

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

PRINTED: 12/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 12/31/2014
NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE GENESIS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS An offsite revisit was conducted and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance as alleged on 12/23/14.	{F 000}			

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

TITLE

(X6) DATE

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

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

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NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601
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F 000 INITIAL COMMENTS

An Abbreviated Survey to investigate KY00022476 was initiated on 11/18/14 and concluded on 11/21/14. KY00022476 was unsubstantiated with related deficiencies cited.

F 514 483.75(I)(1) RES
SS=D RECORDS-COMplete/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and staff interviews, it was determined the facility failed to properly document an incident of exposure to insects on 11/11/14, for two (2) of five (5) sampled residents (Residents #1 and #2).

The findings include:

Review of the facility's policy, "NSG113 - Nursing Documentation", dated 10/01/12, revealed nursing staff were to practice good

F 000

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bradford Square does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

F 514

1. LPN #1 notified family members of resident #1 and #2 on 11/11/14 on skin assessment and interim room moves at time of occurrence. LPN # 1 was re-educated to NSG-113 Policy nursing documentation on 11/20/13 by the Director of Nursing to ensure documentation is completed on all events.
2. LPN performed skin assessments on the remaining of residents residing on the same unit on 11/11/14 and no other residents were identified to be affected. Rounds completed by Maintenance Director and Environmental Services Director on 11/11/14, no other unit affected.
3. All licensed nursing staff will be re-educated to NSG-113 Policy on nursing documentation initiated on 12/12/14 to be completed by 12/19/14 by Administrator, Director of Nursing and Nurse Practice Educator. Post-test will be given to determine competency. Social Services Director was reeducated on documenting interim room moves on 11/20/14 with a post test for competency. No additional room moves needed.
4. Audits to be completed by Administrator, Director of Nursing Nurse Practice Educator, Licensed Nurse, Resident Services Director and/or Social Services Director to ensure documentation policy is followed as evidenced by subsequent and/or routine care and procedures to be completed by exception or the use of checklist, flow charts and/or other

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

TITLE

(X6) DATE

Jane Curran, Administrator

12/16/14

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

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F 514	Continued From page 1 communication by documenting concisely, clearly, pertinently, and accurately. Continued review revealed narrative charting was to be used for initial and subsequent treatments or procedures. Further review revealed nursing documentation was to be consistent with facility policy and federal and state regulations. In addition, the purpose of the policy was to ensure communication regarding a resident's status and to provide an accurate accounting of care and monitoring provided to the resident. Review of the medical record revealed Resident #1 was admitted by the facility on 10/28/14 with diagnoses which included Dementia, Anxiety, Chronic Obstructive Pulmonary Disease, and Chronic Kidney Disease. Further review of the resident's record, including the Nurses Notes, revealed no documentation regarding the exposure, physician notification, family notification or the completion of a skin assessment on 11/11/14, when an insect was observed in Resident # 1's bed by staff. Interview with Licensed Practical Nurse (LPN) #1, on 11/20/14 at 2:05 PM, revealed she was caring for Resident #1 on 11/11/14, and found an insect in the resident's bed. She stated a skin assessment was performed on Resident #1 and Resident #2 (the roommate), and both residents were showered, re-dressed and transferred to another room while their room was inspected, treated and cleaned for insects. LPN #1 further stated she notified the facility Social Worker, the Unit Manager, and the residents' Physician. In addition, LPN #1 performed skin assessments on the remaining residents residing on the same unit. Further interview revealed LPN #1 could not say why she did not document the incident and	F 514	documentation tools on all further events not entered into Risk Management System daily for two weeks, three times a week for two weeks, weekly for four weeks, then monthly for six months. Any concerns will be addressed immediately and a summary of findings will be submitted monthly to the performance improvement committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor.	12/23/14
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F 514	<p>Continued From page 2</p> <p>her responsive actions. She stated she knew if an action was not documented, it was considered not done.</p> <p>Interview with the Unit Manager for the hall where Residents #1 and #2 resided, on 11/20/14 at 3:10 PM, revealed she first became aware of the insect exposure on the morning of 11/11/14 during the facility's daily Clinical Management meeting. She acknowledged there was no documentation on the medical record for either resident related to the incident. She stated she did not know why there was no documentation, but the room change, notifications and the incident itself should have been documented.</p> <p>Interview with the Resident Services Director, on 11/20/14 at 3:20 PM, revealed she notified the families of Residents #1 and #2 related to the possible insect exposure, but did not document the phone calls. She stated she was in the process of receiving training on the facility's new computer system and did not know how to document. She further stated she did not know she should have documented the phone calls.</p> <p>Interview with the Director of Nursing, on 11/20/14 at 5:25 PM, revealed she was was not working the week of the insect exposure, but would expect to see the incident and subsequent actions documented. She stated the documentation could have been completed on paper instead of on the computer.</p> <p>Interview with the Administrator, on 11/20/14 at 6:05 PM, revealed since the facility "did not find anything", and the residents were not out of their room overnight, documentation was not necessary.</p>	F 514		
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