

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

PRINTED: 02/11/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2011
NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240	
(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 annual survey was conducted , on 01/25/11 through 01/28/11, to determine the facility's compliance with Federal requirements. The facility is not in compliance with Federal requirements with deficiencies cited at the highest S&S of an "F". Abbreviated surveys, KY #14986, KY #15520, and KY #15868, were conducted in conjunction with the annual survey. KY #14986 was substantiated with deficiencies cited. KY #15520 was substantiated with no deficiencies cited. KY #15868 was unsubstantiated with no deficiencies cited.	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to implèment their policy and procedure related to reporting of injuries of unknown origin for two residents, (#2 & #13), in the selected sample of 18. Residents #2 and #13 were observed with bruising to the forearms, on 01/25/11. The facility failed to initiate an investigation immediately to determine the cause of the bruising. Findings include: A review of the facility's Incident/Accident policy, dated 01/07, revealed, "Incidents or accidents occurring, or any injury of unknown origin, must be reported to administration" and "Incidents,	F 226	<u>F226</u> <u>483.13(c) Develop/Implement Abuse/Neglect, etc Policies</u> It is the practice of Bradford Heights Health and Rehab to implement policy and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property and to immediately investigate injuries of unknown origin. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident #2 was assessed by licensed staff and an updated skin assessment was completed on 01-28-11. An incident report and investigation was initiated by the nurse on 01-28-11. The incident was called into the appropriate agencies on 01-28-11 by the Administrator. Upon conclusion of the investigations, there was no indication that the bruises on either resident was the result of abuse. Resident #2 is on aspirin therapy and moves about in her bed and sometimes bumps her arms and hands. Padding was placed on her bed's grab bars. Her plan of care and nurse aide data sheet were updated to reflect the new intervention. Resident #13 did have lab work done on 1/20/11 and the resident stated that the bruising was from that. The investigation revealed no other causative factors. No change in care was indicated based on findings.	3-14-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Selina Beck NHA TITLE: _____ (X6) DATE: 03-04-2011

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 226	<p>Continued From page 1</p> <p>accidents, or injury of unknown origin will be investigated and appropriate interventions taken as needed".</p> <p>1. Resident #2 was admitted to the facility with diagnoses to include Congestive Heart Failure, Aftercare Joint Replacement and Muscle weakness. A Mlnimum Data Set (MDS) assessment, dated 12/21/10, revealed the the facility identified Resident #2 as cognitively impaired, requiring extensive assistance with all care.</p> <p>Observations, on 01/25/11 at approximately 12:00 PM and on 01/27/11 at 12:45 PM, revealed Resident #2 was dressed a short sleeved blouse and had numerous scattered circular and irregular shaped purple and blue discolorations on His/Her bilateral forearms, including the elbow area. Due to the Resident's cognitive impairment, He/She was unable to communicate the cause(s) of the bruising.</p> <p>A review of Resident #2's chart revealed no documentation in the Nurse's Notes regarding the scattered purple discolorations on the resident's bilateral arms. A Weekly Skin Assessment, dated 01/27/11, did not reveal any noted discolored areas on the the resident's arms.</p> <p>2. Resident #13 was admitted to the facility with diagnoses to include Chronic Airway Obstruction, Alzheimer Disease, Anemia and Expressive Disorder. A MDS assessment dated, 01/12/11, revealed the facility identified the resident as cognitively impaired and requiring extensive assistance with all activities of daily living.</p> <p>Observations, on 01/25/11 at approximately 9:45</p>	F 226	<p>Continued From Page 1</p> <p>Resident #13 was assessed by licensed nurse on 02-02-11 and an updated skin assessment completed. A report and investigation was initiated on 01-27-11 by the nurse and DON. <u>How other residents who may have been affected by this practice were identified:</u></p> <p>100% Skin audits were completed on residents in the facility on 2-14-11 No negative findings were identified.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Re-education was initiated on 2/02/11 by the DON, ADON and Unit managers on reporting of all injuries of unknown origin with emphasis being placed on bruising of the skin to all employees. This education will continue thru 03-11-11 the DON will be responsible to arrange or provide in-servicing for any staff who have not completed the re-education prior to the 03-11-11 before the next shift worked. Education included the requirement to immediately initiate an investigation as to the cause of injuries of unknown origin.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>In addition to the scheduled weekly skin audits, unit managers will conduct random skin assessments on 3 residents (approximately 10%) on each hall weekly X 8 weeks and then every 2 weeks X 6 weeks then monthly X 6 months. Results will be reported to the DON or in her absence the ADON, as well as the facility's QA committee. If concerns are identified re-training/discipline will result. The committee will review findings and if no concerns are identified the frequency or number of the audits may be reduced. Conversely if concerns are identified the number and or frequency of audits will increase.</p>	

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F 226	Continued From page 2 AM, revealed the resident sitting in a wheel chair with his/her head lowered, eyes closed and elbows resting on the wheel chair armrests. The resident was observed to have dark purple discolored areas that extended the entire wrist areas of both wrists. Resident #13 did not respond verbally. Observation, on 01/26/11 at 1:05 PM and on 01/28/11 at 4:40 PM, revealed the purple discolorations to the bilateral wrist areas. A review of the Nurse's Note, dated 01/27/11 at 4:12 AM, revealed the purple discolorations located on the resident's wrists might have resulted from laboratory testing. However, the most recent laboratory tests were obtained, on 01/20/11. A Skin Assessment, dated 01/21/11, did not reveal any purple discolorations to the resident's wrists. Interviews with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Regional Consultant, on 01/28/11 at 7:15 PM, revealed bruising of unknown origin was to be reported to the nurse, documented in the resident record and an incident form filled out by the nurse as soon as it was reported.	F 226		
F 244	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	F 244	F244 <u>483.15(c)(6) Listen/Act On Group Grievance/Recommendation</u> It is the routine practice of Bradford Heights Health and Rehab to address and resolve issues and concerns communicated by residents. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident's #28, 23, 26, 29, 22, 30, 31, 32, 33 were interviewed by Social Service Director on 02-15-11	03-14-11

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F 244	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, it was determined the facility failed to implement established grievance policy and procedure to effectively address and resolve issues and concerns communicated by residents during Resident Council Meetings. Findings include:</p> <p>A review of the Residents Rights Agreement, provided to all residents on admission, revealed the resident will be encouraged and assisted throughout their stay to exercise their rights and to voice grievances.</p> <p>A review Resident Council minutes, dated 11/29/10, revealed numerous residents had expressed their concerns that call lights were not being answered timely. During a Group Meeting conducted, on 01/25/11 at 3:30 PM, residents expressed their concern that the issue of slow call light response had not been addressed and had continued, resulting in incidents of waiting for assistance for up to an hour at times.</p> <p>Interviews conducted during the Group Meeting, on 01/25/11 at 3:30 PM, with Residents #26, #28, #29, #30, #31, #32 and #33, revealed continued complaints that call lights were not being answered timely. Resident #28 stated the delays in response to the call light and assistance to the bathroom had resulted in an incontinent episode. Resident #32 stated he/she could not wait long periods of time assistance, due to skin soreness.</p> <p>Interviews with Resident #27 and #23, on 01/25/11 at 9:30 AM and on 01/27/11 at 9:00 AM, revealed he/she had waited as long as an hour</p>	F 244	<p>specifics of concerns, any patterns, times or frequency. Staff were re-educated to promptly answer call lights of these and other residents. <u>How other residents who may have been affected by this practice were identified:</u></p> <p>Residents in the facility who utilize the call light system have the potential to be affected by the practice. Staff were re-educated and promptly answer call lights. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Residents determined to be inter-viewable according to the MDS will be interviewed by the Social Service Director to verify that their issues and concerns are being addressed.</p> <p>All employees will be re-educated on answering call lights by the ADON/QA Nurse. The DON will be responsible to provide or arrange for education to any employees who have not attended the in-service by 03-11-11 prior to their next shift worked.</p> <p>An additional resident council meeting will be held on on 02-24-11 by the activity director and the administrator. Specific discussion of call lights being answered timely will be held.</p> <p>The activity director was re-educated by the administrator on the grievance policy and procedure with emphasis being placed on follow up and resolution of residents concerns on 02-15-11.</p> <p>The Activity Director will log concerns voiced during the resident council meeting on the concern/grievance log. A copy of concerns will be given to the social service director and</p>	

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F 244	Continued From page 4 for staff to answer their call lights. The waiting for assistance and response to the call had made them feel as if no one cared about them. An observation, on 01/27/11 at 12:45 PM, revealed Resident #22 pushed his/her call light to request repositioning assistance. Certified Nurse Aide (CNA) #3 entered the resident's room, switched the call light off and told the resident she would be back with another staff member to help with repositioning the resident. The CNA proceeded to assist with bathing another resident and did not return to assist Resident #22. Resident #22's call light was pushed again, at 1:03 PM. CNA #4 entered the room at 1:10 PM and assisted Resident #22 to reposition. An interview with CNA #3, on 01/27/10 at 2:45 PM, revealed she had planned to obtain assistance from another staff member to reposition Resident #22. While looking for other staff members, she received a request to assist with a bath and she forgot to return to assist Resident #22. She stated she felt pulled in different directions and was not able to perform her duties as assigned, due to the number of residents assigned. She stated a call light should be answered within ten minutes. The facility had no policy related to answering the call light system.	F 244	Continued from page 4 administrator for review. A copy will also be sent to the head of the department(s) which is/are involved in the concern for follow up. Within 10 days the department head will report findings and the resolution of the concern to the Social Service Director and Administrator for their review And evaluation of effectiveness. <u>Monitoring Measures to Maintain On-going Compliance:</u> The activity director will schedule additional resident council meetings to be conducted 2 X per month for 3 months then monthly there after. Social Services Director will interview 9 residents (10%) monthly for 6 months to verify ongoing compliance. The outcome of each resident council meeting and social service interview findings will be reported to the administrator and the facility's quality assurance committee. If any areas of concern are identified the frequency and or number of meetings will be increased or conversely if no areas of concern are identified the number or frequency may be decreased.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	<u>F281</u> <u>483.20(k)(3)(i) Services Provided Meet Professional Standards</u> It is the routine practices of Bradford Heights Health and Rehab to provide or arrange services that meet professional standards of quality including provision of oxygen as ordered.	03-14-11

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F 281	<p>Continued From page 5</p> <p>Based on observation, interviews and record review, it was determined the facility failed to provide or arrange services that met professional standards of quality for two residents (#9 and #13), in the selected sample 18, related to the failure to provide oxygen in accordance with physician orders.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Resident #9 was admitted to the facility with diagnoses to include Chronic Obstructive Pulmonary Disease, Short of Air, Cerebral Vascular Accident and Dementia. A Minimum Data Set (MDS) assessment, dated 12/02/10 revealed Resident #9 required moderate to extensive assistance with activities of daily living. <p>Observation, on 01/26/11 at 5:30 PM, revealed Resident #9 was sitting in a wheel chair with a nasal oxygen cannula in place, however, the oxygen concentrator was turned off. The resident stated he/she did not know whether the oxygen was "working" or not.</p> <p>An interview with a Licensed Practical Nurse (LPN) #1, on 01/26/11 at 5:31 PM, verified the oxygen concentrator was in the off position. She stated Resident #9 was supposed to have oxygen administered continuously and she was responsible to ensure it was provided.</p> <ol style="list-style-type: none"> Resident #13 was admitted to the facility with diagnoses to include Chronic Airway Obstruction, Alzheimer Disease, Anemia and Expressive Disorder. A MDS assessment, dated 01/12/11, revealed the facility identified the resident as cognitively impaired and requiring extensive assistance with all activities of daily living. 	F 281	<p>Continued from page 5</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u></p> <p>Oxygen was reapplied to resident #9 and oxygen saturation's have been monitored daily since 01-28-11 results have been within normal range.</p> <p>Resident #13 was assessed by licensed nurse on 01-28-11 and his oxygen was replaced. C N A #1 was re-educated on notifying the nurse for oxygen placement by the QA nurse on 01-28-11 and disciplinary measure was taken on 01-28-11</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Remaining residents in the facility receiving oxygen therapy were checked for proper oxygen delivery and placement on 02-02-11 by the QA nurse. All residents oxygen was applied and was delivered properly.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The charge nurse on each unit will be responsible for the routine monitoring of oxygen saturations and administration of oxygen therapy for residents with orders for oxygen. Re-education was initiated on 02-02-11 by the QA nurse/ADON to all nursing staff on proper application and delivery of oxygen therapy. Re-education will continue thru 03-11-11. The Director of Nursing will be responsible to provide or arrange education for any nursing staff who have not completed the session by 03-11-11 before their next shift worked.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The Quality Assurance Nurse/Assistant Director</p>	

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F 281	<p>Continued From page 6</p> <p>An observation, on 01/25/11 at 9:45 AM, revealed Resident #13 was sitting in a wheel chair with nasal oxygen cannula in place, however, the portable oxygen cylinder secured to the back of the wheel chair and connected to the oxygen tubing was turned off.</p> <p>An observation, on 01/26/11 at 1:05 PM, revealed the resident was sitting in a wheel chair and the oxygen tubing and cannula was wrapped around the top of the oxygen cylinder, located on the back of the wheel chair and was not connected to the resident. The oxygen regulator was set and running at 2 liters per minute.</p> <p>An observation, on 01/28/11 at 4:40 PM, revealed Resident #13 was in the Activity room sitting in a wheel chair. There was no oxygen cylinder attached to the wheel chair. A nurse was alerted by the surveyor. Resident #13 was assisted to the Nursing Station and oxygen was provided at 2/lm. Oxygen saturation was measured multiple times, during the period of 4:40 PM through 4:55 PM. The resident's oxygen saturation ranged from 86% at 4:40 PM to 97% at 4:55 PM.</p> <p>An interview, with Certified Nurse Aide (CNA) #1, on 01/28/11 at approximately 4:45 PM, revealed the oxygen concentrator was turned on while the resident was in bed, however, a portable oxygen cylinder was not attached to the resident's wheelchair, when the resident was assisted to the chair. CNA #1 stated she disconnected the oxygen and transported the resident to the activity room for the evening meal, without the oxygen. CNA #1 stated she usually turned off the oxygen from the concentrator and attached the oxygen tubing to the portable cylinder on the chair and turned on the rate, when she transferred the</p>	F 281	<p>Continued from page 6</p> <p>of Nursing will audit residents who are receiving oxygen daily X 1 week then weekly X 8 weeks then monthly X 3 months to verify proper delivery of oxygen therapy.</p> <p>The audit results will be reported to the DON as well as the facility's QA committee. If areas of concern are identified the audits will be increased in number or frequency conversely if no concerns are identified the number or frequency will be decreased.</p>		

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F 281	Continued From page 7 resident to the wheel chair.	F 281		
F 282 SS=D	<p>An interview with the Activity Director, on 01/28/11 at approximately 5:00 PM, revealed Resident #13 had been observed sitting in the Activity room without oxygen, since about 4:30 PM.</p> <p>An interview with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #2, revealed nurses were responsible for ensuring the oxygen was provided and was set at the correct rate. The facility did not present a policy for the administration of oxygen.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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 and record review, it was determined the facility failed to implement care plan interventions for one resident, (#2), in the selected sample of 18, related to the use of protective geri sleeves. Resident #2 was observed on two occasions sitting in a chair without the protective geri sleeves on his/her forearms. Findings include: Resident #2 was admitted to the facility with diagnoses to include Congestive Heart Failure, Aftercare Joint Replacement and Muscle weakness. A Minimum Data Set (MDS) assessment, dated 12/21/10, revealed the facility identified the resident as cognitively impaired and</p>	F 282	<p>F282 <u>483.20(k)(3)(ii) Services By Qualified Persons/Per Care Plan</u></p> <p>It is the routine practice of Bradford Heights Health and Rehab to implement care plan interventions for each resident.</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u></p> <p>Geri-sleeves were reapplied to resident #2 on 01-28-11 and she will have geri-sleeves or long sleeves on when out of bed in accordance with residents plan of care. C N A #2 was re-educated by the unit manager on following the residents plan of care on 02-02-11 C N A's working on resident #2's unit were re-educated on following the plan of care on 02-02-11 by the unit manager.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>All nurse aid data sheets of remaining residents in the facility were reviewed by the DON on 02-14-11 5 residents out of 82 were identified as having geri-sleeves or long sleeves as interventions on their plan of care. Those residents were observed to validate that geri-sleeves were in place.</p>	03-14-11

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F 282	<p>Continued From page 8 requiring extensive assistance with all care.</p> <p>Observations, on 01/25/11 at approximately 12:00 PM and on 01/27/11 at 12:45 PM, revealed the resident was dressed in a short sleeved blouse and had numerous scattered circular and irregular purple and bluish discolorations on both forearms and elbow areas.</p> <p>An interview with a Certified Nurse Aide (CNA) #2, on 01/27/11, revealed the resident was supposed to wear geri sleeves, whenever he/she was out of bed. No explanation was provided to explain why the resident was not wearing geri sleeves during the observations, on 01/25/11 and 01/27/11.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 01/27/11 at approximately 3:00 PM, revealed Resident #2's care plan interventions included the application of geri sleeves when the resident was up and out of bed. The CNAs were responsible to ensure the geri sleeves were applied.</p> <p>An interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), on 01/28/11 at 7:15 PM, revealed the nursing staff were responsible to ensure care plan interventions were implemented.</p> <p>A record review revealed the care plan intervention, dated 05/18/10, included the application of geri sleeves to be applied by the licensed nurse or CNA when the resident was out of bed.</p> <p>A review of the facility policy and procedure for care plans, dated 01/01/07, revealed the facility</p>	F 282	<p>Continued from page 8</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>All C N A's will be re-educated on following residents plan of care by the ADON/QA Nurse. Emphasis will be placed on residents wearing long sleeves or geri-sleeves The DON will be responsible to provide or arrange education to any C N A who has not completed the training by 03-11-11 prior to working their next scheduled shift.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>Unit managers will observe the five identified residents from each unit to validate compliance with following the nurse aid data sheet. The observations will be conducted weekly X 4 weeks then every 2 weeks X 4 weeks then monthly X 6 months. The results will reported to the DON as well as the facility's quality assurance committee if concerns are identified re-training /discipline will result. The committee will review findings and if no concerns are identified the number or frequency of audits may be decreased conversely if concerns are identified the audit will be increased in number or frequency.</p>	

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F 282	Continued From page 9 was responsible to develop a care plan with interventions for assessed needs, however, the policy did not address implementation of the care plan.	F 282		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as was possible to prevent accidents. Observation revealed a janitor closet was left unlocked and contained hazardous chemicals and cleaning supplies. Observation revealed medication was disposed of in a shallow open trash bin, attached to the medication cart, which was stored on the open hallway, which was accessible to confused and wandering residents. Observation revealed medications were left unattended by staff, at the bedsides of two residents (#23 and #24), not in the selected sample. Findings include:	F 323	F323 <u>483.25(h) Free of Accident Hazards/Supervision/Devices</u> It is the normal practice of Bradford Heights Health and Rehab to ensure each resident receives adequate supervision and assistance devices to prevent accidents. <u>Corrective Measures for Resident Identified in the deficiency:</u> The janitor closet door was locked immediately on 01-25-11 Resident #23 medications are administered by nursing staff as of 01-29-11 Resident #24 medications are administered by nursing staff as of 01-29-11 CMT #1 was re-educated on 01-28-11 on proper medication administration to include medications not being left at bedside and disposing of medications in the proper manner. This was conducted by the unit manager. <u>How other residents who may have been affected by this practice were identified:</u> A review of residents cognition and mobility was completed to identify cognitively impaired residents who wander and may have the potential to be impacted by this practice.	03-14-11

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F 323	Continued From page 10 1. An observation, on 01/25/11 at 9:10 AM, revealed a janitor's closet located in the open hallway near the kitchen, was unlocked and accessible to confused and wandering residents. The closet contained the following with hazardous warning labels: 1 (2 and 1/2) gallon open bottle of degreaser 12 (1 gallon) containers of bleach (two were open) 3 (1 pint) bottles of lime remover (one open) 1 (2 1/2) gallons of floor cleaner 2 (2 1/2) gallons of "quat" sanitizer (one opened) 3 (18 oz) spray opened cans of oven cleaner 2 (1) gallon containers of freezer cleaner 4 (1) gallon containers of lime remover 1 (5) gallon bucket of degreaser 2. An observation, on 01/26/11 at 11:30 AM, revealed medication cart (#1), located on the open hallway near the nurses station, on 100 hall, was unattended. A medication cup with five pills was observed resting on top of the trash inside of the shallow trash bin attached to the side of the medication cart. Medication cart (#2) was also observed on the open hallway near the nurses station, on the 100 hall, and was unattended. A medication cup with one pill and several empty capsules, a drinking cup with approximately 3 oz of a yellowish liquid with sediment in the bottom of the cup were observed resting on top of the trash in the shallow trash bin attached to the side of the medication cart. A cognitively impaired resident (#29), was observed propelling his/her low wheelchair past the medication carts. An interview with Certified Medication Technician	F 323	Continued from page 10 <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> A new lock, that locks automatically on closing was placed on the janitors closet door on 02-03-11 All janitor closets were checked on 01-25-11 by the maintenance director to verify that remaining janitor closet doors were locked. All dietary staff were re-educated on keeping the janitor closet door locked at all times on 02-04-11 by the dietary manager. The key to the janitor closet will be kept in the dietary managers office during day time hours and will be maintained by the kitchen supervisor on weekends and off hours. Residents identified as being inter-viewable according to the MDS which were 25 out of 82 were interviewed by the QA nurse to verify that there medications were not being left at the bedside on 02-15-11 In-servicing of licensed nurses and medication techs was initiated on 02-02-11 by the Pharmacist/DON on proper medication administration and disposal. The DON will be responsible to arrange or provide in-servicing to any staff that have not attended the last session by 03-11-11 prior to their next shift worked. Lids were obtained for all trash bins on the medication carts on 02-14-11 <u>Monitoring Measures to Maintain On-going Compliance:</u> The maintenance director will audit the janitors closet in the facility daily X 2 weeks then 2 X a week for 4 weeks then monthly X 6 months to verify that doors are remaining locked. The audit findings will be reported to the facility's quality assurance meeting. If any areas	

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F 323	<p>Continued From page 11</p> <p>(CMT) #1, on 01/26/11 at 11:30 AM, revealed the trash bin was usually emptied twice a shift. She had completed a medication pass earlier in the morning and a resident had refused their medication. She disposed of the cup containing the pills in the open trash bin. After the interview, she was observed to dispose of the medication cups containing medication in the sharps containers and removed the cup of liquid from medication cart #2.</p> <p>An interview with the LPN #2, (Unit Manager for the 100 hall), on 01/26/11 at 11:45 AM, revealed pills should be discarded in the sharp containers and liquids should be poured down the sink.</p> <p>An interview with the Administrator and the Director of Nursing (DON), on 01/28/11 at 11:10 AM, revealed medications should not be left open and exposed in the trash bins; the medications should be discarded in the sharps containers and that improper disposal of medication was considered a safety risk.</p> <p>A review of information provided by the facility revealed fourteen residents had been identified as active wanderers and would potential have access to the medication carts and the open janitor's closet.</p> <p>3. Resident #24 was admitted to the facility with diagnoses to include Diabetes Mellitus, Anxiety, Depressive Disorder, Hypertension and Osteoarthritis.</p> <p>An observation, on 01/25/11 at 10:20 AM, revealed Resident #24 was sitting in His/Her room in a wheel chair. A medication cup containing six (6) pills was observed on the over</p>	F 323	<p>Continued from page 11</p> <p>of concern are identified the frequency and number of audits will be increased conversely if no concerns are identified the number or frequency may be decreased.</p> <p>The Unit Managers/QA Nurse will conduct random audits of at least 3 residents (10%) on 100 hall during medication pass to monitor for ongoing compliance with proper medication delivery. This will be conducted weekly X 8 weeks then every 2 weeks X 8 weeks then monthly X 6 months.</p> <p>In addition trash bin audits will be conducted by the QA nurse weekly X 8 weeks then every 2 weeks X 8 weeks then monthly X 6 months. The committee will review finding and if no concerns are identified the number or frequency of audits may be decreased conversely if concerns are identified the audit will be increased in number of frequency.</p>		

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F 323	<p>Continued From page 12</p> <p>bed table, without direct staff supervision. Resident #24 stated He/She took the medicine after morning bathing and grooming. The nurse left the medications for the resident to take independently as he/she desired. During the interview, Resident #24 stated a wandering resident occasionally entered the room and rummaged through the dresser drawers. Resident #24 stated he/she had to "Guard" the medication and ring the call light for staff to remove the wandering resident from the room.</p> <p>An interview with a Certified Medication Technician (CMT), on 01/25/11 at approximately 10:35 AM, revealed she left medications on the over bed table for Resident #24 to take independently at the resident's request. The CMT stated Resident #24 enjoyed independence with bathing and preferred to wait until after bathing to take the medications. She stated she left medications on the table for Resident #23 also, due to requests for the medications to be left to be taken at a later time.</p> <p>4. Resident #23 was admitted to the facility with diagnoses to include Diabetes, Muscle Weakness, Congestive Heart Failure, Hydronephrosis and Atrial Fibrillation.</p> <p>An interview with Resident #23, on 01/25/11 at approximately 11:00 AM, revealed the medication nurse frequently left his/her medications on the table per the resident's request and he/she took the medication independently.</p> <p>An interview with the Director of Nursing (DON), on 01/28/11 at 12:00 PM, revealed Residents #23 & #24 had not been assessed for self administration of medication, until after the issue</p>	F 323		

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F 323	Continued From page 13 was identified through the survey process, on 01/28/11.	F 323		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure each resident received food that was palatable and at the proper temperature. Findings include: 1. An observation, on 01/25/11 at 11:30 AM, revealed the food on the steam table remained uncovered for thirty minutes after temperatures were taken prior to preparation of the trays. After service began, five trays remained on the tray line uncovered awaiting the meat entree. 2. An observation, on 01/25/11 at 12:55 PM, revealed test tray temperatures as follows: Ground meat: 110 degrees Fahrenheit (F.) Pureed squash: 104 degrees F Meat patty: 86 degrees F Carrots: 104 degrees F 3. A taste test of foods on the test tray revealed all items lacked palatability, due to temperature of the foods being barely warm. Interview with the Registered Dietician revealed the food temperatures were low.	F 364	F364 483.35(d)(1)-(2) Nutritive Value/Appear, Palatable/Prefer Temp It is the normal practice of Bradford Heights Health and Rehab to provide foods that are palatable, attractive and at the right temperature. <u>Corrective Measures for Resident Identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents receiving oral foods have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> All dietary staff are being/will be re-educated on keeping food items covered on the steam table to maintain temperatures. They were also re-trained not to leave prepared trays uncovered on the tray line. The in-servicing was initiated on 02-04-11 by the dietary manager and registered dietician. The registered dietician will be responsible to provide or arrange in-servicing to any dietary staff that have not received education by 03-11-11 prior to their next shift worked. Test tray audits will be conducted daily for 7 days, then 3 X weekly. If temperatures on test trays and audits remain in acceptable parameters, audit will be reduced to weekly on an ongoing basis at varying meals and units. The dietary manager or her designee will be responsible for completing the audits. Additionally 4 residents on	03-14-11

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F 364	Continued From page 14 A review of instructions on the facility's "Food Temperature Record", dated 2010, revealed a "Minimum Standard" notation stated, "Hot foods should leave the kitchen at a minimum of 135 degrees F". A review of the Dietary Services, Clinical Practice Guidelines, dated 01/01/07, revealed foods served to residents were to be consistent with required food temperature for hot and cold foods.	F 364	Continued from page 14 each unit (12%) will be interviewed by the Social Service director to review food satisfaction weekly, for 4 weeks then every 2 weeks for 8 weeks then monthly for 6 months. <u>Monitoring Measures to Maintain On-going Compliance:</u> The dietary manager and Registered Dietician will report the test tray audit results to the facility's QA committee meeting. Social Services Director will also report interview results to the facility's QA committee for review. If any areas of concern are identified the frequency and number of audits will be increased conversely if no concerns are identified the number or frequency may be decreased.	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to prepare food in form designed to meet individual needs for one resident (#14), in the selected sample of 18 and three residents (#25, #26 and #27), not in the selected sample. Findings include: 1. A record review revealed Resident #14 was admitted to the facility, on 01/20/11, with diagnoses to include Morbid Obesity and Aftercare for Gastric By-Pass Surgery. A review of a physician's order, dated January 2011, revealed Resident #14 was to receive a pureed diet. An observation, on 01/25/11 at 11:45 AM, revealed the resident was served a mechanical	F 365	<u>F365</u> <u>483.35(d)(3) Food In Form To Meet Individual Needs</u> It is the normal practice of Bradford Heights Health and Rehab to provide food prepared in a form designed to meet individual needs. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident's #14, 25, 26 and 27 tray cards were reviewed and verified as correct on 02-15-11 by the Dietary Manager. Dietary staff responsible for preparing food trays were re-educated on 02-04-11 by the dietary manager regarding following residents preferences for likes and dislikes when serving food. Residents # 14, 25, 26 and 27 are now being followed. <u>How other residents who may have been affected by this practice were identified:</u> Resident's receiving meal trays in the facility have the potential to be affected by the practice.	03-14-11

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F 365	<p>Continued From page 15</p> <p>soft meat and vegetables for lunch. A review of the dietary slip revealed the pureed diet should have been served.</p> <p>An interview with the Dietician, on 01/28/11 at 6:45 PM, revealed Resident #14 had an order for a pureed diet and should have received the appropriate diet.</p> <p>An interview with the Dietary Manager, on 01/28/11 at 7:45 PM, revealed staff should follow the meal plan for each resident.</p> <p>2. Observation during the lunch and evening meal, on 01/25/11 revealed the following:</p> <p>A review of Resident #25's dietary slip revealed the resident was allergic to chocolate and was supposed to receive grilled chicken.</p> <p>Observation of the resident's lunch meal tray, at approximately 12:00 noon, revealed Resident #25 received a chocolate Magic Cup and peppered steak instead of grilled chicken. An attempt at interviewing Resident #25 was unsuccessful.</p> <p>3. A review of Resident #26's dietary slip revealed the resident disliked carrots.</p> <p>An observation of the resident's lunch meal tray, at approximately 12:10 PM, revealed Resident #26 received carrots. An interview with the resident revealed the resident did not like carrots and he/she was not going to eat them.</p> <p>4. A review of Resident #27's meal slip revealed the resident disliked rice.</p> <p>An observation of the resident's supper meal tray,</p>	F 365	<p>Continued from page 15</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Tray cards along with a food preference sheet will be reviewed with each resident and the food preference sheet will be added to or revised per the residents request and tray cards will be updated to reflect those changes. This will be conducted by the dietary manager and Registered Dietician.</p> <p>The cart loader is responsible to check the tray card for accuracy.</p> <p>In-servicing was initiated for dietary staff by the dietary manager on 02-04-11 in regards to tray card accuracy. Dietary Manager/Registered Dietician will be responsible to provide or arrange in-servicing for any dietary staff that has not attended an in-service session by 03-11-11 before their next shift worked.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>Tray card accuracy audit will be conducted on 8 residents trays (10%) weekly X 4 weeks then every 2 weeks X 8 weeks then monthly there after. This will be conducted by the dietary manager and Registered Dietician.</p> <p>The audit results will be reported to the facility's QA committee. If areas of concern are identified the audit frequency and number will be increased conversely if no concerns are identified the number and frequency may be decreased.</p>		

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F 365	Continued From page 16 at approximately 5:45 PM, revealed the resident received rice. An interview with the resident revealed he/she did not like rice and was not going to eat it. An interview with the Dietician, on 01/29/11 at 3:45 PM, revealed she had observed the tray line, after the surveyors initiated the survey and verified the cook's review of the dietary slips to identify the type of diet for residents, however, no one reviewed the dietary slip to identify dislikes.	F 365		
F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: An observation of the dietary department, on 01/25/11, revealed the following: 1. The bottom of a drawer containing scooping utensils was observed to be stained and dirty. Several utensils were placed on a weaved paper	F 371	F371 <u>483.35(i) Food Procure, Store/Prepare/Serve - Sanitary</u> It is the normal practice of Bradford Heights Health and Rehab to store, prepare and serve food under sanitary conditions. <u>Corrective Measures for Resident Identified in the deficiency:</u> There were no residents identified under this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents receiving oral feedings, meal trays have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The bottom of the drawer containing scooping utensils was cleaned on 01-25-11 by the Registered Dietician. The woven paper was removed on 01-25-11 by the registered dietician. The bleach oven cleaner and degreaser were removed and placed in the closet on 01-25-11 by the dietary manager. The floor of the walk in freezer and refrigerator were cleaned on 02-15-11 by the	03-14-11

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F 371	Continued From page 17 cloth. An interview, 01/25/11 at 9:00 AM, with Dietary Staff (DS) #1, revealed the paper cloth was there to "catch water". An interview with Regional Support Dietician (RSD) and the Dietary Manager (DM), on 01/25/11 at 11:00 AM, revealed staff should not be putting wet utensils in the drawers. 2. Two gallon sized containers of bleach were observed under the rinse sink at the dirty dish area receiving window. An interview with DS #2, revealed she was aware the bleach should have been stored in the "closet" and that it was under the sink when she came in to work. 3. A one gallon container of bleach, two spray cans of oven/grill cleaner and one container of degreaser were observed stored on a shelf under the three compartment sink. 4. The floor of the walk in freezer was observed with dust, food crumbs and other debris. There was no assignment of cleaning chores posted for the day. 5. In one reach in refrigerator, the temperature was observed at 50 degrees and dried spillage was noted in the bottom of the refrigerator. 6. A container of ice was observed with the ice scoop inside the container with the handle down touching ice. DS #3 was observed using the scoop to fill pitchers with ice and afterwards, DS#3 returned the scoop back inside the ice	F 371	Continued from page 17 kitchen staff. A cleaning schedule was posted on 02-16-11 by the dietary manager. DS #1 and DS #2 were re-educated on proper sanitation procedures that includes wearing gloves and hand washing by the dietary manager on 01-25-11. All dietary staff were re-educated by the dietary manager and regional dietician on sanitation procedure on wearing gloves, hand washing, storage of ice scoop, covering and storage of food, proper storage of chemicals and cleaning schedule. This was initiated on 01-25-11 by the dietary manager and registered dietician. The registered dietician will be responsible to arrange or provide education to any dietary staff who have not attended by 03-11-11 prior to their next shift worked. Monitoring Measures to Maintain On-going Compliance: Dietary sanitation audits including safe and sanitary food handling, chemical storage and hand washing practices will be conducted weekly by the registered dietician and 2 additional times by the dietary manager for 6 weeks. If findings are acceptable, audits will be reduced to weekly by either the registered dietician or dietary manager. Random audits of hand washing technique was conducted daily X 5 days and completed on 02-11-11 by the dietary manager. Audits will continue weekly on an ongoing basis by the dietary manager and/or registered dietician. The registered dietician will conduct weekly audits for posting of cleaning schedule X 8 weeks then every 2 weeks X 8 weeks then monthly X 6 months. Results of the audits conducted will be reported to the quality assurance committee if concerns are	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2011
NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240	
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F 371	Continued From page 18 container. DS#3 was also observed going in and out of the kitchen and taking items from the refrigerator, without changing gloves before handling food items. 7. During the trayline preparation, DS #3 was observed placing pats of butter on each tray, without gloves. 8. Observation revealed the foods on the trayline remained uncovered for 30 minutes prior to service and after temperatures were taken. An interview, on 01/25/11 at 11:30 AM, with the RSD and the facility's Registered Dietician (RD), revealed they were working on improvement in the dietary department. An interview, on 01/28/11 at 7:55 PM, with the DM revealed she had identified issues and was in the process of inservicing staff. A review of the facility policy for Dietary Sanitation, dated 01/01/2007, revealed drawers were to be kept clean and organized. Cleaning schedules for all equipment and areas of the dietary department were to be posted daily, with cleaning posted by the staff member assigned. The DM was to monitor daily to verify the assignment was being followed by staff. Hand washing occurred after any contact with soiled/unclean items, prior to returning to food preparation, and glove use by staff during meal service was recommended.	F 371	Continued from page 18 identified the frequency and number of the audits will be increased conversely if no concerns are identified the frequency and number may be decreased.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	F441 <u>483.65 Infection Control, Prevent Spread, Linens</u> It is the normal practice of Bradford Heights Health and Rehab to provide a safe, sanitary and	03-14-11

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NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240		
(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 441	Continued From page 19 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record	F 441	Continued from page 19 comfortable environment and help prevent the development and transmission of disease and infection. <u>Corrective Measures for Resident Identified in the deficiency:</u> There were no residents identified for this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents receiving medications from the two carts identified had the potential to be impacted by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The medication carts and pill crushers on 100 hall were cleaned on 01-28-11 by the CMT. Personal items were removed from the medication cart and placed in a lock box in the administrative office by the unit manager on 01-28-11 A cleaning schedule was developed on 02-16-11 for the medication carts to be cleaned daily by the CMT or nurse utilizing the cart. All licensed nurses and medication aids will be in-serviced on the cleaning schedule and the medication storage policy which includes keeping the cart organized and free of clutter. The training has been provided by the pharmacist and ADON beginning on 02-04-11 and will completed by 03-11-11. The DON will be responsible to assure that all employees requiring training that have not been educated by 03-11-11 will be trained before their next shift worked.		

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NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240	
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F 441	<p>Continued From page 20</p> <p>review, it was determined the facility failed ensure infection control procedures were utilized for two of the facility's six medication carts.</p> <p>Findings include:</p> <p>An observation, on 01/26/11 @11:20 AM, revealed the following:</p> <ol style="list-style-type: none"> Two medication carts were stored on the 100 hallway, near the nurses station. Both carts were observed soiled on the tops and exterior, with shallow trash bins filled with trash. Pill crushers on each cart were dirty and stained. Medication cart drawers were disorganized with dust and debris covering the drawer bottoms with numerous loose pills. The liquid medication drawer contained bottles covered with dried medication around the tops and dripping down the sides of the containers. Valuable belonging of residents were stored in the locked narcotic drawer, some unidentified. <p>An interview, on 01/26/11 at 11:30 AM, with Certified Medication Tech (CMT) #1 on the 100 hall, revealed she tried to cleaned the medication carts once a week. She stated the resident valuables had been in the narcotic drawers, "Ever since I've been doing it".</p> <p>An interview, on 01/26/11 at 12:00 PM with CMT #2 on the 200 hall, revealed she cleaned the carts on the 200 hall daily.</p> <p>An interview, on 01/28/11 at 10:38 AM, with the</p>	F 441	<p>Continued from page 20</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>Medication carts will be audited weekly for 4 weeks then every 2 weeks for 4 weeks then monthly for 6 months by the QA nurse or unit manager for on-going compliance.</p> <p>The audit results will be reported to the DON and in addition the facility's quality assurance committee. If no concerns are identified the audits may be decreased in frequency and number conversely if concerns are identified the number and frequency of the audits will increase.</p>	

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NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240		
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F 441	<p>Continued From page 21</p> <p>Unit Manager of 100 hall revealed it was the CMTs' responsibility to keep the medication carts clean and organized. She stated the carts should be cleaned daily and loose pills should discarded in the sharps container.</p> <p>An interview, on 01/28/11 at 11:10 AM, with the Director of Nursing and the facility Administrator, revealed they expected the medication carts to be clean and organized. Residents' valuables should be stored in the narcotic drawer short term and turned over to Administration for long term storage.</p> <p>A review of the Medication Storage policy, dated 09/10, did not address a cleaning schedule for the medication carts, however, medication storage, should be kept clean, well lit, organized and free of clutter.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240	
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 01/28/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 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.