

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

PRINTED: 09/30/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/17/2015
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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 40240
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F 000	INITIAL COMMENTS An Abbreviated Survey (KY#23798, KY#23804, and KY#23805) was conducted on 09/16/15 through 09/17/15. KY#23804 and KY#23805 were unsubstantiated with no deficient practice identified. KY#23798 was substantiated with deficient practice identified at the highest Scope and Severity of a "D".	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 151 SS=D	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. 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 ensure the rights of one (1) resident in the selected sample of three (3) residents (Resident #1), related to a dinner meal tray not being served to the resident upon his/her request. A family member of Resident #1's roommate had brought restaurant food in to the facility for Resident #1, and when the dinner trays arrived, Licensed Practical Nurse (LPN) #3 withheld the resident's meal tray in an attempt to follow a prescribed diet order for Resident #1. The findings include: Review of the facility's policy and procedure, titled	F 151	F 151 483.10(a)(1)&(2) Right to Exercise Rights- Free of Reprisal Corrective Measures for Resident[s] identified in the deficiency Resident #1 was offered a tray from facility by SRNA on the night of 9/2/15 when she told SRNA that she did not get a tray and that she wanted one. LPN #3 was placed on immediate investigative leave on the date of 9/3/15. How Other Resident[s] Who May Have Been Affected by this Practice were Identified Charge nurses on duty verified all other residents had received their supper tray on the night of 9/2/15. Measures Implemented/ Systems Altered to Prevent Re-occurrence Licensed nurse and nurse aides were educated by the staff development coordinator regarding offering a resident a tray even if food was brought in from the outside. Also, all staff were educated on resident rights. All education began on 9/3/15.	10/7/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordan Haden TITLE: NHA (X6) DATE: 10/15/15

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

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F 151	<p>Continued From page 1</p> <p>"Rights of Nursing Home Residents", (not dated), revealed "Our residents have the right to be treated with respect and dignity and to make choices about how they want to live their lives and receive care".</p> <p>Record review revealed the facility admitted Resident #1 on 02/18/12 with diagnoses which included Hypertension, Diabetes Mellitus Type II, Hyperlipidemia, Arthritis, Cerebrovascular Accident, Anxiety, Depression, Neuropathy, Insomnia, and Obesity.</p> <p>Review of the annual Minimum Data Set (MDS) assessment, dated 03/27/15, revealed Resident #1 had a Brief Interview Mental Status (BIMS) score of fifteen (15), indicating the resident was capable of making daily decisions.</p> <p>Review of the Comprehensive Care Plan, dated 04/01/15, revealed Resident #1 was at risk for altered nutrition risk related to Congestive Heart Failure, Diabetes, Hypertension, and Obesity. An approach was to provide a Low Concentrated Sweets (LCS)/No Added Salt (NAS) diet with no fried foods, as ordered by the physician.</p> <p>Review of the Physician's orders, dated 09/01 through 09/30/15, revealed an order for a LCS/NAS diet with thin liquids.</p> <p>Review of the facility's investigation report, dated 09/02/15, revealed the resident reported an allegation of not receiving his/her dinner meal tray because "the nurse was jealous" of him/her getting outside food brought in by another resident's family.</p> <p>Observation and interview with Resident #1, on</p>	F 151	<p>LPN #3 received individual education regarding resident rights to include the right to refuse prescribed diet. LPN #3 also received education on providing a tray to resident regardless of what food has been brought in for them by visitors.</p> <p>Monitoring Measures to Maintain On-going Compliance</p> <p>The Activities Director will ask residents at monthly Resident Council Meeting if meal choices are being honored by staff x3 months. Random interviews will be conducted with at least 10% of residents by Social Service Director weekly x 4 weeks to ensure rights and meal service choices are being honored. All started education will be included in new hire orientation. Findings will be reported to Quality Assurance Committee by Administratorat Monthly QA. The Quality Assurance committee consists of Medical Director, NHA, DON, Social service director, Staff educator, Unit Managers (3 total), Admissions coordinator, and MDS nurses.</p>		

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F 151	<p>Continued From page 2</p> <p>09/16/15 at 7:00 AM, revealed him/her sleeping while sitting up in a wheel chair in his/her room. He/she awakened when the surveyor knocked on the door and he/she began to speak about the 09/02/15 alleged occurrence. Interview with Resident #1 revealed a resident's family member had brought him/her some food from a restaurant and he/she ate the food. The resident stated he/she went to sleep afterward. The resident revealed he/she woke up around 8:00 PM and realized he/she had not received a dinner tray. The resident stated he/she asked the Certified Nurse Aide (CNA) who came in the room about his/her dinner tray. The resident stated the CNA told him/her it was sent back to the kitchen per LPN #3's instruction, because he/she had already eaten food that was brought in to him/her. Further interview with Resident #1, on 09/17/15 at 7:13 AM, revealed he/she did not think LPN #3 was attempting to follow a diet order. He/she revealed LPN #3 had closed the door to his/her room, and he/she was unable to open the door easily related to a stroke. The resident revealed he/she was unsure if the door was that difficult to open, or if he/she had gotten stronger because he/she was able to open the door now.</p> <p>Interview with LPN #3, on 09/17/15 at 3:23 PM, revealed she withheld Resident #1's tray on the evening of 09/02/15, because Resident #1 had received food from an outside source, and the physician had ordered restrictions on the resident's diet related to his/her heart condition and obesity. LPN #3 stated she was attempting to follow the prescribed diet order. She revealed Resident #1 had been to the cardiologist and had several stints placed in to his/her heart, and following a prescribed LCS/NAS diet was in his/her best interest. She revealed she made an</p>	F 151		

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F 151	<p>Continued From page 3</p> <p>error in judgment by withholding the dinner tray as it was Resident #1's right to be served a dinner tray.</p> <p>Interview with the Registered Dietitian (RD), on 09/17/15 at 9:15 AM, revealed Resident #1's diet order was prescribed by the physician because he wanted the resident to lose weight; however, withholding the resident's dinner tray was a violation of the resident's rights.</p> <p>Interview with the Director of Nursing (DON), on 09/17/15 at 4:35 PM, revealed Resident #1 had the right to have his/her meal tray regardless of his/her diet.</p> <p>Interview with the Administrator, on 09/17/15 at 4:20 PM, revealed she expected resident rights to be practiced and LPN #3 should have given Resident #1 his/her meal tray.</p>	F 151		
F 282 SS=D	<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 interview, record review, and review of the facility's Standards of Practice, it was determined the facility failed to ensure the care plan was followed for one (1) resident in the selected sample of three (3) residents (Resident #1), related to not allowing the resident to make his/her own decisions. On 09/02/15, Resident</p>	F 282	<p>F 282 483.20 (k)(3)(ii) Services by Qualified Persons/Per Care Plan</p> <p>Corrective Measures for Resident(s) Identified in the Deficiency</p> <p>Resident #1 was offered a tray by facility when resident #1 made SRNA aware that she didn't receive a tray and wanted one.</p> <p>How Other Resident(s) Who May Have Been Affected by this Practice were Identified</p> <p>An audit of all residents with dietary refusals were reviewed. No issues were noted with resident choices not being honored.</p>	10/7/15

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F 282	<p>Continued From page 4</p> <p>#1's meal tray was withheld because the resident had food brought in to the facility from an outside source; however, an approach on the care plan, dated 04/07/15, revealed Resident #1 was able to make daily decisions regarding meals.</p> <p>The findings include:</p> <p>Review of the facility's Standards of Practice (Clinical Nursing Skills, Basic to Advanced Skills, Sixth Edition), not dated, revealed "Care plans are written guidelines for client care that all health care workers use to deliver individualized care".</p> <p>Record review revealed the facility admitted Resident #1 on 02/18/12 with diagnoses which included Hypertension, Diabetes Mellitus Type II, Hyperlipidemia, Arthritis, Cerebrovascular Accident, Anxiety, Depression, Neuropathy, Insomnia, and Obesity.</p> <p>Review of the annual Minimum Data Set (MDS) assessment, dated 03/27/15, revealed Resident #1 had a Brief Interview Mental Status (BIMS) score of fifteen (15), indicating the resident was capable of making daily decisions.</p> <p>Review of the Comprehensive Care Plan, dated 04/07/15, revealed Resident #1 was alert and oriented, able to make his/her needs known, and make daily decisions regarding his/her care. An approach on the care plan revealed Resident #1 made daily decisions regarding meals.</p> <p>Interview with the Director of Nursing (DON), dated 09/17/15 at 4:35 PM, revealed the care plan should have been followed and the resident should have been allowed to have a meal tray as he/she so desired.</p>	F 282	<p>Measures Implemented/Systems Altered to Prevent Reoccurrence</p> <p>All staff were educated by staff development coordinator regarding resident rights starting on 9/3/15. Also, all nursing staff were educated regarding following a residents care plan. This education was initiated on 9/3/15.</p> <p>Monitoring Measures to Maintain On-going Compliance</p> <p>The Activities Director will ask residents at monthly Resident Council Meeting if meal choices are being honored by staff x3-months. The SSD will randomly interview residents to ensure meal preferences are being honored weekly x 4 weeks. At least 10% of resident population will be interviewed. Findings will be reported to Quality Assurance Committee by Administrator at Monthly QA.</p>		

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F 282	Continued From page 5 Interview with the Administrator, on 09/17/15 at 4:20 PM, revealed she expected staff to follow the care plan and allow the resident the right to make his/her own decisions.	F 282			