

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

PRINTED: 11/02/2015
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 11/02/2015
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 on 10/31/15 as alleged.	{F 000}		

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

TITLE

(X8) DATE

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

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F 000	INITIAL COMMENTS	F 000		
F 252 SS=E	<p>A Recertification Survey was initiated on 09/15/15 and concluded on 09/17/15. Deficient practice was identified with the highest Scope and Severity (S/S) of a "F".</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the "Maintenance Supervisor Job Description", it was determined the facility failed to ensure the residents environment was safe, clean, comfortable, and homelike. Observation of the facility revealed dusty ceiling fans in the common shower rooms on the 100 and 200 hallways. In addition, resident rooms had chipped paint, the resident room air conditioner filters were dusty, the baseboards were loose and coming off the wall on the 400 hall, there was a hole in the ceiling on the 400 hall, and the 200 hall Exit door had rust and erosion.</p> <p>The findings include:</p> <p>Review of the Maintenance Supervisor Job Description, undated, revealed regular daily, weekly and monthly maintenance checks were to</p>	F 252	<p>F252</p> <p>1. Maintenance Director will replace chipped paint and smoothed rough wall edges of hallways, TV room, Hall 1 shower room, Hall 2 shower room, resident rooms 217, 308,310, 403,412 and dining room by 10/16/15. Maintenance Director will clean ceiling exhaust fan in 100 Hall shower room and 200 Hall Shower room, common shower room on hall 4. Maintenance Director tightened lavatory in room 105 and replaced missing tile around lavatory by 10/16/15. Maintenance Director ordered new exit doors for Hall 2 on 10/02/15, will be installed by 10/27/15 by an outside vendor. Maintenance Director replaced broken tile in room 311 by 10/16/15. Black substance on floor in room 311 removed by Housekeeping Supervisor 09/15/15. Maintenance Director replaced bathroom light in 414 on 09/15/15 and air conditioner removed from window 09/18/15. Maintenance Director replaced ceiling tile on Hall 400 on 10/02/15 and baseboards replaced 10/02/15.</p> <p>2. All residents of the facility have the potential to be affected. An Environmental Audit of building completed by Maintenance Director on 9/16/15. All identified concerns and</p>	10/3/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jane Curran TITLE: Administrator (X6) DATE: 10/28/15

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 252 Continued From page 1
be performed, and the facility and grounds should be maintained in compliance with federal and state laws.

Initial tour on 09/15/15 from 10:45 AM to 11:30 AM and the environmental tour on 09/17/15 from 4:15 PM to 5:39 PM revealed the following:

Hallways, television rooms, and dining rooms had chipped paint on the walls and rough wall edges.

100 Hall
The common shower room had peeling paint and a dusty ceiling fan.

Room 105 bathroom had a loose lavatory and missing tile around the lavatory.

200 Hall:
Exit door had rust and erosion on the lower portion of the door. The shower room and room 217 had chipped paint on the walls. Also, the shower room ceiling fan had a build up of dust like particles.

300 Hall:
Chipped paint was observed on the walls in rooms 308, and 310. Also, room 311 had broken floor tile and a black substance on the floor tile.

400 Hall:
Chipped paint was observed on the walls in rooms 403 and 412. Also, the bathroom light in room 414 was not working and the air conditioning unit had a dirty filter. The ceiling fan in the common shower room had a build up of dust like particles. Also, there was a hole in the

F 252 issues including missing or broken tile, chipped paint, rough wall edges, dusty ceiling exhaust fans, lavatory, exit doors, bathroom lights in working order, air conditioner filters free of dust, ceiling free of holes, baseboards in-tact and floor free of black substance were addressed appropriately during audit on 09/16/15 with corrective action initiated upon discovery.

3. All staff will be reeducated regarding work order requests, new employees will be educated during orientation per Administrator, Maintenance Director, Director of Nursing and Assistant Director of Nursing by 10/25/15. Maintenance Director reeducated regarding home like environment by Administrator on 09/15/15. A post-test was given to validate understanding. Staff not available during this timeframe will be provided reeducation including posttest by the Director of Nurses, Assistant Director of Nurses or Maintenance Director upon return to work.

4. Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Admissions Director, Social Services Director, Activities, MDS Nurse, Medical Records or Unit Manager will complete an Environmental Audit(see attachment # 1) of center to determine a safe, clean, comfortable, homelike environment daily times 2 weeks then 3 times per week times 2 weeks then as determined by the

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F 252	<p>Continued From page 2 hallway ceiling and the baseboards were loose and coming off the walls.</p> <p>Interview with the Maintenance Supervisor on 09/15/15 at 11:01 AM, during initial tour, revealed he did not have a process in place to routinely do environmental rounds in resident rooms or the facility to check for concerns. He continued by stating the staff would fill out work orders, put them in a basket at each nurses station and he would check them daily. Further interview on 09/17/15 at 4:30 PM revealed he depended on staff to let him know of repairs needed.</p> <p>Interview on 09/17/15 at 5:35 PM, with Certified Medication Technician (CMT) #1, revealed she would write on the maintenance board and verbally tell the Maintenance Supervisor if repairs were needed.</p> <p>Interview on 09/17/15 at 5:37 PM, with State Registered Nurse Aide (SRNA) #3 revealed if she observed something needing fixed, she would tell the Maintenance Supervisor, and if he was not there, she would fill out a form and leave it at the nurse's station.</p> <p>Interview on 09/17/15 at 5:38 PM, with Registered Nurse (RN) #1 revealed if she noted something needed fixed, she would fill out a work order and leave it at the nurse's station.</p> <p>Interview with the Administrator on 09/17/15 at 6:03 PM revealed the Maintenance Supervisor had a corporate generated electronic logging system in place to prompt the facility for routine inspections such as checking the resident wandering monitoring system to ensure the wander bracelet would engage the door alarm,</p>	F 252	<p>Monthly Quality Improvement Committee. Any concerns will be addressed via a work order with a plan developed for corrective action upon discovery. A summary of findings will be submitted by the Maintenance Director to the Monthly Quality Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Supervisor for further any additional follow up and/or in-servicing needs until the issue is resolved and randomly thereafter.</p> <p>Completion date 10/31/15</p>	
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F 252	Continued From page 3 checking dryer lint traps and cleaning and inspecting the oxygen concentrators. Continued interview with the Administrator revealed, based on the Maintenance Supervisor's Job Description, Maintenance needed to perform daily rounds to monitor for needed repairs and safety issues.	F 252		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322	F 322 1. Licensed Practice Nurse #2 was re-educated 09/17/15 related to enteral tube medication administration policy by the Director of Nursing. Post- test was given to validate understanding. Resident #6 did not experience any negative outcome. 2. All residents of the facility have the potential to be affected including residents who receive medications via Gastrostomy tube (G/T). An observation of all nurses to ensure proper administration of medications and flushing of enteral tubes will be completed per Director of Nursing by 10/25/15 with corrective action upon discovery.	10/31/15

	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to follow the facility policy related to administering medication through a Gastrostomy-tube (G/T) and flushing a G/T for			
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F 322	<p>Continued From page 4</p> <p>one (1) of nine-teen (19) sampled residents. (Resident # 6)</p> <p>Observation revealed staff dissolved medication in ice water, prior to administering the medication, and flushed the GT with ice water before and after the medication administration.</p> <p>The findings include:</p> <p>Review of the facility policy "Medication Administration: Enteral", revised 01/02/14, revealed during the preparation for administration of medication the nurse should crush pills and dissolve in medicine cup with ten (10) to twenty (20) milliliters (ml's) of tap water. Further review, revealed after administration of the medication the nurse should flush with at least fifty (50) ml's of tap water.</p> <p>Review of Resident #6's medical record revealed the facility admitted the resident on 05/28/15 with diagnoses including: Cerebrovascular Accident, Dysphagia, PEG (Percutaneous gastrostomy) (endoscopic-medical procedure in which a tube is passed into a patients stomach through the abdominal wall most commonly to provide a means of feeding) , and Chronic Pain.</p>	F 322	<p>3. All nurses will be re-educated on enteral medication administration policy to ensure proper administration of medication and flushing of enteral tubes by Director of Nursing, Assistant Director of Nursing and/or Unit Managers by 10/25/15. Post- test will be given by Director of Nursing, Assistant Director of Nursing and/or Unit Managers to validate understanding. Staff not available during this time frame will be provided reeducation including post-test upon returning to work and new staff during orientation.</p> <p>4. Director of Nursing, Assistant Director of Nursing and/or Unit Managers will perform clinical competency of medication administration for six residents via gastrostomy tube across all shifts daily x 2 weeks then 3 x per week x 2 weeks then as determined by the Monthly Quality Improvement Committee with corrective action upon discovery. Findings will be reported to the Director of Nurses or Assistant Director of Nurses daily. A summary of findings will be submitted by the Director of</p>	
	<p>Observation on 09/17/15 at 11:45 AM, during medication pass, revealed Licensed Practical Nurse (LPN) #2 dissolved a Oxycodone 7.5 milligrams tablet (medication used to treat severe pain) with ice water and administered the</p>		<p>Nursing or Assistance Director of Nursing to the Monthly Quality Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Supervisor for any additional follow up and/or in-servicing needs until the issue is resolved and randomly thereafter.</p> <p>Completion Date: 10/31/15</p>	

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F 322	<p>Continued From page 5</p> <p>medication mixed with the ice water. She then flushed the G/T with fifty (50) milliliters of ice water before and after the administration of the medication.</p> <p>Interview on 09/17/15 at 5:00 PM, with LPN #2, revealed she was not knowledgeable of the facility policy regarding the administration of medications through a G/T and the flushing of fluid through a G/T. LPN #2 stated " I do not know why I did that, I usually use tap water, I guess I was just nervous, I will remember in the future. "</p> <p>Interview conducted on 09/17/15 at 5:30 PM with the Assistant Director of Nursing (ADON) revealed it was her expectation that all nurses who provide G/T care should follow the facility policy and use tap water - room temperature water, and not ice water or hot water to administer medication and fluid flushes through a G/T.</p> <p>Interview on 09/17/15 at 6:00 PM with the Director of Nursing (DON) revealed it was her expectation for nursing staff to be knowledgeable in reference to the facility policy related to the administration of medication through a G/T tube. The DON stated " All nurses should use tap water when administering medication to a resident as well as during the routine fluid flushes of water through a G/T. "</p>	F 322		
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F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p>	F 323		
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F323	<p>Continued From page 8</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the "Maintenance Supervisor Job Description", it was determined the facility failed to ensure the resident environment remains as free of accident hazards as is possible. Initial tour and environmental tour of the facility revealed missing toilet bolt covers in the common bathrooms and resident room bathrooms, and sharp, splintered door edges in resident rooms.</p> <p>The findings include: Review of the "Maintenance Supervisor Job Description", undated, revealed duties included ensuring the safety of residents environment to minimize the potential for accidents and injury.</p>	F323	<p>F323</p> <p>1. Maintenance Director replaced all missing bolt covers on base of toilets in 200 hall common bathroom and bathrooms on 09/22/15 for rooms 217,301,308,310,311,401,403,408,412,414 and 415. Maintenance Director applied door coverings to ensure no sharp splintered door edges in resident rooms 102,111,403,404,405,406,407,408,409,410 and 412. Maintenance Director was reeducated on 09/17/15 by Administrator regarding need to ensure that the resident environment remains as free of accident hazards including toilet bases are secured and door covering are intact as possible. A post-test was given to validate understanding.</p> <p>2. All residents of the facility have the potential to be affected. On 09/18/15 facility rounds completed by the Administrator and Director of Nursing on 09/18/15 to ensure door coverings were intact and toilet bases were secured with protective covering. Concerns identified were addressed upon discovery.</p> <p>3. Staff will be reeducated per Administrator, Director of Nursing and Assistant Director of Nursing by 10/25/15 regarding need to ensure that the resident environment remains as free of accident hazards as possible included toilet bases are secured and door facings are intact. A post-test will be given to validate understanding. Staff not available during this time frame will be provided reeducation including post-test upon</p>	10/31/15
	<p>Observation on initial tour, on 09/15/15, from 10:45 AM to 11:30 AM, and environmental tour, on 09/17/15, from 4:15 PM to 5:39 PM, revealed missing toilet bolt covers, leaving sharp uncovered screws in the base of the toilets in the 200 hall common bathroom, and resident room bathrooms for rooms 217, 301, 308, 310, 311, 401, 403, 408, 412, 414 and 415. In addition, observation revealed sharp, splintered door edges in resident rooms 102, 111, 403, 404, 405, 406, 407, 408, 409, 410 and 412.</p>			

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F 323	<p>Continued From page 7</p> <p>Interview with the Maintenance Supervisor, on 09/15/15 at 11:01 AM, during initial tour, revealed he did not have a process in place to routinely do environmental rounds in resident rooms or other rooms in the facility to check for environmental safety concerns. Further interview on 09/17/15 at 4:30 PM and 6:00 PM, revealed he depended on staff to let him know if there was environmental concerns or repairs needed and he was unaware the toilet bolts needed to be covered. He revealed, if a resident fell on the uncovered toilet bolts, it could cause injuries and he would take care of it "right away". He also revealed he was unaware of the sharp splintered door edges.</p> <p>Interview with the Administrator, on 09/17/15 at 6:03 PM, revealed there was a corporate generated electronic logging system in place to prompt the facility and the Maintenance Supervisor for routine inspections such as checking the resident wandering monitoring system to ensure the wander bracelet would engage the door alarm, checking dryer lint traps and cleaning and inspecting the oxygen concentrators. However, she stated the Maintenance Supervisor also needed to perform daily rounds to monitor for any needed environmental repairs and safety issues.</p>	F 323	<p>returning to work and new staff will be educated during orientation.</p> <p>4. Audits to be completed by Administrator, Director of Nursing, Assistant Director of Nursing, Admissions Director, Social Services Director, Activities, MDS Nurse, Medical Records and/or Unit Manager to ensure environment remains as free of accident hazards including door facings intact and toilet bases secured daily across all shifts times 2 weeks then 3 times per week times 2 weeks then as determined by the Monthly Quality Improvement Committee with corrective action upon discovery. Findings will be reviewed with the Administrator daily. A summary of findings will be submitted to the Monthly Quality Improvement Committee by the Administrator/or Maintenance Director consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Supervisor for any additional follow up and/or in-servicing needs until the issue is resolved and randomly thereafter.</p>	
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F 371 SS=F	<p>Continued interview revealed it would be a hazard to have uncovered toilet bolts and doors with sharp splintered edges.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local</p>	F 371	Completion Date: 10/31/15	
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F 371	<p>Continued From page 8 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed to prepare and distribute food under sanitary conditions. Observation of the kitchen revealed there was an accumulation of dust like particles on the pipe above the food preparation area and the exposed back of the range. Further observation of the kitchen revealed there was peeled paint inside the exhaust hood and the fire extinguishers which were located over the food preparation area of the range had an accumulation of dust like particles.</p> <p>The findings include:</p> <p>Review of facility policy, titled "Food and Nutrition Services Policies and Procedures: Cleaning Standards" dated 04/14/14, revealed the purpose of the policy was to ensure all food service equipment and areas were clean and sanitary.</p> <p>Review of the facility Food and Nutrition Services Master Cleaning Schedule, dated 04/14/14, revealed the scheduled cleaning for the ceiling was semi-annually, the scheduled cleaning for the exhaust hood and filters was weekly and quarterly and the scheduled cleaning of the range</p>	F 371	<p>F371</p> <ol style="list-style-type: none"> Maintenance Director cleaned and removed dust like particles from pipe located near ceiling above food prep area and on fire extinguisher under exhaust hood as well as exposed back of range on 09/18/15. Maintenance Director will remove peeling paint and repaint inside area of exhaust hood by 10/25/15. Maintenance Director reeducated by Administrator on 09/18/15 on Food and Nutrition Services Policies and Procedures: Cleaning Standards to ensure all food service equipment foods clean and sanitary. Post-test was given to validate understanding. All residents of the facility have the potential to be affected. On 09/22/15 an audit completed per Administrator, Maintenance Director and Housekeeping Supervisor on 09/22/15 to ensure kitchen is free from dust like particles and peeling paint in food prep area. No further areas of concern identified. The Maintenance Director, Housekeeping Supervisor and Dietary Supervisor and dietary staff will be re-educated by 10/25/15 by Administrator, on Food and Nutrition Services Policies and Procedures: Cleaning Standards to ensure all food service equipment and areas are clean and sanitary and Policy 4.7 Food Handling to ensure foods are stored, prepared and served in a safe and sanitary environment to prevent cross contamination including following the 	10/3/15
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2015
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 09/17/2015
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 371	Continued From page 9 was weekly. Observation on 09/16/15 at 9:20 AM, during the kitchen revisit revealed an accumulation of dust like particles on the pipe, located near the ceiling above the food preparation area; and under the exhaust hood the fire extinguishers had a dust like appearance of particles which formed a web above the range. Further observation revealed the inside of the exhaust hood had peeled paint over the food preparation area of the range and the exposed back of the range had an accumulation of dust like particles and dried residue. Interview on 09/17/15 at 10:25 AM, with Dietary Aide #1 revealed there was a schedule posted for monthly, weekly and daily cleaning in the kitchen. The Dietary Manager was to check to see if staff had completed the cleaning. Interview on 09/17/15 at 10:35 AM, with Cook #1 revealed there was a schedule for cleaning daily, weekly and monthly posted and the Dietary Manager was responsible for cleaning the exhaust hood. Interview on 09/17/15 at 10:45 AM, with the Dietary Manager revealed the cleaning schedule was posted for daily, weekly and monthly assignments. She revealed she cleaned the exhaust hood weekly and as needed. Further interview revealed a contracted company cleaned the exhaust hood on a quarterly basis. She stated the area behind the range needed to be dusted and scraped clean of the dried food particles. She further stated Maintenance was responsible for cleaning the ceiling and for repairs. The Dietary Manager revealed the	F 371	posted cleaning schedule. Post-test will be given to validate understanding. 4. Audits by Administrator, Registered Dietician, Cooks and/or Dietary Supervisor to ensure kitchen is free from dust like particles and peeling paint in food prep area will be conducted daily for 2 weeks then 3 times per week times 2 week, then as determined by the monthly Quality Improvement Committee with corrective action upon discovery. A summary of findings will be submitted by Dietary Supervisor to the Monthly Quality Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Supervisor any additional follow up and/or inservicing needs until the issue is resolved and randomly thereafter. Completion Date: 10/31/15		

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

PRINTED: 10/12/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 10/27/2015
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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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(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
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{K 000} INITIAL COMMENTS

{K 000}

Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/27/15 as alleged.

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.

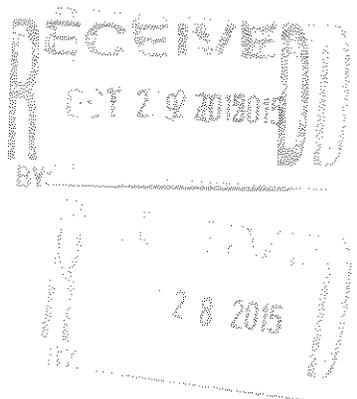
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2015
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 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 09/15/2015
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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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 007/14/76</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Wet SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel Generator.</p> <p>A life safety code survey was initiated and concluded on 09/15/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility was licensed for one hundred (100) beds and the census was ninety-five (95) the day of the survey.</p> <p>Deficiencies were cited with the highest</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jane Curran</i>	TITLE <i>Administrator</i>	(X8) DATE <i>10/31/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 10/01/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2015
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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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K 000 K 062 SS=F	<p>Continued From page 1 deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure automatic sprinkler systems were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, one hundred (100) residents, staff and visitors.</p> <p>The findings included:</p> <p>Record review of the automatic sprinkler inspection records on 09/15/15 at 3:45 PM, with the Maintenance Director, revealed the last internal pipe inspection was performed on 08/05/2010. Interview, with the Maintenance Director, revealed he was unsure why the internal pipe inspection for the automatic sprinkler system was not performed as required.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>NFPA 25 (1998 Edition) 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed</p>	K 000 K 062	<p>Bradford Square provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.</p> <p><u>K062</u></p> <ol style="list-style-type: none"> 1. A sprinkler company performed internal condition of sprinkler piping on 09/17/15 that resulted in satisfactory condition. 2. All residents of the facility have the potential to be affected. Maintenance Director completed audit of sprinkler piping 09/17/15 and no further areas of concern were identified. 3. Maintenance Director was reeducated on 09/15/15 by Administrator to meet NFPA25 (1998 Edition) 10-2.2 standards. A post-test was given to validate understanding. 4. Administrator entered internal pipe inspection into the TELS system in order to track next due date on 10/06/2020. The Maintenance Director will submit a summary of the findings to the monthly <u>Monthly Quality Improvement Committee</u> consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Supervisor monthly for any additional follow up and/or in-servicing needs until the issue is resolved and randomly thereafter. <p>Completion Date 10/31/15</p>	10/31/15
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2015
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2015
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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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(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
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K 062	Continued From page 2 piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.	K 062		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical systems were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, one hundred (100) residents, staff and visitors. The findings include:	K 147	K147 1. Maintenance Director labeled emergency #2 electrical panel breakers on 10/09/15. 2. All residents of the facility have the potential to be affected. On 09/15/15 an audit of center was completed by Maintenance Director with corrective action completed on 10/09/15. Maintenance Director determined proper requirements were met regarding maintaining proper labeling of electrical panels in accordance to NFPA 70 standards. 3. Maintenance Director was reeducated on life safety code standards regarding NFPA-70 9.1.2 standards on 09/15/15 per the Regional Property Manager. A post-test was given to validate understanding. 4. Maintenance Director will monitor electrical panels monthly during preventive maintenance rounds with corrective action upon discovery to ensure determine proper labeling to meet NFPA 70 9.1.2 standards is in place. A summary of findings will be submitted by the	10/31/15

	Observation on 09/15/15 at 2:48 PM, with the Maintenance Director, revealed the Emergency # 2 Electrical Panel breakers were not labeled properly. Interview, with the Maintenance Director, revealed he was unaware the Emergency #2 Electrical Panel breakers were not labeled properly. Refer 110-22. Identification of Disconnecting			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2015
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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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K 147	<p>Continued From page 3</p> <p>Means. Each disconnecting means required by this Code for motors and appliances, and each service, feeder, or branch circuit at the point where it originates, shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved. Where circuit breakers or fuses are applied in compliance with the series combination ratings marked on the equipment by the manufacturer, the equipment enclosure(s) shall be legibly marked in the field to indicate the equipment has been applied with a series combination rating. The marking shall be readily visible and state the following: CAUTION - SERIES COMBINATION SYSTEM RATED _____ AMPERES. IDENTIFIED. REPLACEMENT COMPONENTS REQUIRED. FPN: See Section 240-83(c) for interrupting rating marking for end-use equipment. ence: NFPA 70 (1998 Edition)</p>	K 147	<p>maintenance director to the Monthly Quality Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Supervisor monthly for any additional follow up and/or in-servicing needs until the issue is resolved and randomly thereafter. Completion 10/31/15</p>	
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