

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

PRINTED: 04/28/2011  
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  C 04/14/2011
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NAME OF PROVIDER OR SUPPLIER  BRADFORD SQUARE CARE AND REHABILITATION CENTER	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)	(X6) COMPLETION DATE
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F 000  F 282 SS=G	<p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated Survey investigation ARO#KY00016269 and ARO#KY00016270 was initiated on 04/12/11 and concluded on 04/14/11. ARO#KY00016269 and ARO#KY00016270 were substantiated with deficiencies cited.</p> <p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and Emergency Room report, it was determined the facility failed to follow the plan of care for one (1) of four (4) sampled residents (Resident #1). The facility who assessed Resident #1 as at risk for falls failed to ensure the care plan intervention for removal of the lift pad after transfer was implemented. On 04/02/11 at approximately 8:30 AM, Resident #1 fell out of the wheelchair and sustained a right elbow and clavicle fracture after Certified Nursing Assistant (CNA) #6 failed to remove the lift pad after she transferred Resident #1 to the chair.</p> <p>The findings include:  Review of the clinical record for Resident #1 revealed the facility admitted the resident on 07/05/05 with diagnoses which included a Cerebrovascular Accident (CVA) with Right Hemiparesis and Severe Expressive Aphasia and Seizer Disorder. Review of the annual Minimum</p>	F 000  F 282	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bradford Square Care &amp; Rehabilitation Center 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."</p>	5/7/2011
	<p>RECEIVED MAY 09 2011</p> <p>F282</p> <p>1. Resident #1 's care plan was reviewed and updated to reflect the current needs of the resident on 4/5/2011 by the interdisciplinary team which includes the Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, Social Services Director and Administrator. CNA #6 is no longer employed at the facility.</p> <p>2. Current residents were reviewed by the interdisciplinary team which includes the Director of Nursing Services, Assistant Director of</p>			

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Kathy Jones NHA	TITLE  Administrator	(X8) DATE  5/5/2011
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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.

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F 282	<p>Continued From page 1</p> <p>Data Set (MDS), dated 12/15/10, revealed the facility assessed Resident #1 as a falls risk due to an unsteady gait, diagnosis of seizure activity, and a CVA with right Hemiparesis. The resident's cognitive score on the MDS, revealed a score of 15 out of a possible 15 indicating Resident #1 exhibited no cognitive impairment.</p> <p>Review of the comprehensive care plan revealed the facility had care planned the resident for risk for falls related to unsteady gait, Seizures, and medications that was initiated on 01/28/10. Further review revealed Resident #1 sustained a fall on 03/23/11 with no evidence of added interventions. Continued review revealed Resident #1 sustained a fall on 03/27/11. At that time the interventions to remove the lift pad while in the wheelchair and Dysem to the wheelchair were added to the care plan. Review of the MDS Kardex Report, which functioned as the nurse aide care plan, revealed an order for Dycem to wheel chair and an intervention to remove the lift pad after the resident is tranfered to the wheelchair. Interview with the Director of Nursing (DON), on 04/14/11 at 11:00 AM, revealed after Resident #1's fall on 03/27/11, they had a Performance Improvemnet (PI) meeting and determined the lift pad should be removed and Dycem added to wheelchair seat.</p> <p>Review of the Event Investigation Record, dated 04/02/11 at 8:30 AM, revealed Resident #1 was found by CNA #8, lying on the floor shortly after he/she was transfered to the wheelchair, bleeding noted from the right elbow, swelling to the right elbow, complaining of right arm pain. Further review revealed Resident #1 was transfered to the Emergency Room (ER). The report noted the ER had diagnosed a right arm fracture. The</p>	F 282	<p>Nursing Services, Unit Managers, Social Services Director and Administrator on or before 5/6/2011. Care plans were updated to reflect current needs of the residents on or before 5/6/11.</p> <p>3. The nursing staff was re-educated on the falls management program and following the care plan on or before 4/15/2011 by the Director of Nursing Services and/or Assistant Director of Nursing. As part of new employee orientation a review of the CNA care cards, care plan interventions and falls management program will be completed by the Director of Nursing and/or the Assistant Director of Nursing.</p> <p>4. The Director of Nursing Services, Assistant Director of Nursing Services or Administrator will review 5 residents per week for 4 weeks then monthly for 2 months to determine care plan reflects current resident status and that interventions are being followed. The Director of Nursing Services will report findings to Performance Improvement Committee meetings for three (3) months for review and recommendations.</p> <p>5. Completion date is 5/7/2011.</p>

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F 282	<p>Continued From page 2</p> <p>record also noted the CNA did not follow the care plan.</p> <p>Interview with CNA #6, conducted by phone on 04/14/11 at 2:30 PM, revealed she cared for Resident #1 the morning the incident occurred. She stated she knew Resident #1 had a new order for the lift pad to be removed, but for some reason she forgot all about removing the lift pad. Interview further revealed after the resident fell, the lift pad was still in the wheelchair. Interview with Registered Nurse (RN) #1 conducted on 04/13/11 at 2:30 PM, revealed she was on the floor passing medications the day Resident #1 fell. She stated she responded to the incident to assess Resident #1 and observed the resident lying on the floor in front of the wheelchair and the lift pad was still in the wheelchair. Interview with the DON on 04/14/11 at 10:00 AM, revealed she initiated an investigation after she was notified of the fall. Interview further revealed as part of the investigation, she interviewed CNA #6 who reported she knew the lift pad was to be removed after the transfer, but she did not remove it.</p> <p>Review of the Emergency Room report, revealed Resident #1 was sent to the Emergency Room after falling out of the wheelchair. The Emergency Room discharged Resident #1 with the diagnoses of an acute fracture of the right clavicle and an acute fracture of the right elbow.</p> <p>Observation, on 04/12/11 at 11:10 AM and at 1:50 PM, revealed Resident #1 had a sling to the right arm and a large bruise to the resident's left hand. Interview with Resident #1 conducted on 04/13/11 at 2:00 PM, confirmed on 04/02/11 CNA #6 did not remove the lift pad after the transferring him/her to the wheelchair.</p>	F 282		

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F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</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 record review, policy review, and emergency room report, it was determined the facility failed to ensure the residents' environment remains as free from accident hazards as possible and provide adequate supervision for one (1) of four (4) sampled residents (Resident #1). The facility assessed Resident #1 as at risk for falls in 2010; however, failed to ensure revised falls interventions were implemented for Resident #1 in an effort to prevent accidents. Resident #1 fell from the wheelchair on 04/02/11 sustaining a right elbow and clavicle (collar bone) fracture. The findings include: 1. Review of the facility's Fall Management Program, dated 01/08, revealed "Fall Prevention: Risk of falling can be minimized by using assessment, planning, implementing, and evaluation process ... and the interdisciplinary team reviews the incident to ensure appropriate treatment, interventions, and root cause analysis have been done ...".</p> <p>Review of the clinical record for Resident #1, revealed the facility admitted the resident on 07/05/05 with diagnoses which included a</p>	F 323	<p>F323,</p> <p>1. Resident #1 was reassessed for falls risk by the Director of Nursing Services on 4/4/2011. The falls care plan was reviewed and updated to reflect the current needs of the resident on 4/5/2011 by the interdisciplinary team which includes the Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, Social Services Director and Administrator. CNA #6 is no longer employed at the facility.</p> <p>2. Current residents at risk for falls were reviewed by the interdisciplinary team which includes the Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, Social Services Director and Administrator on or before 5/6/2011. Interventions were implemented to reflect current needs of the residents on or before 5/6/2011.</p> <p>3. The nursing staff were re-educated on the falls management program on or before 4/15/2011 by the Director of</p>	5/7/2011

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F 323	<p>Continued From page 4</p> <p>Cerebrovascular Accident (CVA) with Right Hemiparesis and Severe Expressive Aphasia, Seizer Disorder, and Hypertension.</p> <p>Review of the annual Minimum Data Set (MDS) dated 12/15/10, revealed the facility assessed Resident #1 as a risk for falls due to an unsteady gait, diagnosis of seizure activity, and a CVA with right Hemiparesis. The assessment further revealed Resident #1 exhibited no cognitive impairment. Review of the comprehensive care plan for falls initiated on 01/28/10 revealed interventions which included: ensure environment is free of clutter, have commonly used articles within easy reach, report changes in ability to transfer and ambulate in room, observe and report signs and symptoms of acute illness, and medication as ordered for seizure disorder.</p> <p>Review of the nurses Progress Notes revealed Resident #1 fell from the wheelchair on 03/23/11. Review of the falls care plan revealed the facility made no revision to the interventions after the fall on 03/23/11. Review of the nurses Progress Notes on 03/27/11 revealed Resident #1 fell from the wheelchair and sustained an injury to the right eye which was detailed as severely bruised with moderate swelling. The note detailed staff educated the resident on not leaning forward while in the wheelchair and calling for assistance. Review of the comprehensive care plan revealed the facility added, after the fall on 03/27/11, remove the lift pad after transfer and add Dycem under the resident while in the wheelchair.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/12/11 at 3:25 PM, revealed she worked on 03/27/11 when Resident #1 fell. She stated new interventions were added to the care plan for</p>	F 323	<p>Nursing Services and/or Assistant Director of Nursing. As part of new employee orientation a review of the CNA care cards, care plan interventions and falls management program will be completed by the Director of Nursing and/or the Assistant Director of Nursing.</p> <p>4. The Director of Nursing Services, Assistant Director of Nursing Services or Administrator will review 5 residents per week for 4 weeks then monthly for 2 months to determine care plan reflects current resident status and that interventions are being followed related to falls. The Director of Nursing Services will report findings to Performance Improvement Committee meetings for three (3) months for review and recommendations.</p> <p>5. Completion date is 5/7/2011.</p>	
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F 323	<p>Continued From page 5</p> <p>Dycem to be placed in the seat of the wheelchair and for the lift pad to be removed. It was found after investigating the fall the resident was sliding out of the wheel chair because the lift pad was slick.</p> <p>Review of the MDS Kardex Report, which functioned as the nurse aide care plan, revealed the order for Dycem to the wheel chair and the lift pad to be removed was added to the care plan 03/27/11. LPN #1 stated on 03/29/11 CNA #6 had asked her for assistance with transferring Resident #1 and had to remind CNA #6 of the order to place the Dycem in the wheel chair and removal of the lift pad had been added to care plan.</p> <p>Interview with the Director of Nursing (DON), on 04/14/11 at 10:00 AM and at 11:00 AM, revealed after Resident #1's fall on 03/27/11, they had a Performance Improvement (PI) meeting and determined the lift pad should be removed and Dycem added to wheelchair seat.</p> <p>Review of the nurses Progress Notes revealed Resident #1 fell from the wheelchair on 04/02/11. Review of the Event Investigation Record dated 04/02/11 at 8:30 AM, revealed Resident #1 was found on floor at 8:30 AM, lift pad left under resident after transfer. Bleeding noted from right elbow, swelling noted to right elbow, and resident complaining of right arm pain. CNA responsible suspended pending investigation. Resident admitted to hospital with right arm fracture. Investigation/Causative Factors: Lift pad left in wheel chair after transfer.</p> <p>Interview with CNA #1, on 04/13/11 at 11:15 AM, revealed she was working the day that Resident</p>	F 323		
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F 323	<p>Continued From page 6</p> <p>#1 fell and she helped with the transfer of Resident #1 to the wheelchair. CNA #1 revealed that Dycem was in the seat of the wheel chair and after the transfer, the lift pad remained under the resident on top of the Dycem in the wheelchair.</p> <p>Interview with CNA #6, on 04/14/11 at 2:30 PM, revealed she was assigned to Resident #1's hall on 04/02/11 when the fall occurred. CNA #6 further stated the Dycem was placed in the seat of the wheel chair and the lift pad remained under the resident on top of the Dycem. She stated she was aware Resident #1 had a new order for the lift pad to be removed, but for some reason forgot all about removing the lift pad. She confirmed after Resident #1 fell the lift pad was still in the wheel chair. Interview revealed that she found the resident on the floor while she was passing the breakfast trays. She called for the nurse, who assessed the resident and told her to call 911 because his/her arm was swollen.</p> <p>Interview with Registered Nurse (RN) #1, on 04/13/11 at 2:30 PM, revealed she was on the floor passing medications the day Resident #1 fell. RN #1 stated CNA #6 called for assistance. She saw Resident #1 lying on the floor in front of the wheel chair and the lift pad was still in the wheel chair. She further stated Resident #1 would lean forward and with the pad it was easy to slide. Further interview revealed she assessed Resident #1 and told CNA #6 to call 911 because his/her arm was already swelling and the resident said that he/she was in a lot of pain.</p> <p>Review of the Emergency Room report, dated 04/02/11, revealed Resident #1 was diagnosed and treated for an acute fracture of the right elbow and clavicle.</p>	F 323			

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F 323	Continued From page 7  Observation, on 04/12/11 at 11:10 AM, revealed Resident #1 was in bed with a sling to the right arm. The Resident's left hand had a large bruise. Observation, on 04/12/11 at 1:50 PM, revealed Resident #1 was in a wheel chair, with a sling on the right arm at elbow. Interview with Resident #1 conducted on 04/13/11 at 2:00 PM, revealed he/she remembered falling on 04/02/11 and confirmed CNA #6 did not remove the lift pad after the transfer to the wheelchair.	F 323			