developed ) areas. In addition, staff pulse at the resident's left et. The physician was t #1 was transferred to the al at the hospital, Resident #1 a distal occlusion of the left tery (the artery that supplies to 04/25/2020, Resident #1's ras amputated (surgically left knee.  was identified on 05/06/2020 to exist on 04/14/2020 at 42 at Rights (F580), 42 CFR tive Person-Centered Care to CFR 483.25 Quality of Care was notified of the Immediate 020. Substandard Quality of ended survey was conducted to efficient practice was also "G" level, and F842 at "D"  ation of Compliance was 120, which alleged removal of on 05/13/2020. The State mined the Immediate ed on 05/13/2020 as alleged, 1/2020, which lowered the to "D" level at 42 CFR 483.10	F	000			

IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	E SURVEY PLETED
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185262	B. WING _		05	5/21/2020
ATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		
EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE
monitors the ic changes and quality				
y/Decline/Room, etc.)  p-(iv)(15)  ion of Changes. liately inform the resident; t's physician; and notify, er authority, the resident there is- g the resident which the potential for requiring  in the resident's physical, status (that is, a mental, or psychosocial atening conditions or  ment significantly (that is, n existing form of the consequences, or to of treatment); or er or discharge the the as specified in  ation under paragraph (g) the facility must ensure that specified in §483.15(c)(2) d upon request to the oppromptly notify the ent representative, if any, troommate assignment (e)(6); or trights under Federal or	F 5	80		
	ATION CENTER  EMENT OF DEFICIENCIES BUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)  In monitors the fic changes and quality  y/Decline/Room, etc.)  y-(iv)(15)  ion of Changes. liately inform the resident; t's physician; and notify, ar authority, the resident there is- g the resident which the potential for requiring  in the resident's physical, status (that is, a mental, or psychosocial atening conditions or  ment significantly (that is, n existing form of the consequences, or to of treatment); or er or discharge the the as specified in  ation under paragraph (g) the facility must ensure that specified in §483.15(c)(2) d upon request to the or promptly notify the ent representative, if any,  roommate assignment (e)(6); or	ATION CENTER  THENT OF DEFICIENCIES (IDENTIFYING INFORMATION)  The monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the circ changes and quality (IDENTIFYING INFORMATION)  To monitors the changes and qu	ATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE RICHMOND, KY 40475  MENT OF DEFICIENCIES RUST BE PRECEDED BY FULL PREFIX TAG  TOOM TOOM TOOM TOOM TOOM TOOM TOOM TO	A BOILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE RICHMOND, KY 40475  MENT OF DEFICIENCIES  WINT GO PERFICIENCIES  ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  FOOD  Tronitors the ic changes and quality  ID PROVIDER'S PLAN OF CORRECTION  WE CROSS-REFERENCED TO THE APPROPRIATE  FOOD  To Changes.  WINT GO PERFICIENCY  FOOD  To Changes.  WINT GO PERFICIENCY  FOOD  The APPROPRIATE  THE APPROPRIATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185262	B. WING		<u> </u>		0
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL		<u> </u>	13	TREET ADDRESS, CITY, STATE, ZIP CODE  11 MEADOWLARK DRIVE  ICHMOND, KY 40475	<u>  05/</u>	21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	update the address (phone number of the representative(s).  §483.10(g)(15)  Admission to a comp that is a composite d §483.5) must disclos its physical configura locations that compri part, and must specifications.	ı. record and periodically mailing and email) and	F	580			
	by: Based on observation and review of the facility inform the physician when a significant character for one (1) of three (3) (Resident #1). Resignotified on 04/08/202 developed a red area The facility made subnotifications when the foot on 04/10/202 unable to bear weight 04/16/2020, when the the foot on other than the foot on other than the foot on other than the foot on other weight 04/16/2020, when the the foot on other than the for color pressure has been a refill time may indicate perfusion or peripher abnormal and the left	y failed to immediately and the responsible party ange in condition occurred B) sampled residents lent #1's physician was to that the resident had a to the top of the left foot. beequent physician e resident was having pain to CO; when the resident was t on 04/13/2020; and, on e resident's capillary refill to return normal after pplied. A prolonged capillary the decreased peripheral al artery disease) was					

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		185262	B. WING			C 05/21/2020	
	ROVIDER OR SUPPLIER  HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		33/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	thready pulses (pulse commonly rapid) an mottled (mottling is of the skin which ca underlying condition. However, there was physician was made Resident #1's medic resident's foot/leg of the resident's physic 04/24/2020 at approresident had no pulse the left, lower leg was with the resident's daware that the resident's roommate a window on 04/10/2 was not aware how condition was until s resident was transfer. Resident #1 was transfer with "Occlusion of the artery distally (artery was blocked)."  Resident #1 was the medical center when amputated (surgical knee on 04/25/2020 ischemia (restricted (corpse like) left low.  The facility's failure physician of a change.	20, that the resident had se that is not easily felt and d the left foot was cold and blotchy, red-purplish marbling in be a symptom of a serious a, such as vascular disease). In no documented evidence the eaware. Further review of cal record revealed the continued to decline; however, cian was not notified. On eximately 4:00 AM, the ses at the knee or foot, and as cold and mottled. Interview aughter revealed she was not ent's foot was injured until the extend her of the injury through 2020. She further stated she serious the resident's she saw the resident after the extend to the hospital.  Insferred to a local hospital on gnosed with Critical Lower ricted blood supply to tissue) he mid left superficial femoral by that supplies blood to the leg on transferred to a larger re the resident's left leg was ly removed) above his/her or related to "Profound blood flow) and cadaveric	F 58	30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185262	B. WING				21/2020
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 31 MEADOWLARK DRIVE RICHMOND, KY 40475	1 03/	21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	resident. Immediate 05/06/2020, and was 04/14/2020 at 42 CFR (F580), 42 CFR 483.2 Person-Centered Car 483.25 Quality of Car notified of the Immed 05/06/2020. Substant identified at 42 CFR 4 (F684).  An acceptable Allegar received on 05/13/20 Immediate Jeopardy Survey Agency deter Jeopardy was remove prior to exit on 05/21/scope and severity to Resident Rights (F58 Comprehensive Pers (F657), and 42 CFR 4 (F684), while the faci effectiveness of systems assurance activities.  The findings include:  Interview with the Add 5:40 PM revealed if rechange in condition, areassess the resident condition continued, aresident's physician.  However, review of the "Change in a Resider to The Resident to The	impairment, or death to a Jeopardy was identified on determined to exist on R 483.10 Resident Rights 21 Comprehensive re Plans (F657), and 42 CFR re (F684). The facility was iate Jeopardy on idard Quality of Care was 483.25 Quality of Care  tion of Compliance was 20, which alleged removal of on 05/13/2020. The State mined the Immediate red on 05/13/2020 as alleged, 2020, which lowered the red on 05/13/2020 as alleged, 2020, which lowered the red on CFR 483.21 on-Centered Care Plans 483.25 Quality of Care lity monitors the remic changes and quality  ministrator on 05/05/2020 at residents experienced a she expected staff to t, and if the change in retaff should notify the	F	580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		185262	B. WING			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	<u> </u>	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	the resident's cogniresident's medical/n The policy defined a condition as a decliresident's status tha itself without interve disease-related clin implemented (is not also stated a signific that impacted more resident's health sta interdisciplinary revi plan.  Review of Resident the facility admitted with diagnoses that and Muscle Weakne Admission Minimum dated 01/29/2020, r Resident #1 to be c Interview for Mental (5). Further review the resident to requi two (2) staff member and bed mobility; ar (walk) with the assis According to the ME venous or arterial ul ankle caused by po- ulcers, wounds, or se Review of Nurses' N at 5:10 PM, Resider and tender to touch Ulcer/Injury Form' fo 04/08/2020 at 5:00	dent representative based on tion, of changes in the nental condition and or status. a "significant change" of the or improvement in a set would not normally resolve notion by staff or by standard ical interventions being "self-limiting"). The policy cant change was something than one area of the stus, and required ew and/or revision to the care the resident on 01/23/2020 included Alzheimer's disease ess. Review of Resident #1's an Data Set Assessment (MDS) evealed the facility assessed organitively impaired with a Brief Status (BIMS) score of five revealed the facility assessed in extensive assistance of ers with toileting, transfers, and, he/she could ambulate stance of one person. DS, Resident #1 had no cers (wounds on the leg or or circulation), and no other skin problems of the foot.	F 58	30		

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		185262	B. WING _			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 131 MEADOWLARK DRIVE RICHMOND, KY 40475	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 580	04/10/2020 at 1:53 Resident #1's left for bruise was noted to the left great toe, and According to the dorphysician was contapain medication becalert enough to ask resident's "pain is of linear to 100 linear to 1	f Nurse's Notes revealed on PM, staff documented that not was swollen, red, a small of the top of the left foot and to and the resident had pain. Cumentation, the resident's facted to request scheduled cause Resident #1 was not for pain medication, until the for pain medication, until the form that singury/pain. She shaware of any change in the facility she was informed by the fact the resident's food and was informed by the food and was informed by the food and was informed by the food and the resident had injured for the facility and spoke with the worker, who told her that she dent and the injury was not a see Nurse's Notes revealed on PM, a nurse documented that sing staff that Resident #1 that to the left lower extremity. The physician order for an x-ray of the left	F	580			
	left foot x-ray was o showed that the res	#1's x-ray report revealed the ompleted on 04/13/2020 and cident had diffuse osteopenia lensity), mild osteoarthritic					

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		185262	B. WING _			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475	•	00/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	Continued From pa	ge 8	F 5	80			
	(joint disease) chan heel spur (a foot co	ges, and a small posterior ndition created by calcium e fracture or dislocation was					
	revealed on 04/14/2 Nurse (RN) #1 doct foot was" now cold, thready", and the re abnormal. Howeve evidence the reside	esident #1's Nurse's Notes 2020 at 4:07 AM, Registered umented that the resident's left mottled, (his/her) pulses were esident's capillary refill was r, there was no documented int's physician was notified the resident's condition was					
	revealed that she diphysician that the recold and mottled withe resident's x-ray acute findings durin the change in the reconcoming shift. According	1 on 05/05/2020 at 8:15 AM id not notify Resident #1's esident's foot had become th thready pulses. She stated results had returned with no g her shift, so she reported esident's condition to the cording to the RN, Resident y not answer the phone at uld have waited."					
	04/16/2020, at 8:36 revealed Licensed I documented that Reextremity was discorefill was "slow." Acresident's physician a Venous Doppler L	#1's Nurse's Notes dated PM, two (2) days later, Practical Nurse (LPN) #2 esident #1's left lower slored, and his/her capillary ecording to the Note, the was notified and an order for altrasound (a test to check the r clots in the large veins in the					
		#2 on 05/04/2020 at 4:50 PM only informed Resident #1's					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		(X3) DATE	SURVEY
		185262	B. WING				C / <b>21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHABI	LITATION CENTER		STREET ADDRES  131 MEADOWLA  RICHMOND, K		1 03/	21/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION ICH CORRECTIVE ACTION SHOULD E SS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 580	physician that the reand foot "in general" capillary refill was shrevealed LPN #2 did physician of the three Further review of Re 04/17/2020 at 4:51 Fit documented the rescold to touch from the discoloration was obthe toes, the left foor resident's pedal puls Note stated the Vencompleted and they Further review reveadocumented evidency physician was notified discoloration had we resident's leg.  Interview with LPN # confirmed that on 04 pedal pulses were fawas discolored from However, the LPN s resident's physician, she should have not Review of Resident study/test results rev conducted on 04/17/findings were indicat revealed the physici results on 04/17/2022	sident's left lower extremity was discolored and his/her ow. Further interview I not notify the resident's lady pulses.  sident #1's Nurse's Notes for PM, revealed LPN #1 ident's left leg had become le knee down to the toes, beserved from his/her shin to t was swollen, and the less were faint. The Nurse's lous Doppler study had been were awaiting the results. laded there was no led that the coldness and lorsened and was affecting the  #1 on 05/04/2020 at 3:50 PM I/17/2020, Resident #1's laint, and the resident's left leg the shin to his/her toes. Itated she did not inform the libut stated that looking back, lified the physician.  #1's Venous Doppler lealed the test was lealed. Review of Nurse's Notes an was notified of the test	F S	580			
	revealed on 04/18/2	Resident #1's Nurse's Notes 020, 04/19/2020, 04/21/2020 N #1 and RN #1 continued to					

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F 580	extremity was cool to However, there was that the resident's ph the resident's foot had Review of LPN #1's of 04/23/2020 at 1:35 P documented that Resextremity continues the discoloration noted from also documented "pit observed to the resident's performed interview of at 3:50 PM, with RN AM, revealed they not physician that the resident's leg from the knee to the should have notified when she identified the condition. The LPN so other diagnostic test sooner," and a different occurred for the resident resident's leg/foot aft RN #1 stated, "My guitable and the resid	sident's left foot and/or left touch and was discolored. no documented evidence ysician was made aware that d become "cool."	F	580		
	05/05/2020 at 5:00 P	nt's leg to be cold and				

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F 580	timely when a change was identified. She resident medical reconducted an invest care/treatment, which notification for Reside were identified.  Continued review of revealed on 04/24/2 documented that the "appeared" on 04/08 foot were now dry not toes; lateral, ventral, foot; and the heel we areas. The left kneed covering most of the patella (knee), and ventre The RN also docume pain, no palpable per pulses (pulses in the between the knee are According to the Nurphysician's office was member at the physician resident's foot when office.  Continued interview 8:15 AM, revealed so 04/24/2020 and at a identified that the resworsened. She state (dead tissue) to the state of the	sure physicians were notified be in a resident's condition stated the team reviewed ords, which included Nurse's pensure physician notification of the DON stated the facility igation related to the included physician tent #1, and no concerns  Resident #1's Nurse's Notes 2020 at 8:35 AM, RN #1 be "bruises" that had be corotic areas. The resident's and plantar surfaces of the ere deep purple with black that a red/purple area proximal aspect of the was cool and tender to touch be ented that the resident had dal pulses nor popliteal to foot and knee), and the skin and foot was cold and mottling. The se's Note, the resident's as contacted and a staffician's office was going to make a "tele call" to view the the physician arrived at the cared for Resident #1 on pproximately 4:00 AM, she	F 5	80			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		ATE SURVEY DMPLETED
		185262	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		00/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	covering most of the center) of his/her kn that she was unable #1's left foot or behi the RN, she paged to approximately 6:30 attempt to notify him resident's condition; not return the call at waited until the physical approximately 8:00 office; however, office was at the hospital. her shift documental physician's office at notified the physicia #1's condition. RN adirected his office state to the hospital for fut treatment.  Interview with Physical and a small bruise at However, staff did in #1's pulses were that the resident's left o4/24/2020 at approximately approximately with page the physician and when he returned call unknown, the nurse however, the RN call him photographs of physician stated states.	d a new red/purple area e proximal aspect (front ee. In addition, the RN stated e to obtain pulses to Resident and his/her knee. According to the resident's physician at AM on 04/24/2020 in an a of the change in the however, the physician did e that time. She stated she sician's office opened at AM and called the physician's ce staff stated the physician RN #1 stated she completed tion and went to the approximately 9:00 AM and n of the change in Resident #1 stated the physician aff to contact the hospital of nt #1 to be directly admitted	F			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY
		185262	B. WING _				C <b>21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL	LITATION CENTER		131	EET ADDRESS, CITY, STATE, ZIP CODE  MEADOWLARK DRIVE  HMOND, KY 40475	1 00	21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	ongoing changes in the Venous Doppler of 04/17/2020, he would Doppler study and the potentially had a difference of Review of Resident #Hospital #1 revealed hospital at approximation diagnostic tests were 04/24/2020, Residen Critical lower limb isosupply) and "Occlusive femoral artery distally artery, which is located."	re informed him of the he resident's condition, after ultrasound was conducted on d have ordered an Arterial e resident could have erent outcome.  It's medical record from he/she arrived to the ately 12:30 PM. After a completed at 3:43 PM on the themia (restricted blood on of the mid left superficial red) (blockage in the femoral ed in the groin). Resident #1 to a larger medical center	F	580			
	Hospital #2 revealed amputated (surgically knee on 04/25/2020 ischemia (restricted be (corpse like) left lower on 05/18/2020 at 10: learned of the resider facility notified her set that was being conducted the facility did not relaced to see the resident be restrictions due to CO was not aware how be until she saw the resident.	with Resident #1's Daughter 00 AM revealed after she nt's injury on 04/10/2020, the everal times about testing acted. However, she stated ay how bad the resident's ne had not been able to visit					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185262	B. WING	B WING		·	24/2020	
NAME OF P	ROVIDER OR SUPPLIER	100202			TREET ADDRESS, CITY, STATE, ZIP CODE	05/	21/2020	
	HEALTH AND REHABIL	ITATION CENTER		1	31 MEADOWLARK DRIVE RICHMOND, KY 40475			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	"mottled" and the resistated the resident's I worse" since the amp since required another of that leg." Resident resident was 91 years spending the last part The daughter stated gotten [the resident] It that far and got that be "***The facility implement to remove Immediate 05/13/2020:  1. Resident #1 no lost 2. The facility held as Assurance and Perfocommittee meeting of Immediate Jeopardy development of the accordant development of the accordant development of the conducted head-to-to 05/08/2020, which incompulses and capillary resulting the pulses and capillary resul	the resident's leg it was ident's toes were black. She eg had "gotten progressively butation on 04/25/2020, had er surgery to remove "more t #1's Daughter stated the sold, and should not be t of his/her "life like this." the facility " should have nelp sooner, before it went had."  The ented the following actions Jeopardy effective  The ad hoc QAPI (Quality rmance Improvement) on 05/07/2020 to review the findings and discuss the ction items to be completed.  The skin inspections on cluded checking pedal efill for all residents. No	F	580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		185262	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	103202		STREET ADDRESS, CITY, STATE, ZIP COD		5/21/2020	
				131 MEADOWLARK DRIVE			
MADISON	HEALTH AND REHABI	LITATION CENTER		RICHMOND, KY 40475			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 580	Continued From pag	e 15	F 5	80			
	baseline from 05/07/ assessments will imiconcerns. The monifacility meets regulat team will review the track the facility's procompliance.  6. The Minimum Da provided education to Director (ETD) regar plans when a resider occurs. The ETD the all licensed nurses be was required to verb	aring to the documented (2020. Staff completing the mediately address any toring will continue until the tory compliance. The QAPI results at least weekly to ogress toward regulatory ta Set (MDS) Coordinator to the Education Training reding updating resident care int's change in condition en provided this education to by 05/08/2020. Each nurse alize the process to update Electronic Medical Record to					
	licensed nurses on p in condition and Med 05/07/2020 through also included docum physician notification Resident skin inspec limited to, circulatory pedal pulses, and vit new/undocumented signs/symptoms of c immediate physician documentation in the nursing progress not update care plans w related to a change i	skin impairments or irculatory problems require					
	1	e required to complete a ining competency related to					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED	
		185262	B. WING _			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	Medical Director No required to receive resuming duties. Libe required to have posttest prior to retulired licensed nurse education/testing froto assuming duties.  9. On 05/08/2020 the Coordinator, Wound completed a review Interdisciplinary Tear orders to ensure stanotification in any contification in any contification and any and Director of Nursing, Nurse, and Nurse Nurse, and Nurse, an	on, change in condition and obtification. The nurses were a score of 100% before censed nurses on leave will this education and pass a curning to work. Any newly e will receive this om the ETD and/or DON prior	F	580	1)		
	second ad hoc mee skin/circulatory aud care plan updates, licensed nurse's ed 05/07/2020. The Ad	the QAPI team held a ting to review the initial its, physician notifications and as well as the status of the ucation initiated on dministrator reviewed the dical Director on 05/08/2020.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185262	B. WING		C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  HEALTH AND REHAE	SILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 580	Continued From pa	ge 17	F 580			
	implemented the fo Immediate Jeopard 1. Review of the m facility transferred F	y Agency verified the facility llowing actions to remove y on 05/13/2020, as alleged: edical record revealed the Resident #1 to the hospital on e resident did not return to the				
	dated 05/07/2020 reviewed the Imme and the action plan Review of the meet 05/07/2020, reveals heads attended. In 05/21/2020, with th Director, Director of Managers, and the Coordinator reveals QAPI meeting on 0 immediate jeopardy	PI Committee meeting minutes evealed the committee diate Jeopardy notifications is for facility compliance. Ing sign in sheet dated ed the facility's department terviews, conducted on the Administrator, Medical for Nursing (DON), the Unit Minimum Data Set (MDS) and the facility had conducted a 5/07/2020 to discuss the for and to initiate the lan of action for compliance.				
	o5/06/2020 through residents had a heat performed to include and capillary refill. completed for Resident #7 were completed with Observation of skin and Resident #7 coincluded evaluation refill with no concert the DON, Unit Man	assessments conducted from 05/08/2020 revealed all ad to toe skin assessment e evaluation of pedal pulses Review of skin assessments dent #4, Resident #5, Resident revealed the assessments h no concerns identified. assessments for Resident #6 anducted on 05/20/2020, of pedal pulses and capillary in identified. Interviews with ager #1, and Unit Manager #2 alled all residents' skin, pedal				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185262	B. WING			C / <b>21/2020</b>	
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 131 MEADOWLARK DRIVE RICHMOND, KY 40475	•	72 172020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	4. A review of skin by the DON on 05/0 audited a sample of assessments with n the May 2020 skin a Resident #4, Reside Resident #7 revealed completion or accur Interview with the Drevealed she had coassessments perfor (3) residents from existed or changes of the same of	assessment audits completed 18/2020 revealed the DON had iffifeen (15) completed skin to issues identified. Review of assessments completed for ent #5, Resident #6, and ad no concerns with the acty of the assessments. ON on 05/21/2020 at 2:38 PM conducted audits of the skin amed on 05/08/2020, of three ach hallway with no new of condition found.  audits completed from 05/20/2020 by the DON, Unit Nurse, and the Weekend at five (5) residents from each daily for circulatory changes, with the DON, Unit Manager 2, the Wound Nurse, and the or conducted on 05/21/2020 assessing a sample of ach unit for circulatory any changes in a resident's	F	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	, ,	DATE SURVEY COMPLETED
		185262	B. WING _			C 05/21/2020
	ROVIDER OR SUPPLIER  HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	<b>_</b>	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	resident had a chang with the EDT Nurse revealed the MDS Nupdating resident cate EDT stated she educexcept employees with the EDT revealed leave could not work completed. Review education sign in she employees were education sign in she employees were educated with LPN #1, Unit Manager #2 Supervisor on 05/21 education on 05/08/2020 by the conducted with LPN #1, Unit Manager #2 Supervisor on 05/08/2020 through care plans when a recondition.  7. A review of Education of Education notification Medical Director Notinot be reached and for physician notification Medical Director Notinot be reached and for physician notification pedal pulses, and virunew/undocumented signs/symptoms of commediate physician of commediate physician in medical physician notification medicate physician in medi	te the plan of care when a ge of condition. Interview on 05/21/2020 at 1:57 PM, urse had educated her on re plans on 05/07/2020. The cated all licensed nurses tho were on leave regarding 05/08/2020. Further interview ed employees who were on a until the training was of employee in-service eets revealed all licensed ucated on updating resident thange in condition occurred to EDT Nurse. Interviews #3, LPN #4, Unit Manager 4, and the Weekend 1/2020 revealed they received 1/2020 by the EDT on updating 1/2020 revealed they received 1/2020 by the EDT on updating 1/2020 revealed all led by the DON and EDT on 1/20, change of condition, iffication if the physician could 1/2020 documentation requirements 1/2020 to 1/2020 revealed all led by the DON and EDT on 1/2020, change of condition, iffication if the physician could 1/2020 revealed they received 1/2020 revealed all led by the DON and EDT on 1/2020 revealed all led by the DON and EDT on 1/2020 revealed all led by the DON and EDT on 1/2020 revealed they received 1/2020 revealed all led by the DON and EDT on 1/2020 reveal	F	580		
	updating the plan of interventions related	e medical record and care with the new to a change in resident's ith the DON at 2:38 PM and				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		185262	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHAE	1	STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		03/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	revealed they had in from 05/07/2020 the physician notification conducting assessing updating the plan of medical record. Interest conducted with LPN #1, Unit Manager #1 Weekend Supervist DON had in service for physician notifical conducting skin assignification.	ige 20 :57 PM on 05/21/2020, in serviced all nursing staff rough 05/08/2020 regarding on, change of condition, ments for circulatory issues, if care and documenting in the reviews on 05/21/2020 in #3, LPN #4, Unit Manager is, the MDS Nurse and the or revealed the EDT and the red them related to the process ration of change of condition, resessments to identify in the resident's plan renting in the resident's medical	F 5	80		
	nursing staff on 05/revealed all nursing post-test with a sati with LPN #1, LPN # Manager #2, the M supervisor on 05/2 completed a post-te provided by the ED or 05/08/2020.  9. Review of the pand Physician Order DON, MDS Coordin Nurse Managers or concerns with notificand resident care paccordingly. Observed.	a-tests completed by licensed (707/2020 and 05/08/2020 g staff had completed a disfactory score. Interviews (42, Unit Manager #1, Unit DS Nurse, and the Weekend 1/2020 revealed they est after the education T and the DON on 05/07/2020 ast thirty days Progress Notes er audits completed by the mator, Wound Nurse and 105/08/2020, revealed no cation of change of condition blans being updated evations conducted on ent #4, Resident #5, Resident 7 revealed no concerns with				
	accordingly. Obset 05/20/20 for Reside #6, and Resident # change of condition	vations conducted on				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED	
		185262	B. WING		C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	1 00/2 1/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	O BE COMPLETION	
F 580	physicians orders, splan of care revealed condition, updating notification. Interview Manager #1, and Ur 05/21/2020 revealed days of progress not residents' care plan condition had been notified, and the residents' care plan condition had been notified, and the resident with new intervention issues identified.  10. A review of dail physician's orders of through 05/20/20 by and the Weekend Stones and physician for any concerns with condition, circulator care plan had been interventions. A reversident #4, Resident #7 to incluin Physicians Orders, no concerns with profice condition or with the residents. Intermanager #1, Unit M Supervisor on 05/2 reviewed the previous notes and physician physician notificatio updated to reflect a condition.	2020 Nurse's Notes, skin assessments, and the ad no concerns with change of the plan of care or physician lews with the DON, Unit mit Manager #2, on they had reviewed thirty lotes, physician orders, and is to ensure changes of identified, physicians were sident's care plan was updated ons on 05/08/2020 with no or y nursing note audits and completed from 05/08/2020 or the DON, Unit Managers, supervisor revealed nursing as orders were reviewed daily the resident changes in y status, and validating the	F 58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185262	B. WING				C <b>21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHABI	LITATION CENTER		13	TREET ADDRESS, CITY, STATE, ZIP CODE 31 MEADOWLARK DRIVE LICHMOND, KY 40475	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	assessments, physic updates, and the state education initiated or QAPI Committee Meand 05/19/2020 reversions are education initiated or QAPI Committee Meand 05/19/2020 reversions are educated with the Meat 2:49 PM reveled to the QAPI meeting or review the Immediate the Plan of Action. If Medical Director reversions are educated by a meeting on 05/08/20 facility's audits and educated Director stated within thirty minutes a resident's physicial change of condition. She had been attend monitor the facility's with the Administrator revealed she had be process for compliar morning meetings to completed and any it addressed. In additic conducted weekly Q review of audit finding facility's compliance removal.	l audit findings of skin cian notifications, care plan tus of licensed nurse's no 5/07/2020. A review of ceting Minutes for 05/12/2020 caled the QAPI Committee to review audit findings and c's plan of action. An edical Director on 05/21/2020 che Medical Director attended no 5/07/2020 by phone to be Jeopardy Notification and Further interview with the ealed she attended the QAPI 1/20 in person to review the education progress. The sted staff would contact her if they were not able to reach nowhen the resident had a The Medical Director stated ling weekly QAPI meetings to compliance. An interview for on 05/21/2020 at 3:05 PM from monitoring the QAPI need aily by conducting the ensure daily audits were dentified concerns were on, the Administrator had API Meetings for continuedings and monitoring the and Immediate Jeopardy		580			
F 657 SS=J	Care Plan Timing an CFR(s): 483.21(b)(2 §483.21(b) Compreh §483.21(b)(2) A com	)(i)-(iii)	F	657			
	be-						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED	
		185262	B. WING_			C 05/21/2020	
	ROVIDER OR SUPPLIER  HEALTH AND REHABI			STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		03/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	the comprehensive a (ii) Prepared by an ir includes but is not lir (A) The attending ph (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of foo (E) To the extent pra the resident and the An explanation must medical record if the and their resident re not practicable for th resident's care plan. (F) Other appropriate disciplines as detern or as requested by th (iii)Reviewed and re-	7 days after completion of assessment.  Atterdisciplinary team, that mited to ysician.  Be with responsibility for the aresponsibility for the and nutrition services staff.  Cticable, the participation of resident's representative(s).  Be included in a resident's participation of the resident presentative is determined be development of the estaff or professionals in mined by the resident's needs are resident.  Vised by the interdisciplinary essment, including both the	F 6	257			
	by: Based on interview, the Resident Assess Manual, it was deter ensure one (1) of thr (Resident #1) was re a significant change 04/08/2020, Resider area to the top of his 04/10/2020, the resid	record review, and review of ment Instrument (RAI) mined the facility failed to see (3) resident's care plans eviewed and/or revised when in condition occurred. On at #1 developed a red, tender s/her left foot; and, on dent developed bruising and required scheduled pain					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185262	B. WING _			C <b>05/21/20</b> 2	20
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	03/21/202	
MADIOON	LIEALTH AND DELIABIL	ITATION OFNITED		131 MEADOWLARK DRIVE			
MADISON	HEALTH AND REHABIL	ITATION CENTER		RICHMOND, KY 40475			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIA	COMP	X5) PLETION ATE
F 657	Continued From page	e 24	F 6	657			
	revised the resident's with an intervention to as ordered and on 04 bruising. However, the resident's care plan with measurable intervent care plan's effectivent Manual. In addition, resident's care plan with the resident's care with became cold, mottled red-purplish marbling symptom of a serious as vascular disease), is not easily felt and could out the resident's care with the resident's care plan with the resident's care with the	ions that could evaluate the ess as required by the RAI the facility failed to revise the with interventions to address then the resident's foot/leg if (mottling is blotchy, of the skin can be a sunderlying condition, such with thready pulses (pulse					
	Resident #1's left foo necrotic (dead) tissue the resident had no p foot. Resident #1 wa hospital on 04/24/202 diagnosed with Critic (restricted blood support the mid left superfit The resident was the medical center where amputated (surgically knee on 04/25/2020 dischemia (restricted blood support to the mid left superfit in the resident was the medical center where amputated (surgically knee on 04/25/2020 dischemia (restricted bloods). The facility's failure to when a significant chi	olood flow) and cadaveric					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SI COMPLE	
		185262	B. WING		05/2	1/2020
	ROVIDER OR SUPPLIER  HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	03/2	172020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	Immediate Jeopardy 05/06/2020, and was 04/14/2020 at 42 CF (F580), 42 CFR 483 Person-Centered Ca 483.25 Quality of Ca notified of the Immed 05/06/2020. Substate identified at 42 CFR (F684).  An acceptable Allegareceived on 05/13/20 Immediate Jeopardy Survey Agency dete Jeopardy was removexit on 05/21/2020, severity to "D" level Rights (F580), 42 CI Person-Centered Ca 483.25 Quality of Camonitors the effective and quality assurance. The findings include Email corresponden 05/05/2020 at 10:14 not have a care plan stated the facility foll Assessment Instrum plans.  Review of the RAI M the care plan must in and timeframes, and that are to be furnish	r death to a resident. was identified on s determined to exist on FR 483.10 Resident Rights L21 Comprehensive are Plans (F657), and 42 CFR are (F684). The facility was diate Jeopardy on Indard Quality of Care was 483.25 Quality of Care ation of Compliance was L20, which alleged removal of fr on 05/13/2020. The State rmined the Immediate led on 05/13/2020, prior to which lowered the scope and fat 42 CFR 483.10 Resident FR 483.21 Comprehensive fare Plans (F657), and 42 CFR fare (F684), while the facility feness of systemic changes five -activities.  The Administrator on AM revealed the facility did policy. The Administrator	F 6:	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185262	B. WING _			1	C <b>21/2020</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2020
MADICON	HEALTH AND DEHABIL	ITATION CENTER		1	31 MEADOWLARK DRIVE		
WADISON	HEALTH AND REHABIL	HATION CENTER		F	RICHMOND, KY 40475		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page		F 6	357			
	and psychosocial wel	l-being.					
	Further review of the Management, revealed utilize identification of interventions, review management, and remet. The Manual furth would need a compression of the management regiment. Skin Conditions, revession changes should interdisciplinary care Manual, the care plarth ongoing basis to refleated the care that the Review of Resident # the facility admitted the with diagnoses that in and Muscle Weakness Admission Minimum I dated 01/29/2020, revextensive assistance with transfers/toileting mobility; and could ar	RAI, Section JO100 Pain ed planning for care must					
	Resident #1 had no v	enous or arterial ulcers					
	, `	r ankle caused by poor ther ulcers, wounds, or skin					
	, ·	The MDS also indicated					
	Resident #1 had no p						
	scheduled pain medic assessment period.	cation regimen during the					
	he/she had problems incontinence of urine/	1's care plan also revealed of hypertension, bowels, and limited mobility e care plan stated the goals					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTR	RUCTION	(X3) DATE COMP	SURVEY LETED
		185262	B. WING _				C <b>21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL	LITATION CENTER		131 MEAD	DDRESS, CITY, STATE, ZIP CODE  OWLARK DRIVE  ND, KY 40475	1 00	2172020
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F 657	breath, complaints of vital signs, etc.) and Interventions implem plan dated 01/31/202 assess and report re abrasions, or skin breads indicated staff wand elevate the reside turn and reposition thours and as needed. Review of Resident at 5:10 PM on 04/08/200, at 1:53 February was slightly red and 04/10/2020, at 1:53 February was swollen, red, as the left great toe and foot, and the resident facility revised the calinclude the resident's concern and an interdays later on 04/13/2 [medications] per ord Administration Record address an individual regimen for Resident Manual, nor did the of the effectiveness of the effectiveness of the revealed on 04/13/20 bruising was identified facility revised the readministration Record	to be free of ardiac distress (shortness of a chest pain and abnormal maintain intact skin integrity. ented on Resident #1's care 20, included that staff were to dness, rashes, bruises, eakdown. The care plan arere to monitor for edema dent's legs, as needed; and he resident every two (2) d.  #1's Nurse's Notes revealed (2020, the resident's left foot attender to touch. On PM, the resident's left foot attender to touch. On PM, the resident's left foot attender to touch. On PM, the resident's left foot attender to touch are plan on 04/10/2020 to a left leg and foot pain attended the are plan on 04/10/2020 to a left leg and foot pain avention was added three (3) (2020 that stated "meds alters see mars [Medication and]." The care plan did not altered pain management at #1 as required by the RAI care plan facilitate review of the pain management.  Sident #1's medical record (20), three (3) days after the add to the resident's foot, the	F	557			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		185262	B. WING			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  HEALTH AND REHABI			STREET ADDRESS, CITY, STATE, ZIP COD 131 MEADOWLARK DRIVE RICHMOND, KY 40475		312 112020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 657	was discontinued on treatment" monitorin was added. Staff do 04/14/2020 through was monitored. How Resident #1's care pevidence that the factorie plan when their redness, or swelling time-frames and a divere required to be the resident's highest mental, and psychos #1 as required by the Further review of Rerevealed on 04/14/20 left foot was cold, mand capillary refill (tinnormal after pressur prolonged capillary redecreased peripheral artery disease) was of Resident #1's care revised the care plan staff to "monitor discresolved." However address the resident mottled, nor did it ad being thready. Substant include measural established timefram items needing additionand review/notification that may require address defined that may require address the resident mottled and review/notification that may require address that may require addre	r signs/symptoms of Further review revealed this 04/14/2020 when "non-drug g of the bruise twice daily boumented each shift from 04/23/2020 that the bruise vever, further review of blan revealed no documented cility revised the resident's resident developed bruising, to the left foot/toe with rescription of the services that furnished to attain or maintain at practicable physical, social well-being for Resident re RAI Manual.  Sident #1's Nurse's Notes 020 at 4:07 AM, the resident's retilled, pulses were thready, me for color to return to re has been applied. A refill time may indicate real perfusion or peripheral abnormal. Continued review re plan revealed the facility real on 04/14/2020 and directed colorations to left foot until rectile the care plan did ress the resident's pulses requently, the care plan did ble objectives with res; specific interventions; ronal assessment, testing, ron of the physician; nor, items	F 6	57			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  HEALTH AND REHABIL	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 131 MEADOWLARK DRIVE RICHMOND, KY 40475	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 657	to worsen. On 04/17 documented that the cool/cold, had discold faint/thready pulses. resident's Physical T and 04/21/2020 reve decreased weight be weight to the left foot the resident's care pl timeframes and a dewere required to be f the resident's highes mental, and psychos  Review of Resident # 04/24/2020 at 8:35 A foot had developed reblack areas to the fooknee had a red/purpl knee and was cool a nurse also document pain, no palpable per pulses (pulses in the between the knee and Review of Resident # Hospital #1 revealed	ident #1's foot/leg continued /2020 and 04/21/2020, staff resident's left leg/foot was bration/bruising, and/or had In addition, review of the herapy Notes for 04/17/2020 aled the resident had aring and was unable to bear /leg by 04/23/2020. Again, an was not revised with scription of the services that urnished to attain or maintain the practicable physical, ocial well-being.  #1's Nurse's Notes dated M, revealed the resident's recrotic (dead tissue) and/or bot, toes, and heel. The left rearea covering most of the left red that the resident had dal pulses nor popliteal foot and knee), and the skin d foot was cold and mottling.				
	PM. Further review in tests were completed PM on 04/24/2020, it had a Critical lower liblood supply to tissue left superficial femora resident was transfer center (Hospital #2) the evaluation/treatment	20 at approximately 12:30 revealed after diagnostic d and with the results at 3:43 was determined the resident mb ischemia (restricted e) and "Occlusion of the mid al artery distally." The red to a larger medical for further on 04/24/2020, where the samputated (surgically				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 657	related to "Profound flow) and cadaveric (extremity."  Interview with Licens at 3:50 PM on 05/04/Resident #1 on 04/17 Resident #1's pedal pleft leg was discolore According to LPN #1 review/revise the cardeveloping interventic concerns/problems.  Interview with Regist AM on 05/05/2020 re Resident #1 on 04/14 determined that the rmottled, and the residentified changes in because she was not care plans at the facilitation with the ME 1:45 PM revealed careviewed/revised dur Monday through Frid that during the meeting physician's orders, at (DON) reviewed the changes in a residen plan." The MDS Nur aware of the ongoing	ner knee on 04/25/2020 ischemia (restricted blood corpse like) left lower  ed Practical Nurse (LPN) #1 2020 revealed she assessed 7/2020 and determined that bulses were faint, and his/her d from the shin to the toes. nursing staff did not e plans, to include ons to address the resident's  ered Nurse (RN) #1 at 8:15 vealed she assessed 1/2020 and 04/21/2020, and esident's foot/leg was cold, dent's pulses were thready. To RN #1, she did not ident's care plan when she the resident's condition t responsible to review/revise lity.	F 6	57			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		03/2 1/2020
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F 657	revealed residents' reviewed/revised du Team (IDT) Meeting The DON stated that the IDT reviewed du plans were reviewe resident's condition she did not recall redocumentation related change in condition the resident's left for and his/her pulses waccording to the DO would not "trigger" a Resident #1 because change" for the resident #1 because change for the resident #2 with the A 5:40 PM revealed sometings regularly, process to ensure reviewed/revised as ***The facility imple to remove Immedia 05/13/2020:  1. Resident #1 no Idas a surface and Percommittee meeting Immediate Jeopard development of the conducted head-to-	ON on 05/05/2020 at 5:00 PM care plans were uring the Interdisciplinary planed Monday through Friday. At she and other members of ocumentation to ensure care d/revised when changes in a occurred. The DON stated eviewing nursing ted to Resident #1's ongoing, which included the notes that ot/leg was cold and mottled were thready. However, DN, the assessment findings a care plan revision for see it was not a "permanent dent.  dministrator on 05/05/2020 at the did not attend IDT She stated she had no esident care plans were	F 6	57		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING		COMF	(X3) DATE SURVEY COMPLETED C				
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	ROVIDER OR SUPPLIER  HEALTH AND REHABI	LITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		00/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From pag		F	657			
		refill for all residents. No erns were identified.					
	selected a sample o inspection forms from	he Director of Nursing (DON) f three (3) completed skin m each hall (15 in total), as a DON identified no concerns.					
	Manager, Wound Nu will assess five (5) re assess circulatory of pedal pulses, compa baseline from 05/07/ assessments will im concerns. The mon facility meets regular team will review the	12/2020, the DON, Unit urse, and/or Nurse Supervisor esidents per unit daily to nanges, capillary refill, and aring to the documented (2020. Staff completing the mediately address any itoring will continue until the tory compliance. The QAPI results at least weekly to ogress toward regulatory					
	provided education to Director (ETD) regal plans when a reside occurs. The ETD the all licensed nurses be was required to verb	ta Set (MDS) Coordinator to the Education Training reding updating resident care nt's change in condition en provided this education to by 05/08/2020. Each nurse halize the process to update Electronic Medical Record to					
	licensed nurses on p in condition and Med 05/07/2020 through also included docum physician notification Resident skin inspec	ursing and ETD educated all obysician notification, change dical Director Notification on 05/09/2020. The education mentation requirements for mentation in the medical record. Setions to include, but not a indicators of capillary refill,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From page pedal pulses, and vi		F 6	57		
	signs/symptoms of c immediate physiciar documentation in the nursing progress no update care plans w	circulatory problems require				
	licensed nurses wer post-test to verify traphysician notification Medical Director No required to receive a resuming duties. Lie be required to have posttest prior to return hired licensed nurse	e required to complete a saining competency related to en, change in condition and tification. The nurses were a score of 100% before censed nurses on leave will this education and pass a rrning to work. Any newly will receive this em the ETD and/or DON prior				
	Coordinator, Wound completed a review Interdisciplinary Tea orders to ensure stanotification in any characteristic and the review included resident care plans condition and any as Director of Nursing,	ne Director of Nursing, MDS I Nurse, and Nurse Managers of the last thirty days of m (IDT) notes and physician's ff had made physician nange of resident condition. ensuring staff had updated to reflect the change of essociated interventions. The MDS Coordinator, Wound anagers identified no				
	Manager and/or We on-going audit of the	the Director of Nursing, Unit ekend Supervisor, initiated an prior 24- hour nursing notes ers to ensure the identification				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		185262	B. WING		05/21/2020
	PROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	03/2 1/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 657	of any resident circumotification, and care leadership will addred discovered.  11. On 05/08/2020, second ad hoc meet skin/circulatory audit care plan updates, a licensed nurse's edu 05/07/2020. The Adresults with the Med  ***The State Survey implemented the foll Immediate Jeopardy  1. Review of the mefacility transferred R 04/24/2020 and the facility.  2. A review of QAPI dated 05/07/2020 rereviewed the Immediand the action plans Review of the meetin 05/07/2020, reveale heads attended. Int 05/21/2020, with the Director, Director of Managers, and the N Coordinator revealed QAPI meeting on 05 immediate jeopardy development of a plans. A review of skin as a contraction of the skin and the skin and the skin and the skin and the N Coordinator revealed QAPI meeting on 05 immediate jeopardy development of a plans. A review of skin as a contraction of skin as a cont	latory concerns, physician e plan updates. Nursing ess any concerns when the QAPI team held a ing to review the initial is, physician notifications and is well as the status of the location initiated on liministrator reviewed the ical Director on 05/08/2020.  Agency verified the facility owing actions to remove on 05/13/2020, as alleged:  Edical record revealed the esident #1 to the hospital on resident did not return to the committee meeting minutes wealed the committee iate Jeopardy notifications for facility compliance. In gign in sheet dated did the facility's department erviews, conducted on Administrator, Medical Nursing (DON), the Unit Minimum Data Set (MDS) did the facility had conducted a //07/2020 to discuss the	F 69	57	

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	performed to include and capillary refill. F completed for Resid #6 and Resident #7 were completed with Observation of skin and Resident #7 cor included evaluation refill with no concerr the DON, Unit Mana on 05/21/2020 revea pulses, and capillary 05/08/2020.  4. A review of skin a by the DON on 05/0 audited a sample of assessments with not the May 2020 skin a Resident #4, Reside Resident #7 reveale completion or accural Interview with the Dor revealed she had co assessments perform (3) residents from existence or changes on 5. A review of daily 05/12/2020 through Managers, Wound Noupervisor revealed unit were assessed capillary refill, and passessments were completed on 05/08, identified. Interview	d to toe skin assessment evaluation of pedal pulses Review of skin assessments ent #4, Resident #5, Resident revealed the assessments in no concerns identified. assessments for Resident #6 iducted on 05/20/2020, of pedal pulses and capillary is identified. Interviews with ger #1, and Unit Manager #2 alled all residents' skin, pedal ir refill status was assessed by assessment audits completed 8/2020 revealed the DON had fifteen (15) completed skin o issues identified. Review of assessments completed for int #5, Resident #6, and d no concerns with the acy of the assessments. ON on 05/21/2020 at 2:38 PM inducted audits of the skin med on 05/08/2020, of three ach hallway with no new f condition found.  audits completed from 05/20/2020 by the DON, Unit lurse, and the Weekend five (5) residents from each daily for circulatory changes,	F 6	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		185262	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	100202		STREET ADDRESS, CITY, STATE, ZIP CO		5/21/2020	
				131 MEADOWLARK DRIVE			
MADISON	HEALTH AND REHA	ABILITATION CENTER		RICHMOND, KY 40475			
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F 657	Continued From p	-	F	657			
	revealed they wer residents daily on	sor conducted on 05/21/2020 re assessing a sample of each unit for circulatory re any changes in a resident's ntified.					
	sheet dated 05/07 had educated the	in service education sign in 7/2020 revealed the MDS Nurse EDT on updating resident care nge in condition occurred.					
	1:42 PM revealed requirement to up	MDS Nurse on 05/21/2020 at she had trained the EDT on the date the plan of care when a lange of condition. Interview					
	with the EDT Nurs	se on 05/21/2020 at 1:57 PM, 5 Nurse had educated her on care plans on 05/07/2020. The					
	except employees the requirement b	ducated all licensed nurses who were on leave regarding y 05/08/2020. Further interview					
	leave could not we completed. Review	aled employees who were on ork until the training was w of employee in-service					
	employees were	sheets revealed all licensed educated on updating resident a change in condition occurred					
	conducted with LF	the EDT Nurse. Interviews PN #3, LPN #4, Unit Manager #2, and the Weekend					
	education on 05/0	21/2020 revealed they received 8/2020 by the EDT on updating a resident had a change of					
	05/07/2020 throug nurses were educ physician notificat	ucation Sign in Sheets dated gh 05/09/2020 revealed all ated by the DON and EDT on ion, change of condition, Notification if the physician could					

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F 657	for physician notifica. The education refer inspections, circulat pedal pulses, and v new/undocumented signs/symptoms of immediate physician documentation in the updating the plan of interventions related status. Interviews with the EDT Nurse at 1 revealed they had in from 05/07/2020 thriphysician notificatio conducting assessing updating the plan of medical record. Into conducted with LPN #1, Unit Manager #2. Weekend Supervisor DON had in service for physician notification conducting skin associrculatory concerns of care and document of care and do	documentation requirements ations in the medical record. enced resident skin tory indicators of capillary refill, ital signs. Any skin impairments or circulatory problems required in notification and e medical record and	F 65	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 657	and Physician Order DON, MDS Coordin Nurse Managers on concerns with notifice and resident care placcordingly. Observed 05/20/20 for Resident #7 change of condition. for Resident #4, Resident #7's May 2 physicians orders, splan of care reveale condition, updating the solution of the so	st thirty days Progress Notes r audits completed by the ator, Wound Nurse and 05/08/2020, revealed no ration of change of condition ans being updated rations conducted on nt #4, Resident #5, Resident revealed no concerns with Record reviews conducted sident #5, Resident #6, and 1020 Nurse's Notes, kin assessments, and the d no concerns with change of the plan of care or physician	F6	557		
	Manager #1, and Ur 05/21/2020 revealed days of progress no residents' care plans condition had been notified, and the res with new intervention issues identified.  10. A review of daily physician's orders of the condition of th	ws with the DON, Unit nit Manager #2, on they had reviewed thirty tes, physician orders, and is to ensure changes of dentified, physicians were ident's care plan was updated ins on 05/08/2020 with no or nursing note audits and completed from 05/08/2020 the DON, Unit Managers,				
	and the Weekend S notes and physician for any concerns wit condition, circulatory care plan had been interventions. A rev Resident #4, Reside Resident #7 to inclu Physicians Orders, a	upervisor revealed nursing s orders were reviewed daily h resident changes in a ratus, and validating the				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185262	B. WING			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 131 MEADOWLARK DRIVE RICHMOND, KY 40475	DE	0.21.2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	*	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 657	the residents. Inter Manager #1, Unit M Supervisor on 05/22 reviewed the previor notes and physician physician notification updated to reflect accondition.  11. A review of the minutes dated 05/03 Committee reviewer assessments, physician updates, and the streed education initiated of QAPI Committee M and 05/19/2020 review massessments with the M at 2:49 PM reveled the QAPI meeting or review the Immediated the Plan of Action. Medical Director revieweting on 05/08/25 facility's audits and Medical Director stawithin thirty minutes a resident's physicial change of condition she had been attention monitor the facility's	updates to the plan of care for views with the DON, Unit lanager #2 and the Weekend 1/2020 revealed they had us twenty-four hour nursing its orders daily to ensure in and that care plans were in y change in resident.  QAPI Committee meeting 8/2020 revealed the QAPI diaudit findings of skin cian notifications, care plan atus of licensed nurse's in 05/07/2020. A review of eeting Minutes for 05/12/2020 ealed the QAPI Committee in to review audit findings and y's plan of action. An ledical Director on 05/21/2020 the Medical Director attended in 05/07/2020 by phone to the Jeopardy Notification and Further interview with the realed she attended the QAPI 020 in person to review the education progress. The attended the the year of the year of the they were not able to reach an when the resident had a the Medical Director stated ding weekly QAPI meetings to compliance. An interview or on 05/21/2020 at 3:05 PM	F	657		
	process for complia morning meetings to	een monitoring the QAPI nce daily by conducting the o ensure daily audits were identified concerns were				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185262	B. WING			05/	) 21/2020
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	05/2	21/2020
	HEALTH AND REHABIL	ITATION CENTER		131 MEADOWLARK DRIVE RICHMOND, KY 40475			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	ION SHOULD B HE APPROPRIA	<b>I</b>	(X5) COMPLETION DATE
F 657	conducted weekly QA review of audit finding	n, the Administrator had PI Meetings for continued	F	657			
F 684 SS=J	Quality of Care CFR(s): 483.25		F	684			
	applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with professions.	ndamental principle that and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of lensive person-centered					
	by: Based on interview, I the "Merck Manual" (I resource manual), it failed to ensure one ( residents (Resident # and treatment in accostandards. On 04/08, developed a small, re left foot which progres 04/24/2020, when the cold, mottled (Mottling	was determined the facility 1) of three (3) sampled 1) received necessary care ordance with professional /2020, Resident #1 d area on the top of his/her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		(	С
		185262	B. WING			05/	21/2020
	ROVIDER OR SUPPLIER  HEALTH AND REHAE	BILITATION CENTER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 31 MEADOWLARK DRIVE CICHMOND, KY 40475		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	disease), had necro could not palpate a at the knee. Althouphysician on severa through 04/17/2020 extremity, the staff and act upon clinicaresident's circulator decline from 04/08/Subsequently, the contact the residen further diagnostic to 04/24/2020, Reside hospital and diagnot Ischemia (restricted an "Occlusion of the artery distally" (artery distally" (artery distally" (artery distally "continuerevealed on 04/25/2 was surgically remote to "Profound ischemicadaveric (corpse I). The facility's failure care and treatment cause serious injurity to a resident. Immon 05/06/2020, and 04/14/2020 at 42 C (F580), 42 CFR 48: Person-Centered C 483.25 Quality of C notified of the Immo 05/06/2020. Substidentified at 42 CFF (F684).	condition, such as vascular offic (dead) tissue and staff pulse in the resident's foot or ugh staff notified Resident #1's all occasions from 04/08/2020 office regarding the resident's left failed to recognize, identify, all indications that the ry status was continuing to 1/2020 through 04/23/2020. If a cility took no action to 1/2020 through 04/23/2020. If a cility took no action to 1/2020 through 04/23/2020. If a cility took no action to 1/2020 through 04/23/2020. If a cility took no action to 1/2020 through 04/23/2020. If a cility took no action to 1/2020 through 04/23/2020. If a cility took no action to 1/2020 through 04/23/2020. If a cility took no action to 1/2020 through 04/23/2020. If a cility took no action to 1/2020 through 04/23/2020. If a cility took no action to 1/2020 through 04/23/2020. If a cility it to 1/2020 through 04/23/2020. If a cility was 1/2020 through 04/23/2020 through 04/23/2020. If a cility was 1/2020 through 04/23/2020 through	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		185262	B. WING _			C 5/21/2020	
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL			STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 684	Immediate Jeopardy Survey Agency deter Jeopardy was remove alleged, prior to exit of lowered the scope at CFR 483.10 Resider 483.21 Comprehens Plans (F657), and 42 (F684), while the fact effectiveness of syste assurance activities.  The findings include:  Interview with the Ad 1:00 PM revealed the to Nursing Assessme with the Administrator revealed the facility is Professional Standar interview with the Ad 5:40 PM, revealed if change in condition, reassess the residen condition continued, resident's physician.  According to the Mer 2019, symptoms of of disease varied; howe the part of the body i enough blood resultin flow/oxygen). Ischer can cause tissue dar condition will not imp appropriate medical symptoms of ischem	220, which alleged removal of on 05/13/2020. The State mined the Immediate ed on 05/13/2020, as on 05/21/2020, which had severity to "D" level at 42 at Rights (F580), 42 CFR eve Person-Centered Care ever 48.25 Quality of Care elity monitors the emic changes and quality eministrator on 04/30/2020 at exact facility had no policy related ent. Email correspondence on 05/05/2020 also had no policy related to do of Practice. However, eministrator on 05/05/2020 at a resident experienced a	F 6	84			

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185262	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475	•	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	ge 43	F 6	684		
	progress over time to ischemia, the reduct affected extremity the tissue loss. If the tist affected, a non-heal may occur and the stimmediate attention.  Further review of the when the blood supfoot may be cold, are needed to detect put is narrowed further, that do not easily here.	away with rest). This can to critical limb threatening tion of blood flow to the nat results in severe pain or asue of the limb has been ling sore or even gangrene skin turns black; this requires .  The Merck Manual revealed ply is severely reduced, the not special equipment may be alses in the foot. As the artery a person may develop sores all, typically on the lower leg, especially				
	sudden, complete b or an arm may caus numbness in the aff or arm is either pale pulse can be felt be sudden, drastic dec is a medical emerge flow can quickly res paralysis of a limb. long, tissue may die amputated.  Review of Resident the facility admitted with diagnoses that and Muscle Weakne Admission Minimum dated 01/29/2020, rextensive assistance	the Merck Manual revealed lockage of an artery in a leg se severe pain, coldness, and sected limb. The person's leg sor bluish (cyanotic). No low the blockage. The rease in blood flow to the limb ency. The absence of blood sult in loss of sensation in or lf blood flow is absent for too se, and the limb may need to be #1's medical record revealed the resident on 01/23/2020 included Alzheimer's Disease less. Review of Resident #1's an Data Set Assessment (MDS) evealed the resident required the of two (2) staff members and, personal hygiene, and bed				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUC			(X3) DATE SURVEY COMPLETED		
		185262	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 131 MEADOWLARK DRIVE RICHMOND, KY 40475		00/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	could ambulate (wa person. The MDS a cognitively impaired Mental Status (BIMS to the MDS, Reside arterial ulcers (wour by poor circulation); or skin problems of Review of a "Skin U#1, revealed on 04/t resident's physician spot was observed left foot. According resident told staff th foot.  Review of Nurse's Nat 1:53 PM staff doc left foot was "now" swas noted to the top toe, and the resident documented that the contacted to request because Resident # ask" for pain medical of control." Resider revealed on 04/10/2 staff would be asked Review of Resident Physical Therapy evol4/13/2020 and not complained of pain foot/ankle. Continue Notes revealed on 0 therapy staff reported	view revealed the resident lk) with the assistance of one also revealed Resident #1 was with a Brief Interview for S) score of five (5). According nt #1 had no venous or nds on the leg or ankle caused and no other ulcers, wounds, the foot.  Cleer/Injury Form" for Resident 08/2020 at 5:00 PM, the was notified because a red on the top of Resident #1's to the documentation, the at he/she "bumped" his/her  Notes revealed on 04/10/2020, cumented that Resident #1's swollen, red, a small bruise of the left foot and left great at complained of pain. Staff the resident's physician was at scheduled pain medication at was not "alert enough to ation, until his/her "pain is out the this medical record also 2020 at 2:24 PM that therapy do to screen the resident on wall at the resident on wall at the resident on wall at the resident on the resident of the resident on the resident on the resident on the resident of the resident on the resident of the resident on the resident of the resident on the resident on the resident on the resident on the resident of the resident on the resident on the resident of the resident of the resident on the resident of the resident	F	684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING		TIPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED			
		185262	B. WING _			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		D. MINIO			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From pa	ge 45	F 6	684			
	order for an x-ray or obtained; and, the president had no accurate further review of R revealed the next d Registered Nurse (I resident's left foot with thready (pulse is not rapid), and the resident (time take after pressure has be capillary refill time riperipheral perfusion There was no docuracility identified this resident's condition	chysician was notified. An f the left lower extremity was carray report revealed the late fracture or dislocation.  esident #1's Nurse's Notes ay, on 04/14/2020 at 4:07 AM, RN) #1 documented that the late cold, mottled, pulses were late easily felt and commonly dent's capillary refill was en for color to return normal been applied. A prolonged may indicate decreased in or peripheral artery disease). In mented evidence that the lase as an acute change in the graph subsequently, no action was be resident's circulatory					
	Resident #1, reveal documented the resident pain. However, rev Therapy Notes for Cresident was only a rolling walker "with foot pain."  Further review of Rievealed on 04/16/2 #1's left lower extre capillary refill was "the resident's physifor a Venous Doppl	f the Nurse's Notes for ed on 04/15/2020, staff sident's bruises had improved, in had pedal pulses and no iew of the resident's Physical 04/15/2020 revealed the ble to take one step with a significant complaints of left esident #1's Nurse's Notes 2020, at 8:36 PM, Resident mity was discolored and slow". According to the Note, cian was notified and an order er (a test to check the r clots in the large veins in the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		185262	B. WING			C 05/21/2020	
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		03/2 1/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From page	ge 46	F 68	34			
	on 04/17/2020 at 4: had become cold to knee to the toes, had to the toes, the left of the resident's pedal addition, despite be medication, the Not continued to voice pleft leg/foot. According the study had been con awaiting the results. Physical Therapy N 04/17/2020 that the pain in left foot/ankliveight" on his/her lepain". The Notes stordered and staff we test. Again, there we the facility identified resident's condition address the worsen foot/leg.	the Nurse's Notes revealed 51 PM, Resident #1's left leg the touch from the resident's d discoloration from the shin foot was swollen, had bruising than the top of all toes, and pulses were faint. In ing on scheduled pain eralso stated that the resident pain with movement of his/her ling to the Note, a Doppler and the facility was an In addition, Resident #1's lotes also indicated on resident "continues to have ee" and was "unable to bear eff lower extremity "due to lated an ultrasound had been lere awaiting results of the lass no documented evidence this acute change in the land no action was taken to ling condition of the resident's #1's Venous Doppler test test was conducted on					
	04/17/2020 and no indicated. Review of	abnormal findings were of Nurse's Notes dated PM, revealed the physician					
	Nurse's Notes reveat 04/19/2020, and 04. document that the recontinued to be coo	review of Resident #1's aled on 04/18/2020, /20/2020, staff continued to esident's left foot/left extremity I to touch and was discolored. dent's Physical Therapy (PT)					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
		185262	B. WING			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	<u> </u>	00/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	bearing weight to the 04/20/2020. Further no documented evide action to ensure Restreatment to address decreased blood flow.  On 04/21/2020 at 2:0 Resident #1's feet we socks, his/her feet we thready, capillary refibruising to the left for second toe. In additive revealed the resident bearing because of palso indicated, "X-ray negative."  Further review of Reservealed there was nof the resident's footo On 04/23/2020 at 1:3 Notes revealed that I extremity continued to discoloration from the edema to the foot an noted in the resident'#1's Physical Therap revealed the resident'#1'	the resident had difficulty the left lower extremity on review revealed there was ence that staff took any ident #1 received care and the signs/symptoms of to his/her foot and leg.  88 AM, staff documented that ere cold despite wearing ere mottling, pulses were ll was abnormal, and had on and to the great and on, PT Notes for 04/21/2020 to had decreased weight the pain in the left foot, the notes to and Doppler were  sident #1's medical record to documented assessment leg on 04/22/2020.  85 PM, review of Nurse's Resident #1's left lower to be cool to touch with the knee to the toes, pitting down lower leg, and pulses were as foot. In addition, Resident to y Notes for 04/23/2020 to continued to bear weight on tremity only, and the down short wave diathermy is to possible blood flow witive deficits." Again, no address Resident #1's se to the left leg/foot.	F 6	84		
	#1's Physical Therap revealed the resident his/her right lower ex therapist documented contraindicated due to impairment and cogn action was taken to a circulatory compromi	y Notes for 04/23/2020 t continued to bear weight on tremity only, and the d "short wave diathermy is to possible blood flow ditive deficits." Again, no				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		185262	B. WING			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  HEALTH AND REHABI			STREET ADDRESS, CITY, STATE, ZIP COD 131 MEADOWLARK DRIVE RICHMOND, KY 40475		5/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	that had "appeared" side of Resident #1's necrotic areas. In a lateral, ventral, and and the heel were d. The left knee had a most of the proxima and was cool and te documented that the palpable pedal pulse in the foot and knee knee and foot was cool to the Nurse's Note, office was contacted physician's office was make a "tele call" (to the resident's foot with office.  Continued review of revealed staff documented staff documented that the resident staff documented in the foot and knee knee and foot was cooled to the Nurse's Note, office was contacted physician's office was make a "tele call" (to the resident staff documented in the foot and treatment at 12:  Review of Resident Hospital #1 revealed with Critical Lower Left superficial femore	locumented that the "bruises" on 04/08/2020 to the ventral is foot had become dry, ddition, the resident's toes, plantar surfaces of the foot, eep purple with black areas. red/purple area covering aspect of the patella (knee), inder to touch. The RN also e resident had pain, no es nor popliteal pulses (pulses i), and the skin between the old and mottling. According the resident's physician's and a staff member at the is going to have the physician ele medicine/video) to view then the physician arrived at the physician arrived at in the physician sheet revealed the need to transport the ital on 04/24/2020 at 1:10 as was transferred to the ital on 04/24/2020 at 1:53 are of the EMS sheet revealed at the hospital for evaluation 30 PM on 04/24/2020.  #1's medical record from at the resident was diagnosed imb Ischemia (restricted ital artery distally" (the artery in as blocked). Resident #1	F 68	34			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		185262	B. WING		05/21/2020
	ROVIDER OR SUPPLIER  HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	, 332,1222
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 684	(Hospital #2) for furtion of the completed on the resident would be in pain whether we mow #1 stated she report changes she observed foot around 04/09/20 was on leave from with service appearance and the completed on the resident would be in pain whether we mow #1 stated she report changes she observed the completed on the resident would be in pain whether we mow #1 stated she report changes she observed the completed she free and had observed the control of the cont	larger medical center her care/treatment on  #1's medical record from I Resident #1's left leg was y removed) above his/her related to "Profound blood flow) and cadaveric er extremity."  Registered Nurse Aide /2020 at 2:40 PM revealed for Resident #1 and nursing at an ultrasound had been sident's leg and was normal. to SRNA #4, the ea to the resident's foot "just The SRNA stated the noaning and complaining of ved (him/her) or not." SRNA ed to nursing staff the ed to the resident's leg and tated, "It continually got	F 68		
		anges in the resident's leg to ated they were aware of the #1's condition.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		185262	B. WING			C <b>05/21/2020</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	03/21/2020	
MADISON	HEALTH AND REHA	BILITATION CENTER		131 MEADOWLARK DRIVE RICHMOND, KY 40475			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	PM revealed she a Resident #1. She facility received the (approximately 04/observed to Resident #1's left I the right leg and reapproximately two to the hospital. In resident "just hurt, to do with that leg started, hurt." The reported the change facility nurses, incl. Interview with SRN PM revealed Resident, the reasistance with be pain." He further sassistance with be pain. He further sassistance with the	AA #3 on 05/04/2020 at 12:20 also frequently provided care for stated around the time the evenous Doppler results (17/2020) bruising was ent #1's big toe on his/her left days later" the "bruising" started ent's leg. SRNA #3 also stated eg was "colder" to touch than emained that way for (2) weeks before he/she went addition, SRNA #3 stated the period." She stated, "Anything from the time the bruising a SRNA also stated she ges in the resident's condition to	F	684			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185262	B. WING _	B. WING		C <b>05/21/2020</b>	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DE	00/21/2020	
MADICON	HEALTH AND REHABIL	ITATION CENTER		131 MEADOWLARK DRIVE			
WADISON	HEALIH AND REHABIL	LITATION CENTER		RICHMOND, KY 40475			
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F 684	Continued From page	e 51	F6	684			
	"didn't want to put we notified Nursing of the pain and inability to be Therapist stated Res "cooler to touch" thar	eight on it." He stated he e resident's complaints of pear weight. In addition, the ident #1's left leg was n his/her right leg; however, e resident's pulses in his/her					
	revealed she docume assessment findings observed that the restaint, and his/her left shin to the resident's acknowledged the reafter the diagnostic to a venous blood flow acknowledged that n guide care. LPN #1 sphysician should hav diagnostic tests could LPN #1 stated that co	on 04/17/2020 and sident's pedal pulses were leg was discolored from the toes. LPN #1 sident's leg never improved est results were negative for problem on 04/17/2020. She ursing assessments should stated the resident's re been notified so other d have been conducted. Ontacting the physician when improve could have made a some for the resident, her concern was later					
	revealed she assess 04/14/2020 and 04/2 "Looking back, I wou persistent with physic Doppler results." She me something was wapproximately 4:00 A observed dry, necrotic resident's toes, laterationt, and his/her heel	1/2020. RN #1 stated, Id have been more cian notification after the e stated, "My gut was telling rrong." On 04/24/2020 at kM, the RN stated she ic (dead) tissue to the al/ventral aspects of his/her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		185262	B. WING _			C 05/21/2020	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 131 MEADOWLARK DRIVE RICHMOND, KY 40475	•	0/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	center) of his/her obtain pulses to Rhis/her knee.  Further interview the resident's phy on 04/24/2020 to resident's condition to return the call waited until the pharound 8:00 AM, a however, she was the hospital. According to document 8:35 AM on 04/24 completed resident to leave the facility office (around 9:00 hours after the as resident's condition physician of the completed to the physician of the completed to the physician of the complete to notify the hospital for further than the contacting Resident to the physician's linterview with the 05/05/2020 at 5:00 condition was more during an Interdist The DON stated in twenty-four (24) resident to the physician (24) resident to the polysician (24) resident to the polysician (24) resident the polysician (24) resident the polysician (24) resident the polysician (24) resident (24) re	with RN #1 revealed she paged sician at approximately 6:30 AM notify him of the change in the in; however, the physician did at that time. She stated she pysician's office was open, and notified office staff; informed the physician was at ording to the RN, she was not the resident's assessment until /2020. RN #1 stated once she int documentation, and was able y, she went to the physician's 0 AM approximately five [5] sessment of the decline in the in) and notified Resident #1's mange in his/her condition. RN sician directed his office staff to ent #1 to be directly admitted to ther evaluation and treatment. although it was the facility's he physician at the time a on was identified to have I been unsuccessful in int #1's physician prior to going	F	584			

i i i i i i i i i i i i i i i i i i i		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185262	B. WING _			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	<b>I</b>	03/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 684	However, the DON identifying that Res change in condition indicated the reside or his/her pulses we she was notified of condition the mornin arrived at the facility.  Interview with LPN revealed staff had resigns/symptoms of "until this happened to Resident #1.  Email corresponder 05/06/2020 at 1:59 provided no educat symptoms of arterial staff.  Interview with Phys 12:50 PM revealed that Resident #1's pleft foot, or that the touch until 04/24/20 required to notify his resident's condition physician confirmed facility related to Rewas notified of the ron 04/17/2020. He him of the ongoing condition, after the was conducted, he	changes had been addressed. stated she did not recall ident #1 had an ongoing , nor any documentation that int's foot/leg was cold/mottled ere thready. The DON stated the resident's change in ing of 04/24/2020 when she //.  #2 on 05/20/2020 at 1:15 PM not been trained on vascular or arterial issues I to this resident" in reference ince with the Administrator on PM revealed the facility had ion related to the signs and/or all ulcers to direct care nursing it is a staff had not informed him pulses were thready in his/her resident's leg/foot was cold to 120. He stated staff were in when changes in a occurred. However, the is he received no calls from the esident #1's condition, after he normal Venous Doppler results stated if staff had informed change in the resident's Venous Doppler ultrasound would have ordered and it Resident #1 could have	F 6	84			

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		185262	B. WING	B. WING		C <b>5/21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 131 MEADOWLARK DRIVE RICHMOND, KY 40475		0/2 1/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	PM revealed he eva 04/24/2020 at Hosp evaluated the reside resident "could have Physician #2 stated to touch and thread sign that was when Resident #1. He als findings were "tellta wrong and he would inform a physician owere identified.  Interview with Physical 11:10 AM revealed Hospital #2. He staremoval of the reside above the knee on the resident's leg had be Physician #3 stated thick necrosis on more identified worth work worth or resident got to the hodefinitely didn't just "**The facility imple to remove Immediate 05/13/2020:  1. Resident #1 no lead to the facility held assurance and Performittee meeting Immediate Jeopard in the side of the side of the facility held assurance and Performittee meeting Immediate Jeopard in the side of t	aluated Resident #1 on ital #1. He stated when he ent his thought was that the ent his thought was the problem started for so stated those assessment le signs" that something was dexpect licensed nurses to of those findings when they  scian #3 on 05/18/2020 at the evaluated Resident #1 at ted he conducted the surgical lent's left lower extremity 04/25/2020, because the een without blood supply. Resident #1 also had "full cultiple areas of" the foot and resident appeared to have of ischemia" before the loospital and stated, "It	F	584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185262	B. WING _			C <b>5/21/2020</b>	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 131 MEADOWLARK DRIVE RICHMOND, KY 40475		0/2 I/2020	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	conducted head-t 05/08/2020, which pulses and capillatinew circulatory considered as ample inspection forms a second review. The second review is second review. The second review is second review is second review. The second review is second review is second review. The second review is second review is second review. The second review is second review is second review in second review in second review is second review in second review in second review is second review in second review in second review in second review is second review in second review in second review in second review is second review in second review. The second review is second review in second review in second review in second review. The second review is second review in second review in second review in second review. The second review is second review in	e clinical leadership team o-toe skin inspections on included checking pedal ary refill for all residents. No oncerns were identified.  O, the Director of Nursing (DON) of three (3) completed skin from each hall (15 in total), as a she DON identified no concerns.  O5/12/2020, the DON, Unit Nurse, and/or Nurse Supervisor of the residents per unit daily to or changes, capillary refill, and oparing to the documented of 107/2020. Staff completing the immediately address any onitoring will continue until the ulatory compliance. The QAPI the results at least weekly to progress toward regulatory	F6	584			
	provided education Director (ETD) response when a resistance occurs. The ETD all licensed nurses was required to with the care plan in the ensure competen 7. The Director of licensed nurses of in condition and \$1.05/07/2020 through	Data Set (MDS) Coordinator on to the Education Training garding updating resident care dent's change in condition then provided this education to s by 05/08/2020. Each nurse erbalize the process to update the Electronic Medical Record to cy.  If Nursing and ETD educated all in physician notification, change Medical Director Notification on gh 05/09/2020. The education umentation requirements for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED  C 05/21/2020	
		185262	B. WING _				
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 131 MEADOWLARK DRIVE RICHMOND, KY 40475	•	3/2 1/2020	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Resident skin insplimited to, circulate pedal pulses, and new/undocuments signs/symptoms of immediate physicidocumentation in nursing progress related to a change 8. On 05/07/2020 licensed nurses whost-test to verify physician notificated Medical Director Norequired to receive resuming duties. The required to have postest prior to rehired licensed nur education/testing to assuming duties.  9. On 05/08/2020 Coordinator, Wou completed a revied Interdisciplinary Torders to ensure a notification in any The review including resident care plant condition and any Director of Nursing Nurse, and Nurse concerns.	ions in the medical record. Dections to include, but not ory indicators of capillary refill, vital signs. Any ed skin impairments or of circulatory problems require an notification and the medical record in the motes. In addition, staff will with the new interventions are in a resident's status.  Of through 05/08/2020, all through 05/08/202	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		185262	B. WING _			C 05/21/2020
	ROVIDER OR SUPPLIER  HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	•	00/21/2025
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	je 57	F 6	584		
	on-going audit of the and physician's order of any resident circu notification, and care leadership will addred discovered.	ekend Supervisor, initiated an eprior 24- hour nursing notes ers to ensure the identification latory concerns, physician eplan updates. Nursing ess any concerns when				
	second ad hoc meet skin/circulatory audit care plan updates, a licensed nurse's edu 05/07/2020. The Ad	the QAPI team held a ing to review the initial its, physician notifications and its well as the status of the location initiated on liministrator reviewed the local Director on 05/08/2020.				
	implemented the foll	Agency verified the facility owing actions to remove on 05/13/2020, as alleged:				
	facility transferred R	edical record revealed the esident #1 to the hospital on resident did not return to the				
	dated 05/07/2020 re reviewed the Immed and the action plans Review of the meetin 05/07/2020, reveale heads attended. Int 05/21/2020, with the Director, Director of Managers, and the N Coordinator revealed QAPI meeting on 05 immediate jeopardy	Committee meeting minutes vealed the committee iate Jeopardy notifications for facility compliance. In gign in sheet dated did the facility's department erviews, conducted on a Administrator, Medical Nursing (DON), the Unit Minimum Data Set (MDS) did the facility had conducted a wido/7/2020 to discuss the and to initiate the an of action for compliance.				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185262	185262 B. WING		C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 131 MEADOWLARK DRIVE RICHMOND, KY 40475	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLÉTION DATE
F 684	o5/06/2020 through residents had an performed to include and capillary refill completed for Re #6 and Resident; were completed word observation of sk and Resident #7 included evaluation refill with no concurre the DON, Unit Ma on 05/21/2020 repulses, and capill 05/08/2020.  4. A review of ski by the DON on 05 audited a sample assessments with the May 2020 skir Resident #4, Res Resident #7 revercompletion or accompletion or acc	in assessments conducted from gh 05/08/2020 revealed all ead to toe skin assessment ude evaluation of pedal pulses. Review of skin assessments sident #4, Resident #5, Resident #7 revealed the assessments with no concerns identified. In assessments for Resident #6 conducted on 05/20/2020, on of pedal pulses and capillary erns identified. Interviews with anager #1, and Unit Manager #2 wealed all residents' skin, pedal ary refill status was assessed by in assessment audits completed 5/08/2020 revealed the DON had of fifteen (15) completed skin in no issues identified. Review of in assessments completed for ident #5, Resident #6, and aled no concerns with the curacy of the assessments. DON on 05/21/2020 at 2:38 PM conducted audits of the skin formed on 05/08/2020, of three in each hallway with no new is of condition found.	F	584	
	05/12/2020 through Managers, Wound Supervisor reveal unit were assessed capillary refill, and	gh 05/20/2020 by the DON, Unit			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
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			D. WING _		•	5/21/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE		
MADISON	I HEAI TH AND REHA	ABILITATION CENTER		131 MEADOWLARK DRIVE			
				RICHMOND, KY 40475			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	completed on 05/identified. Interview #1, Unit Manager Weekend supervirevealed they were sidents daily on concerns to ensure condition was ide	08/2020 with no concerns ews with the DON, Unit Manager #2, the Wound Nurse, and the sor conducted on 05/21/2020 re assessing a sample of each unit for circulatory re any changes in a resident's ntified.	F 6	684			
	sheet dated 05/07 had educated the plans when a cha Interview with the 1:42 PM revealed requirement to up resident had a ch with the EDT Nursevealed the MDS updating resident EDT stated she e except employees the requirement be with the EDT revealed to the requirement be with the EDT revealed education sign in employees were care plans when a on 05/08/2020 by conducted with LI #1, Unit Manager Supervisor on 05/0 education on 05/0 care plans when a condition.	in service education sign in 7/2020 revealed the MDS Nurse EDT on updating resident care inge in condition occurred.  MDS Nurse on 05/21/2020 at a she had trained the EDT on the idate the plan of care when a sange of condition. Interview se on 05/21/2020 at 1:57 PM, a Nurse had educated her on care plans on 05/07/2020. The iducated all licensed nurses is who were on leave regarding by 05/08/2020. Further interview ealed employees who were on ork until the training was easy of employee in-service sheets revealed all licensed educated on updating resident a change in condition occurred the EDT Nurse. Interviews PN #3, LPN #4, Unit Manager #2, and the Weekend (21/2020 revealed they received 08/2020 by the EDT on updating a resident had a change of					
		ucation Sign in Sheets dated gh 05/09/2020 revealed all					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	. ,	(X3) DATE SURVEY COMPLETED	
		185262	B. WING			C 05/21/2020	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE 131 MEADOWLARK DRIVE RICHMOND, KY 40475	•	1012 H 2020	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI' CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 684	physician notificated Medical Director of Nedical Director of Nedical Director of Nedical Director of Physician notificated physician notificated physician physician notificated physician notificate	rated by the DON and EDT on tion, change of condition, Notification if the physician could and documentation requirements fications in the medical record. Ferenced resident skin latory indicators of capillary refill,	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	` ′	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		185262	B. WING			C 5/21/2020	
	OVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		03/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
	provided by the EDT or 05/08/2020.  9. Review of the parand Physician Order DON, MDS Coordina Nurse Managers on concerns with notificand resident care placeordingly. Observ 05/20/20 for Resident #6, and Resident #7 change of condition. for Resident #4, Res Resident #7's May 2 physicians orders, siplan of care revealed condition, updating the notification. Intervie Manager #1, and Ur 05/21/2020 revealed days of progress not residents' care plans condition had been in notified, and the resi with new intervention issues identified.  10. A review of daily physician's orders of through 05/20/20 by and the Weekend Stronger and physicians for any concerns with the parameter of the progress of the physician's orders and physicians for any concerns with the parameter of	st after the education and the DON on 05/07/2020  st thirty days Progress Notes audits completed by the ator, Wound Nurse and 05/08/2020, revealed no action of change of condition ans being updated vations conducted on at #4, Resident #5, Resident revealed no concerns with Record reviews conducted sident #5, Resident #6, and 020 Nurse's Notes, kin assessments, and the d no concerns with change of the plan of care or physician ws with the DON, Unit at Manager #2, on If they had reviewed thirty tes, physician orders, and to ensure changes of dentified, physicians were dent's care plan was updated as on 05/08/2020 with no  of nursing note audits and completed from 05/08/2020 the DON, Unit Managers, upervisor revealed nursing so orders were reviewed daily th resident changes in of status, and validating the	F 68	4			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		185262	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	100202		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	5/21/2020
MADISON	HEALTH AND REHABI	LITATION CENTER		131 MEADOWLARK DRIVE RICHMOND, KY 40475		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Physicians Orders, a no concerns with phy of condition or with a the residents. Interv Manager #1, Unit Ma Supervisor on 05/21, reviewed the previous notes and physician physician notification updated to reflect an condition.  11. A review of the Cominutes dated 05/08 Committee reviewed assessments, physician updates, and the stateducation initiated of QAPI Committee Me and 05/19/2020 reverses was meeting weekly to monitor the facility interview with the Me at 2:49 PM reveled to the QAPI meeting or review the Immediate the Plan of Action. Medical Director reverseting on 05/08/20 facility's audits and emeting of condition, she had been attend monitor the facility's	de May 2020 Progress Notes, and the Plan of Care revealed visician notification of change pdates to the plan of care for lews with the DON, Unit anager #2 and the Weekend 2020 revealed they had so twenty-four hour nursing so orders daily to ensure and that care plans were and that care plans were yochange in resident  QAPI Committee meeting 2020 revealed the QAPI audit findings of skin sian notifications, care plantus of licensed nurse's 105/07/2020. A review of eting Minutes for 05/12/2020 aled the QAPI Committee to review audit findings and	F 6	84		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185262	B. WING				21/2020
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL	ITATION CENTER		13	TREET ADDRESS, CITY, STATE, ZIP CODE 81 MEADOWLARK DRIVE ICHMOND, KY 40475		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	morning meetings to completed and any id addressed. In additional conducted weekly QA review of audit finding facility's compliance a removal.	ce daily by conducting the ensure daily audits were lentified concerns were on, the Administrator had API Meetings for continued		684			
F 697 SS=G	removal. Pain Management		F	697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		185262	B. WING _			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	'	30.22020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 697	continued to complay when the facility trainospital. Resident is occlusion of the mich distally, and underwilling on 04/25/2020. evidence the facility pain or attempted to ongoing complaints medication was not. The findings include Review of the facility Process," dated Octacility's goal was to appropriate pain relivesident's pain does function within their also stated the facility goals for pain contrained alternative method addition, the policy evaluation, and reconficial evidence of care practice for Review of Resident the facility admitted with diagnoses that and Muscle Weakner Review of Resident Data Set (MDS) asservealed the staff as Brief Interview for Mive (5) indicating the impaired and required the staff and required and required and required the staff and required the staff and required an	revealed the resident ain of pain until 04/24/2020, msferred the resident to the #1 was diagnosed with an I left superficial femoral artery vent surgical removal of the There was no documented re-assessed the resident's manage the resident's of pain when the ordered effective.  E:  y's policy "Pain Management tober 2015, revealed the of ensure all residents received dief measures to ensure a so not affect their ability to designated goals. The policy dity would meet the resident's both by the use of medications mods to reduce pain. In stated necessary intervention, evaluation would be a standard dicensed nurses.  #1's medical record revealed the resident on 01/23/2020 included Alzheimer's Disease	F6	97			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185262	B. WING _				C <b>21/2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL	ITATION CENTER	•	131 M	ET ADDRESS, CITY, STATE, ZIP CODE IEADOWLARK DRIVE MOND, KY 40475	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 697	F 697 Continued From page 65		   F6	697			
		ion, staff assessed Resident nd was not on a scheduled nen.					
	Resident #1 to have a foot, caused by the refoot. Review of Resided dated 04/08/2020 at resident's left foot wa touch, and the reside area. The nurse doonotes that she admin (milligrams) to Reside had ordered on an "a review of Resident #7 revealed no documer administered the med Interview with Licens on 05/20/2020 at 1:50 stated she administer 04/08/2020 as indicated thowever, she stated and sometimes it will "as needed" medication interview with Reside 04/30/2020 at 4:15 Pfacility to visit Reside 04/10/2020. She stated through the she was aware that F	M, revealed staff assessed a red area on top of the left esident "bumping" his/her dent #1's Nursing Notes 5:10 PM, revealed the s slightly red, tender to nt complained of pain to the umented in the nursing istered Tylenol 650 mg ent #1 which the resident s needed" basis. However, I's MARS for 04/08/2020 anted evidence the nurse dication to Resident #1. ed Practical Nurse (LPN) #3 D PM, revealed the LPN red the resident's Tylenol on ted in her nurses notes. the system has a "glitch" in it remove documentation that on had been administered.  Int #1's Daughter on M revealed she went to the nut #1 through the window on ted while at the window, ate (unsampled Resident #1's leg was "hurt"					
	pain." The daughter she had heard about	mity; she stated the facility					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		185262	B. WING _			C 05/21/2020
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475		7572 172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	the facility assessed fourteen (14), indicate cognitively intact, wa at approximately 11:3 unaware of what had leg, but stated, "I just bad." The roommate out and moaned in pour (him/her)". Unsample he/she was glad to so the window so "I coun Resident #1.  Review of Nursing Notes and the window so "I coun Resident #1.  Review of Nursing Notes are revealed #1's physician of the resident's complaints revealed the staff recommedication be ordered cognitive status and request pain medicate control". Continued in Nursing Notes, revealed the facility on condered the resident (pain reliever) 650 m day at 7 AM, 1 PM at (nonsteroidal anti-inflimg twice a day at 7 Areview of Resident # resident also had a pmg four times daily a	sampled Resident #8, whom to have a BIMS' score of ing the resident was so conducted on 04/30/2020 80 AM. The roommate was happened to Resident #1's stated Resident #1 "yelled ain, but I couldn't help ed Resident #8 stated ee Resident #1's Daughter at Id try and get help" for otes dated 04/10/2020 at esident #1 was complaining tileg. Further review of the ed staff contacted Resident	F 6	97		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185262	B. WING				21/ <b>2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHABII	LITATION CENTER	•	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 31 MEADOWLARK DRIVE RICHMOND, KY 40475		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	Administration Record through 04/24/2020 pain on 04/09/2020, 04/13/2020, 04/13/2020, 04/13/2020, 04/23/20 receiving the schedul In addition, the MAR administered "as need the scheduled Tylend 04/10/2020 at 1:56 F 04/16/2020 at 7:23 F 10:45 PM. However evidence found to incre-evaluated the resinotified the physician pain management received and the physician pain management received the physician pain mana	Resident #1's Medication rd revealed from 04/09/2020 Resident #1 complained of 04/10/2020, 04/11/2020, 020, 04/18/2020, 04/19/2020, 020, and 04/24/2020, despite alled Tylenol and Diclofenac. S revealed Resident #1 was reded" Tylenol, in addition to old and Diclofenac on PM and 10:20 PM, on PM and on 04/22/2020 at refer to the that the facility ever ident's on-going pain or in to obtain a more effective regimen.  Therapy Notes for Resident 0, revealed therapy staff on the transport of pain or other than the facility ever weight; and, on ident had "significant of pain." On 04/17/2020, the did that Resident #1 remained on the left extremity due to	F	697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		185262	B. WING _			C 05/21/2020	
	ROVIDER OR SUPPLIER  HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	<b>.</b>	00/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 697	for Resident #1, the assistance of two (2) pain the resident was a linterview with SRNAPM revealed Reside and complain of pain provided or not. The the resident's complaint of pain provided or not. The the resident's complaint of pain and SRNA #5 or revealed both staff's when the left lower of staff stated they not resident's complaint provided.  Interview with SRNAPM revealed she from the stated the resident with the bruising stated the bruising stated in pain.  Interview with Regist AM on 05/05/2020 recare for Resident #1 stated when she took extremity, the resident with the stated with the resident touched or moved it in the stated with Licent on 05/20/2020 at 1: complained of pain assessed and documents.	"last few times" he had cared resident required the staff due to the amount of its experiencing.  A #4 on 05/03/2020 at 2:40 and #1 would be "moaning" in whether care was being the SRNA stated, she reported laints of pain to the nurses.  A #2 on 05/03/2020 at 6:35 at 05/04/2020 at 1:00 PM, stated Resident #1 "moaned" extremity was moved. The iffied the nursing staff of the staff of pain when care was  A #3 on 05/04/2020 at 12:20 at 1:00 PM, stated Resident #1 enter "just hurt, period." SRNA to do with that leg from the arted" caused Resident #1 to stered Nurse (RN) #1 at 8:15 evealed she was assigned to 1 on 04/24/2020. RN #1 at 6:10 ever ent "was yelping" in pain. RN int's leg "only hurt if you	F 6	97			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION  NG	(X	(X3) DATE SURVEY COMPLETED		
		185262	B. WING			C 05/24/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	I	05/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 697	were effective to relied Interview with LPN # revealed if a resident were required to reseat administering medical intervention to evalua LPN #3 stated even ther that Resident #1 (unsure of specific dapain assessment for Interview with Unit M 05/21/2020 at 12:38 required to conduct presidents once a shift Resident #1 voiced of should have assessed documented a follow interventions to manal Interview with the DO revealed she expected resident #1 would be resident #1 would be resident #1 had ong 04/10/2020 through 0 (Interview with Physical 12:50 PM revealed she resident #1 had after he ordered Tyle administered routine) Physician stated staff of Resident #1's ong of the revealed staff of Resident #1's ong of the revealed staff of Resident #1's ong of the residen	ave the resident's pain.  3 on 05/20/2020 at 1:50 PM to complained of pain staff evaluate the pain after ation or a pain relieving ate effectiveness. However, though staff had informed had complained of pain, ates) she failed to conduct a the resident as required.  Idenager (UM) #1 on PM revealed staff were pain assessments for facility at the resident's pain, staff at the resident's pain and the resident's pain and a up assessment to ensure age the pain were effective.  ON on 05/05/2020 at 5:00 PM and staff to assess a so of pain when voiced and to the ess of pain medication that are its effectiveness. The awas not made aware that the loing complaints of pain from	F	397			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185262	B. WING			l	21/ <b>2020</b>
	ROVIDER OR SUPPLIER  HEALTH AND REHABIL	ITATION CENTER	1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 31 MEADOWLARK DRIVE RICHMOND, KY 40475	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 697	04/24/2020 at 12:30 liperformed revealed to lower limb schema (retissue) and occlusion femoral artery distally 04/25/2020, Resident of the left lower extre Resident Records - lo	arrived to the hospital on PM and diagnostic tests he resident had a "critical estricted blood supply to of the mid left superficial v." Subsequently, on t #1 underwent amputation mity.		697 842			
SS=D	(i) A facility may not resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co- agrees not to use or o	nt-identifiable information. elease information that is o the public. elease information that is					
	must maintain medica that are- (i) Complete; (ii) Accurately docum (iii) Readily accessibl (iv) Systematically org §483.70(i)(2) The fac all information contain regardless of the forn records, except when (i) To the individual, co	rdance with accepted ds and practices, the facility al records on each resident  ented; e; and ganized  illity must keep confidential ned in the resident's records, n or storage method of the n release is- or their resident					
	representative where (ii) Required by Law;	permitted by applicable law;					

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 842  Continued From page 71  (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, 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.			185262	B. WING _			_	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 842  Continued From page 71  (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.			ILITATION CENTER		131 MEADOWLARK DRIVE	E	03/21/2020	
(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.	PRÉFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE	
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.	F 842	(iii) For treatment, poperations, as perm with 45 CFR 164.50 (iv) For public healt neglect, or domestic activities, judicial ar law enforcement pupurposes, research medical examiners, a serious threat to he by and in compliance §483.70(i)(3) The forecord information a unauthorized use.  §483.70(i)(4) Medic for- (i) The period of tim (ii) Five years from there is no requiren (iii) For a minor, 3 y legal age under State §483.70(i)(5) The m (i) Sufficient information (iii) A record of the record of the record information of the resident review determinations conductively (iv) The results of a and resident review determinations conductively (vi) Laboratory, radional serior descentiles and resident review determinations conductively (vi) Laboratory, radional serior descentiles are professional's progressional's progressiona	ayment, or health care nitted by and in compliance 106; h activities, reporting of abuse, coviolence, health oversight and administrative proceedings, purposes, or gan donation purposes, or to coroners, funeral directors, and to avert health or safety as permitted be with 45 CFR 164.512.  Accility must safeguard medical against loss, destruction, or the date of discharge when hent in State law; or the date of discharge when hent in State law; or the date of discharge when hent in State law; or the discharge when hent in Sta	F 8	342			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185262	B. WING		05/21/2020
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  131 MEADOWLARK DRIVE  RICHMOND, KY 40475	1 33/2::2320
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 842	Continued From pa	ge 72	F 842	2	
	the facility's policy, failed to maintain ad accordance with propractice for one (1) (Resident #1). Inte Resident #1's medic Resident #1's week staff had assessed Nurse's Notes from 04/23/2020 that Rewas discolored, ededeveloped mottling of the skin due to all However, review of by nursing staff on the skin due to all the sk				
	Guideline," dated A purpose of the polic evaluation of skin ir implement individual factors and a proce interruptions occur also stated a licens weekly skin assess document the findin Review of Resident the facility admitted	y's policy "Skin Care pril 2019, revealed the ry was to provide a system for order to identify risk and al interventions to address risk as for providing care when in skin integrity. The policy ed nurse would complete a ment of residents and gs in the medical record.  #1's medical record revealed the resident on 01/23/2020 included Alzheimer's Disease			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185262	B. WING	B. WING		C 05/21/2020		
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER				131	EET ADDRESS, CITY, STATE, ZIP CODE  MEADOWLARK DRIVE  HMOND, KY 40475	1 03/	21/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Data Set (MDS) asserve aled the facility are require extensive assemembers for bed monomers for Medive (5), indicating the impaired.  Review of Resident # 04/08/2020 at 5:10 Pleft foot was slightly reflected to However, on 04/09/2020 completed a skin assent documented no serve aled on 04/10/2020 documented the resident, and bruising extracross the top of the	this Admission Minimum essment dated 01/29/2020 assessed the resident to sistance of two (2) staff bility, transfers, and toileting. Essed the resident to have a cental Status (BIMS) score of exercise resident was cognitively this Nurse's Notes dated Mr. revealed the resident's red and tender to touch. 020 at 7:00 AM, staff ressment for Resident #1 abnormalities.  Sident #1's Nurse's Notes 020, at 1:53 PM staff dent's left foot was swollen, eended from the left great toe	F	342	DEFICIENCY)			
	red-purplish marbling 3:39 PM, staff docum remained to the residence review of a skin asserous Resident #1 on 04/16 no abnormal findings resident's skin assess.  Continued review of revealed on 04/17/20 left leg was cold to to toes and discoloratio to the toes, and the left.	lent's left foot. However, essment completed for 6/2020 at 7:00 AM, revealed were documented on the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185262	B. WING				C 21/2020
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER				131 I	EET ADDRESS, CITY, STATE, ZIP CODE  MEADOWLARK DRIVE  HMOND, KY 40475	1 05/	21/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		H DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	resident's left foot wa and had pitting eden 4:21 AM, 04/20/2020 2:08 AM, and 04/23/documented the residiscolored, cool to the However, review of Fassessment completed revealed staff had do Interview with Licens on 05/04/2020 at 3:5 documented Resided 04/09/2020 and 04/2 discolorations and alleft lower extremity when she completed 04/09/2020 and 04/2 documented them or assessment.  Interview with LPN #revealed she conduct assessment on 04/10 recalled the resident the left lower extremited the left lower extremited in the left lower	as discolored, cool to touch, na present. On 04/19/2020 at 0 at 3:45 AM, 04/21/2020 at 2020 at 1:35 PM, staff dent's left foot remained buch, and was edematous. Resident #1's skin at ded on 04/23/2020 at 7:00 AM ocumented no abnormalities.  Seed Practical Nurse (LPN) #1 at a present and the skin assessments on 23/2020. LPN #1 stated the conormalities to the resident's are ongoing and present at the skin assessments on 23/2020, but she had not at the resident's skin assessments on 23/2020, but she had not at the resident's skin assessments on 23/2020, but she had not at the resident's skin assessments on 23/2020. She stated she had skin discolorations to ity and the resident's capillary on that date. She stated she discoloration at a seessment findings on	F	342			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		185262	B. WING			C <b>05/21/2020</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	03/21/2020	
MADISON HEALTH AND REHABILITATION CENTER				131 MEADOWLARK DRIVE			
WADIOON	TIERETTI AND RETIROT	ENAMEN SERVER		RICHMOND, KY 40475			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C  (EACH CORRECTIVE ACTIC  CROSS-REFERENCED TO TH  DEFICIENCY	ON SHOULD BE IE APPROPRIAT		
F 842	5:40 PM, revealed sl document skin asses resident's medical re stated the facility did to ensure staff were		F	342			

PRINTED: 06/05/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X:	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED  C 05/21/2020	
	185262					
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITA	'	STREET ADDRESS, CITY, STATE, ZIP C 131 MEADOWLARK DRIVE RICHMOND, KY 40475	CODE	, , , , ,		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO TO DEFICIENCED TO TO TO DEFICIENCED TO TO TO DEFICIENCED TO	TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE
survey was initiated on ( concluded on 05/21/202 to be in compliance with	20. The facility was found a 42 CFR 483.73 ass related to E0024. No	EC				

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.

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

TITLE

(X6) DATE

PRINTED: 06/05/2020 FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						С
		100454	B. WING		05/	21/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
MADISON	HEALTH AND REHABIL	ITATION CENTER	DOWLARK DRI\ ND, KY 40475	/E		
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORI	PECTION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 000	Initial Comments		N 000			
	COVID-19 focused in initiated on 04/30/202 05/21/2020. The con and Immediate Jeopa to 42 CFR 483.25. T violation of imminent A Citation on 05/11/2 Citation was issued of	ation (KY31616) and a infection control survey was 20 and concluded on inplaint was substantiated ardy was identified pursuant the corresponding State danger was cited as a Type 020. An amended Type A on 05/28/2020. No deficient d related to the infection				

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

TITLE (X6) DATE