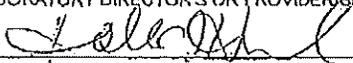


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2012
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 C 11/28/2012
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	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.	01/05/2013
F 280 SS=D	483.20(d)(3), 483.10(l)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to review and revise	F 280	F- 280 483.20(d)(3),483.10(l)(2) Right to participate planning care-revise CP. It is the practice of Bradford Health and Rehab Center to periodically review and revise the plan of care by a team of qualified persons after each assessment. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident #1's comprehensive care plan and Nurse Aide Data Sheet was reviewed and revised to reflect appropriate and new interventions on 11/29/12. This was completed by the unit manager. Gripper socks were placed in resident # 1's room per the plan of care on 11/28/12. <u>How other residents who may have been affected by this practice were identified:</u> The Comprehensive Care Plans and Nurse Aide Data Sheets of all current residents were reviewed on 12/13/12 to verify the interventions listed for fall prevention are appropriate and reflective of the residents assessed needs. This was completed by staff dev. unit manager, DON, Care coordinator. In addition, an audit was conducted of all current residents and verified that all listed interventions are in place. This audit was completed on 12/13/12 by Staff dev. DON, Care Coordinator, Unit Manager.	P-280 (cont)

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



TITLE

Administrator

(X6) DATE

Jan 5, 2013

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 280	<p>Continued From page 1</p> <p>the care plan for one resident (#1), in the selected sample of three residents. Review of the care plan for "Falls," dated 12/29/11, revealed an intervention to include "refuses to ask for assistance with transfers." Resident #1 sustained a fall on 10/08/12 while transferring self from his/her bed to the wheelchair. The intervention implemented, as a result of the 10/08/12 fall, was "remind the resident to ask for help when transferring." On 10/17/12, the resident transferred himself/herself unassisted from his/her bed to the wheelchair to go to the bathroom, and fell to the floor. The resident hit his/her head on the wheelchair when he/she fell between the wheelchair and the bed.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Incident/Accident," dated 08/06/12, revealed the facility was to investigate incidents/accidents and take appropriate interventions as needed. The "Incident/Accident Clinical Practice Guidelines," dated 08/06/12, revealed the facility was to investigate the incident, accident, or injury and reviewed/revise the care plan to include preventative interventions to decrease potential for recurrence.</p> <p>A record review revealed the facility admitted Resident #1 on 06/01/06, re-admitted on 11/03/10, and again on 10/24/12, with diagnoses to include Dementia, Dysthymic Disorder, Golter, Cardiopulmonary Disease, Hypertension, Depression, Anxiety, Insomnia, and Esophageal Reflux.</p> <p>A review of the "Falls" care plan, dated 12/29/11,</p>	F 280	<p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Education for all nursing staff was initiated 12/14/12 on verifying that the interventions listed on the care plan for the residents is in place and appropriate for each resident and following the Care Plan Policy. The education was conducted by Staff Dev. The education will continue until all nursing staff have been re-educated. This will be conducted by the DON /Unit Manger or staff Development Nurse. The DON will be responsible to provide or arrange the education for any nursing staff who are unavailable for the educational sessions.</p> <p><u>Monitoring Measures Implemented to Maintain Ongoing Compliance:</u></p> <p>A DON/Unit Manager/ and MDS Coordinators will randomly select 3 residents from each wing (approx 10%) to review the Plan of care and audit each residents room to verify that all listed interventions are appropriate and in place. This audit will be conducted 3 times a week for 6 weeks, then 2 times a week for 4 weeks, then weekly thereafter for 4 weeks. Results of the audits will be reported to the DON and the Quality Assessment and Committee for review. If any areas of concern are identified the frequency or duration of the audit may be increased to validate ongoing compliance and re education will be provided on an individual basis if indicated.</p>	

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F 280	<p>Continued From page 2</p> <p>revealed the intervention "refuses to ask for assistance with transfers. Encourage the resident to ask, assist the resident as the resident will allow, and encourage use of the call bell (often will not use)."</p> <p>Review of the Care Plan Progress Notes, dated 08/08/12, revealed staff was to assist with transfers and encourage the resident to use the call light.</p> <p>A review of the facility's Fall incident investigation, dated 10/08/12, revealed Resident #1 fell getting out of bed as reported by the resident's roommate. The resident stated he/she "did not hit [his/her] head, just [his/her] butt." The findings of the investigation revealed the resident fell out of bed when trying to self-transfer while the wheels on the wheelchair were unlocked. Additionally, the resident refused to use the call light to request assistance for transfer. The intervention implemented was to "remind the resident to ask for assistance when transferring."</p> <p>A review of the facility's Fall incident investigation, dated 10/17/12, revealed Resident #1 transferred himself/herself unassisted from his/her bed to the wheelchair to go to the bathroom, and fell to the floor. The resident hit his/her head on the wheelchair when he/she fell between the wheelchair and the bed. The wheelchair was found to be unlocked and the resident did not have any footwear on his/her feet. The post falls analysis revealed the resident did not have any footwear or non-skid socks on, and the room lights were low. The intervention implemented was "non-skid socks to be in place at all times."</p>	F 280			

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F 280	<p>Continued From page 3</p> <p>A review of the Minimum Data Set (MDS) assessment, dated 10/31/12, revealed the facility assessed Resident #1 to be severely cognitively impaired, with behaviors to include refusal of care. The resident was assessed to require extensive physical assistance of one staff for transfers. Review of the falls MDS assessment revealed two falls with no injury. Further review of the Care Plan Progress Notes, dated 10/31/12, revealed staff was to assist with transfers and encourage the resident to use the call light.</p> <p>Review of the "Falls" care plan, dated 11/06/12, revealed the intervention "encourage use of the call bell (often will not use)," and "refuses to ask for assistance with transfers. Encourage the resident to ask, assist the resident as resident allows," and "educate to call for assistance with transfers - resident self-transfers and is usually noncompliant with asking for assistance."</p> <p>Observation, on 11/28/12 at 5:55 PM, revealed Resident #1 was self-propelling in the hallway after the evening meal. The resident asked the Nurse Aide to straighten the covers on his/her bed. He/she was told it would be done after all meal trays were delivered. The resident self-propelled into the room, and self-transferred to his/her bed. The resident changed clothes without assistance and waited for the Nurse Aide to come and straighten the cover.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 11/28/12 at 5:30 PM, revealed Resident #1 used the call light at times, but usually transferred himself/herself into the wheelchair and came out in the hall and got someone. The CNA stated the only thing the resident really usually wanted to do</p>	F 280		

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F 280	<p>Continued From page 4 was smoke.</p> <p>Interview with CNA #1, on 11/28/12 at 6:00 PM, revealed Resident #1 went to the bathroom unassisted and staff must catch him/her in the bathroom to get the bed changed. The resident transferred himself/herself without assistance from the bed to the wheelchair and vice versa. He/she was able to lock and unlock the wheels on the wheelchair. The resident used the call light at times, but usually just came out on the hallway.</p> <p>Interview with the Director of Nursing (DON), on 11/28/12 at 6:27 PM, revealed the post falls intervention of "encourage use of the call bell (often will not use)" for assistance was implemented 12/29/11 and had been ineffective. The intervention was implemented again, on 11/06/12, with the additional intervention that the resident was usually noncompliant with asking for assistance. Currently, Resident #1 was known to self-transfer and go to the bathroom without assistance. The DON stated her expectations of the CNA with an incident/investigation was to ensure the resident was safe, and then notify the charge nurse. Her expectation of the charge nurse was to do a complete physical assessment of the resident, notify the physician, notify the family/responsible party, and notify the DON and the Administrator. The incident investigation was to be initiated by the charge nurse. The charge nurse was to interview the staff and take written statements if the DON was not in the facility. The DON stated the root cause of an incident was determined by gathering information related to how the incident occurred. The information was reviewed in the morning meeting and if the cause was not clear, the staff were interviewed. The</p>	F 280			

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F 280	Continued From page 5 intervention was determined by the group attending the morning meeting and was specific to the issue which caused the incident. The DON stated the care plan revision was the responsibility of the MDS Coordinator and the nurses. The nurses were expected to make changes and update the Care Plan as to whether the interventions were effective or ineffective.	F 280		
F 323 SS=D	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, record review, and review of the facility's policy/procedure, it was determine the facility failed to provide adequate supervision and assistive devices to prevent falls for one resident (#1), in the selected sample of three residents. Resident #1 had a care plan for "Falls," dated 12/29/11, with an intervention to include "Refuses to ask for assistance with transfers." On 10/08/12, the resident sustained a fall while transferring himself/herself unassisted from the bed to the wheelchair. The intervention implemented was to "remind the resident to ask for help when transferring." On 10/17/12, the resident sustained another fall while transferring himself/herself unassisted from the bed to the	F 323	F323 <u>483.25(h) Free of Accident Hazards/ Supervision</u> It is the facility's routine practice to maintain the facility in a manner that the resident environment remains as free of hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident #1's comprehensive care plan and Nurse Aide Data Sheet was reviewed and revised to reflect appropriate and new interventions on 11/28/12. This was completed by Unit Manager. Gripper socks were placed in resident # 1's room on 11/28/12 per the plan of care.	1/05/2013
				F- 323 (cont)

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F 323	<p>Continued From page 6 wheelchair.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Incident/Accident," dated 08/06/12, revealed the facility was to investigate incidents/accidents and take appropriate interventions as needed. The "Incident/Accident Clinical Practice Guidelines," dated 08/06/12, revealed the facility was to investigate the incident, accident, or injury and reviewed/revised the care plan to include preventative interventions to decrease potential for recurrence.</p> <p>A record review revealed the facility admitted Resident #1 on 06/01/06, and re-admitted on 11/03/10, and again on 10/24/12, with diagnoses to include Dementia, Dysthymic Disorder, Goiter, Cardiopulmonary Disease, Hypertension, Depression, Anxiety, Insomnia, and Esophageal Reflux.</p> <p>A review of the "Falls" care plan, dated 12/29/11, revealed the intervention "refuses to ask for assistance with transfers. Encourage the resident to ask, assist the resident as the resident will allow, and encourage use of the call bell (often will not use)."</p> <p>A review of the facility's Fall incident investigation, dated 10/08/12, revealed Resident #1 fell getting out of bed. The resident stated he/she "did not hit [his/her] head, just [his/her] butt." The findings of the investigation revealed the resident fell out of bed when trying to self-transfer while the wheels on the wheelchair were unlocked. Additionally, the resident refused to use the call light to</p>	F 323	<p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>The Comprehensive Care Plans and Nurse Aide Data Sheets of all current residents were reviewed on 12/13/12 to verify that the interventions listed for fall prevention are appropriate and reflective of the residents assessed needs. This was completed by Staff Dev. Unit Manager, DON, Care Coordinator. In addition, an audit was conducted of all current residents and verified that all listed interventions are in place. this audit was completed on 12/13/12. This audit was completed by Staff Dev. DON, Unit Manager, Care Coordinator.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Education for all nursing staff was initiated on 12/14/12. on verifying that the interventions listed on the care plan for the residents is in place and appropriate for each resident. The education was conducted by Staff Dev. Nurse.. The education will continue until all nursing staff have been re-educated. This will be conducted by the</p>
			<p>(X6) COMPLETION DATE</p> <p>F- 323 (cont)</p>

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F 323	<p>Continued From page 7</p> <p>request assistance. The post falls analysis revealed the bed was in the low position and no mats, landing strips, or alarms were in use. The intervention implemented was to "remind the resident to ask for assistance when transferring."</p> <p>A review of the facility's Fall incident investigation, dated 10/17/12, revealed Resident #1 transferred himself/herself unassisted from his/her bed to the wheelchair to go to the bathroom, and fell to the floor. The resident hit his/her head on the wheelchair when he/she fell between the wheelchair and the bed.</p> <p>A review of the Minimum Data Set (MDS) assessment, dated 10/31/12, revealed the facility assessed Resident #1 to be severely cognitively impaired, with behaviors to include refusal of care. The resident was assessed to require extensive physical assistance of one staff for transfers. Review of the falls MDS assessment revealed two falls with no injury.</p> <p>Review of the "Falls" care plan, dated 11/06/12, revealed the intervention "encourage use of the call bell (often will not use)," and "refuses to ask for assistance with transfers. Encourage the resident to ask, assist the resident as resident allows," and "educate to call for assistance with transfers - resident self-transfers and is usually noncompliant with asking for assistance."</p> <p>Observation, on 11/28/12 at 5:55 PM, revealed Resident #1 was self-propelling in the hallway, self-propelled into the room, and self-transferred to his/her bed. The resident changed clothes without assistance and waited for the Nurse Aide to come and straighten the cover.</p>	F 323	<p>DON /Unit Manger or staff Development Nurse.</p> <p>Education on the incident/accident policy for all nursing staff was initiated on 12/14/12. This was conducted by Staff Development Nurse. This was continued until all staff have been re-educated. The DON will be responsible to provide or arrange the education for any nursing staff who are unavailable for the educational sessions.</p> <p><u>Monitoring Measures Implemented to Maintain Ongoing Compliance:</u></p> <p>ADON/Unit Manager/ and MDS Coordinators will randomly select 3 residents from each wing (approx 10%) to review the Plan of care and audit each residents room to verify that all listed interventions are appropriate and in place. This audit will be conducted 3 times a week for 6 weeks, then 2 times a week for 4 weeks, then weekly thereafter for 4 weeks. Results of the audits will be reported to the DON and the Quality Assessment and Committee for review. If any areas of concern are identified the frequency or duration of the audit may be increased to validate ongoing compliance and re education will be provided on an individual basis as indicated.</p>		

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F 323	Continued From page 8 Interview with Certified Nurse Aide (CNA) #2, on 11/28/12 at 5:30 PM, revealed Resident #1 used the call light at times, but usually transferred himself/herself into the wheelchair and came out in the hall and got someone. Interview with CNA #1, on 11/28/12 at 6:00 PM, revealed Resident #1 went to the bathroom unassisted and staff must catch him/her in the bathroom to get the bed changed. The resident transferred without assistance from the bed to the wheelchair and vice versa. He/she was able to lock and unlock the wheels on the wheelchair. The resident used the call light at times, but usually just came out on the hallway. Interview with the Director of Nursing (DON), on 11/28/12 at 6:27 PM, revealed the post falls intervention of "encourage use of the call bell (often will not use)" for assistance was implemented 12/29/11 and had been ineffective. The intervention was implemented again, on 11/06/12, with the additional intervention that the resident was usually noncompliant with asking for assistance. Currently, Resident #1 was known to self-transfer and go to the bathroom without assistance. The DON stated her expectations of the CNA with an incident/investigation was to ensure the resident was safe, and then notify the charge nurse. Her expectation of the charge nurse was to do a complete physical assessment of the resident, notify the physician, notify the family/responsible party, and notify the DON and the Administrator. The incident investigation was to be initiated by the charge nurse. The charge nurse was to interview the staff and take written statements if the DON was not in the facility. The	F 323		

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F 323	Continued From page 9 DON stated the root cause of an incident was determined by gathering information related to how the incident occurred. The information was reviewed in the morning meeting and if the cause was not clear, the staff were interviewed. The intervention was determined by the group attending the morning meeting and was specific to the issue which caused the incident. The DON stated the care plan revision was the responsibility of the MDS Coordinator and the nurses. The nurses were expected to make changes and update the Care Plan as to whether the interventions were effective or ineffective.	F 323			