

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

PRINTED: 11/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C. 10/28/2010
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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F 000	INITIAL COMMENTS A Recertification Survey and an Abbreviated Survey investigating ARO#KY00014849, ARO#KY00015016, ARO#KY00015290, ARO#KY00015289, ARO#KY00015486, ARO#KY00015487, ARO#KY00015489, ARO#KY00015488, and ARO#KY00014848 was initiated on 10/26/10 and concluded on 10/28/10. Deficiencies were cited on the Standard Survey. ARO#KY00014849 and KY00015016 were substantiated with deficiencies. ARO#KY00015486, KY00015489, and KY00015488 were substantiated with unrelated deficiencies. ARO#KY00014848, KY00015290, and KY00015289 were unsubstantiated with no deficiencies. ARO#KY00015487 was unsubstantiated with unrelated deficiencies. A Life Safety Code inspection was conducted 10/26/10. The highest scope and severity cited was an "F".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bridge Point Care & Rehabilitation Center does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 174 SS=D	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure privacy was provided for residents' phone calls for one (1) of twenty-six (26) sampled residents (Resident #25). The findings include: Review of the clinical record revealed Resident	F 174	1. Resident #25 had a phone installed in his room on 10/28/10 to use when making private phone calls. A cordless phone was installed on the 100 nurse's station during survey for private resident use. 2. Review of center grievance files and resident council minutes for the last 3 months by the center administrator on 11/5/10 revealed that while other residents had the potential to be affected none were identified with concerns related to privacy use of phone.	12/10/10

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/17/10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 174	<p>Continued From page 1</p> <p>#25 was admitted to the facility on 08/26/10 with diagnoses of Chronic Respiratory Failure, Anxiety, Depression and Cancer. Observation during the Group Meeting on 10/26/10 and in the resident's room, revealed the resident used a modulator at his/her throat for verbalization.</p> <p>Review of the Quarterly Minimum Data Assessment (MDS) dated 08/06/10, revealed the facility assessed Resident #25 as being alert and oriented and Independent in decision-making and cognition. Further review of the MDS revealed the facility assessed the resident's communication ability as "understands" others, and as being "usually understood" by others.</p> <p>Observation on 10/27/10 at 3:00 PM revealed Resident #25 at the nurse's station on the 100 Hall using the desk telephone. The resident was using a modulator for verbalization.</p> <p>Interview on 10/28/10 at 10:00 AM with the resident and the resident's spouse revealed the resident had a problem with having no privacy provided for personal phone calls. Resident #25 did not have a phone in his/her room and the resident's spouse stated they could not afford a cell phone for the resident.</p> <p>Resident #25 stated, "It bothers me. I'd rather have a private place to make and receive phone calls to and from my (spouse)."</p> <p>During the interview with Licensed Practical Nurse (LPN) #6 on 10/27/10 at 11:00 AM she stated, "we had a cordless phone for residents to use in their rooms before the new construction. But we lost the line for the cordless phone. We also used to have an area in therapy with a phone</p>	F 174	<p>3. Residents were provided with instruction regarding the availability of the cordless phone in resident council which was held on October 26, 2010. Framed sign was posted has been posted at each nurse's station on 11/19/10 to further inform residents of the availability of the cordless phone for private use. All staff was provided with additional re-education on 11/18/2010 by the Director of Nursing Services/DON on availability of cordless phones on each unit, requested to inform nursing management if cordless phone is missing or equipment malfunctions, and were re-educated regarding the importance of providing resident privacy when making phone calls. As an additional measure, residents attending monthly resident council meetings will be asked if they are able to make phone calls in private on an ongoing basis.</p> <p>4. The Social Services Director/ Activities Director will conduct an audit of residents 3 times per week for 4 weeks to determine if residents are being provided with privacy when making phone calls. Any deficient practice will be corrected immediately. Audit findings will be forwarded to the DON and Administrator, who will initiate further follow-up as indicated and present findings at the monthly Performance Improvement (PI) meeting. Frequency of audits after initial auditing will be</p>	
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F 174	<p>Continued From page 2 but that was lost in the construction, too."</p> <p>Interview with LPN #5 revealed, "The residents absolutely should have access to private phone calls".</p> <p>Interview with the Administrator on 10/27/10 at 1:00 PM revealed the facility's cell phone for the 100 Hall was not available because a staff member had taken it home. He stated there should have been a cell phone on each unit in addition to a cordless phone on each unit.</p> <p>Observation revealed there was no cordless phone or cell phone on the 100 Hall which residents could use in privacy. Observation revealed there was no phone in Resident #25's room and none in Rooms 101 through 107. The only phone observed to be available to residents on the 100 Hall was the desk phone (with a cord) at the nurse's station.</p>	F 174	<p>determined based on findings and PI team recommendations.</p> <p>Compliance Date 12/10/10</p>	
F 250 SS=E	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure social services were provided to attain and maintain the highest practicable well being for four (4) of twenty-six (26) sampled residents (Resident #2, #5, #6 and #15). Resident #2 was assessed as</p>	F 250	<p>1. Resident #2, #5 and #15 charting in medical record was updated between 10/29/10-11/4/10 by Social Services to reflect missing monies report, investigation, social work follow-up and resident education and resolution. Resident #6's Social Services assessment and care plan were updated and revised to accurately reflect his negative mood and behavior issues and care interventions by the Social Worker on 10/29/2010.</p>	12/1/10

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F 250	<p>Continued From page 3</p> <p>requiring supervision, and as having poor decision making skills. The resident was assisted to the bank by the Social Worker, who failed to provide supervision of the bank transaction and was unaware of the amount of money which was withdrawn. This resulted in lost monies of approximately \$980.00. Further, the Social Worker failed to document in the medical record related to missing monies for Residents #5 and #15. In addition, the Social Worker failed to address negative behaviors exhibited by Resident #6.</p> <p>The findings include:</p> <p>1. Resident #2 was admitted to the facility on 10/17/08 with diagnoses which included Persistent Mental Disorder, Anxiety, Depression and Psychosis. Review of the Annual Minimum Data Set (MDS) Assessment dated 06/16/10 revealed the facility assessed the resident as having short and long term memory deficits, as being moderately impaired with cognitive skills for daily decision making; and, as requiring cues/supervision due to poor decisions. Continued review of the MDS revealed the facility assessed the resident as having a deterioration in cognitive status.</p> <p>Review of the Interdisciplinary Progress Notes dated 06/04/10, revealed the Social Worker transported Resident #2 to the bank, waited in the lobby, and failed to provide the resident with the needed supervision while Resident #2 made the transaction. After leaving the Bank, the Social Worker went through the drive-thru at a local restaurant and Resident #2 paid with a \$20.00 bill. The Social Worker then returned the resident to the facility, and later the same day, informed</p>	F 250	<p>2. All residents with reportable events and documented behaviors have been reviewed to ensure Social Service documentation by the Social Worker. Social Services assessments and care plans have been reviewed by Social Services and with IDT team input for current residents and revised as necessary to determine substantial compliance. This was completed on or before 11/23/2010.</p> <p>3. The nursing staff and Social Services staff was provided with re-education on 10/28/2010 by Administrator on the expectation that Social Services needs to document on any grievance/reportable event of resident in medical record. Nursing staff were re-educated on 11/18/2010 by ADON/DON regarding the importance of reporting negative resident mood and behaviors during morning meeting and on 24 hour report.</p>	

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F.250	<p>Continued From page 4</p> <p>the resident of the need to place the money in the facility's safe. However, Resident #2 stated, he/she would place the money in the safe if he/she didn't leave town.</p> <p>Further review of the Interdisciplinary Progress Notes dated 06/07/10, revealed the Social Worker checked on Resident #2 and the resident informed the Social Worker about the missing monies which the resident had kept in the bank envelope. Further review of the Notes revealed, Resident #2 and the Social Worker called the Bank and verified Resident #2 had withdrawn \$1,000.00. The Social Worker did not search for the monies until the next day, 06/08/10.</p> <p>Review of the Interdisciplinary Progress Notes dated 06/08/10 revealed the Social Worker completed a search of Resident #2's room and Resident #2's roommate's room "without positive results". The Interdisciplinary Notes ended on 06/08/10 and there was no follow up documented.</p> <p>Interview on 10/28/10 at 10:10 AM with Resident #2, revealed that he/she had lost approximately \$1,000.00 the night after withdrawing the monies. The resident stated, "the money went missing from my nightstand drawer, it was in a bank envelope". Resident #2 also stated, he/she had never received a lock box for the monies and the facility had never reimbursed Resident #2 for any of the lost monies.</p> <p>Interview on 10/28/10 at 1:45 PM, with Resident #2's daughter revealed she was never informed about the missing monies, and as of October 6 th, 2010, had Power of Attorney.</p> <p>Interview with the Social Worker involved in the</p>	F 250	<p>4. Social Services will complete a follow-up audit of documentation, assessments and care plans on 5 residents per week for 4 weeks to ensure grievances/reportable events and behaviors are addressed. Completed audits will be forwarded to the DON and Administrator, who will initiate further follow-up as indicated and present findings at the monthly PI meeting. Frequency of audits after initial auditing will be determined based on findings and PI team recommendations. Deficient practice will be corrected immediately.</p> <p>5. Compliance Date 12/10/10</p>	

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F 250	<p>Continued From page 5</p> <p>case, revealed the she did remain in the lobby instead of supervising Resident #2 while the transaction was made. The Social Worker also revealed she did not know how much money was stolen and she didn't know how much money was withdrawn until she and Resident #2 called the Bank. When asked about letting Resident #2 take the monies to the room, the Social Worker stated, she "did not know what Resident #2 would do with the monies". The Social Worker also stated, "some days the resident gets confused".</p> <p>Interview with the Administrator on 10/28/10 at 1:25 PM, revealed he was unaware Resident #2 had monies and stated "we would have educated or given options, had we known about the withdrawal". Further interview revealed, "the way we knew how much it was, was because the Social Worker called the bank". The Administrator also stated, "the money had not been replaced due to the amount".</p> <p>2. Record review revealed Resident #5 was admitted to the facility on 04/16/08 with diagnoses which included Chronic Kidney Disease, Depression, and Congestive Heart Failure.</p> <p>Review of the Quarterly Minimum Data Assessment (MDS) Assessment dated 08/17/10, revealed the facility assessed Resident #5 as being alert, having short and long term memory impairment, and modified independence for daily decision making.</p> <p>Review of the facility's investigation revealed on 07/16/10, Resident #5 reported missing \$10.00 from his/her pocketbook. Further review of the investigative report revealed the facility conducted an investigation, replaced the missing \$10.00 and</p>	F 250			

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F 250	<p>Continued From page 6</p> <p>educated the resident on using the facility provided resident account system for safe keeping of personal spending money.</p> <p>Review of Resident #5's clinical record revealed no evidence Social Services had addressed the missing money. Interview with the facility's Social Worker on 10/28/10 at 1:30 PM revealed she had conducted an investigation and educated Resident #5 on the use of the facility's resident account system. However, there was no documented evidence in the clinical record of the incident or the education provided to Resident #5. Further interview with the facility's Social Worker revealed she should have noted this incident and resident education in the clinical record.</p> <p>3. Record review revealed Resident #15 was admitted to the facility on 04/08/10 with diagnoses which included Chronic Back Pain, Atrial Fibrillation, Chronic Ischemic Heart Disease, Depression, Left Bundle Branch Block, Diabetes and Chronic Respiratory Failure.</p> <p>Review of the Significant Change Minimum Data Set (MDS), with an assessment date of 09/02/10, revealed the facility assessed Resident #15 as being independent in cognitive skills for daily decision making and not having any short or long term memory deficits.</p> <p>Review of the facility's investigation revealed on 10/06/10, Resident #15 reported missing thirty (\$30.00) from his/her top dresser drawer in his/her room. Further review of the investigative report revealed the facility conducted an investigation, gave Resident #15 a metal lock box and educated Resident #15 on using the facility's</p>	F 250		

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F 250	<p>Continued From page 7</p> <p>resident account system for safe keeping of personal spending money.</p> <p>Review of Resident #15's clinical record revealed no documented evidence Social Services had addressed the missing money. Interview with the facility's Social Worker on 10/28/10 at 1:30 PM revealed she had conducted an investigation, given Resident #15 a metal lock box and educated him/her on the use of the facility's resident account system. Further interview with the facility Social Worker revealed she should have noted the incident and resident education in the clinical record.</p> <p>4. Record review revealed Resident #6 was admitted to the facility with diagnoses which included Lumbago, Shortness of Breath, Anxiety and Generalized Pain.</p> <p>Review of the Significant Change Minimum Data Set (MDS), with an assessment date of 07/16/10, revealed the facility assessed Resident #6 as being independent related to decision making skills and was reasonable. The facility assessed the resident as having no behavioral issues on the 07/16/10 MDS. The resident's behaviors, such as refusing care and safety alarms, were addressed on the 07/16/10 Care Plan.</p> <p>Review of Interdisciplinary Progress Notes and Nurses Notes from 07/19/10 to 10/11/10, after the 7/16/10 MDS, revealed Resident #6 often refused care and medications. The resident was an extreme falls risk but was non-compliant with alarms to his/her bed and chair. The resident was noted to often be hostile with combative behaviors towards staff. These behaviors included cursing, yelling and hitting, as well as</p>	F 250		
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F 250	<p>Continued From page 8 removing and cutting cords to safety alarms.</p> <p>Interview with Registered Nurse (RN) #6, who worked on the resident's unit, revealed that on 09/13/10 between 6:00 PM and 7:00 PM the resident's alarms were going off and she and Certified Nurse Assistants (CNA's) # 6 and #7 responded. RN #6 stated she found the resident up unassisted and tried to assist him/her back to bed. The resident yelled and cursed at RN #6 and then grabbed her and hit her.</p> <p>Interview with CNA #7 on 10/27/10 at 5:15 PM revealed she witnessed the resident grabbing and hitting RN #6.</p> <p>Interview with CNA #6 on 10/27/10 at 5:30 PM revealed the resident got very aggressive with RN #6 on 09/13/10 and was cursing her and threatening her with his fist. CNA #6 revealed that she asked the resident to stop. She said she was in the hall, not in the resident's room, when the resident hit RN #6. CNA #6 said the RN had been trying to explain that the resident must not get up without assistance related to safety issues. This CNA indicted the nurse was trying to get the resident to sit down when he/she became so hostile and aggressive.</p> <p>Interview on 10/27/10 at 5:40 PM with Resident #13 revealed that he was in the hall in his wheelchair outside Resident #6's room when he witnessed Resident #6 yelling, cursing and hitting the nurse who was trying to get him to sit down. Resident #13 revealed that he/she yelled for help because of the fear for Nurse #6's safety. Further interview with Resident #13 revealed he/she had often seen Resident #6 angry, aggressive and violent with facility staff.</p>	F 250		

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F 250	Continued From page 9 Review of Resident #6's Care Plan revealed that Social Services assessed the resident as alert, communicates needs and as being pleasant and cooperative with staff. Interview with the Social Worker on 10/27/10 at 2:30 PM revealed she has not experienced anything negative with Resident #6, never had a problem with the resident and never witnessed any negative behavior with staff. She revealed that she though it was just a personality conflict with Nurse #6. The Social Worker indicated that she had heard others say the resident demonstrated behaviors but that was not her experience with this resident. Interview with the MDS Nurse, Licensed Practical Nurse (LPN) #7, on 10/28/10 at 11:00 AM revealed in her experience Resident #6 was not pleasant or cooperative with staff. She stated that it was hard to get the resident to cooperate when she was doing the resident's quarterly MDS assessment in October. LPN #7 did not do the MDS assessment in July.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	1. Resident #7's MDS and care plan reflects that she has limited range of motion in her right hand and she does not use side rails. 2. The nursing management team and the MDS nurse with input from therapy have reviewed all of the residents assessments on or before 11/23/2010 and determined that assessments are complete, accurate, match care plan interventions and are in substantial compliance.	12/10/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/28/2010
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 278	<p>Continued From page 10</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the Comprehensive Assessment accurately reflected the resident's status for one (1) of twenty-five (25) sampled residents (Resident #7).</p> <p>The findings include:</p> <p>Review of Resident #7's medical record revealed diagnoses which included Infantile Cerebral Palsy. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 08/05/10 revealed the facility assessed the resident as using bed rails for bed mobility and transfer.</p> <p>Observation of the resident on 10/26/10 at 1:25 PM revealed the resident was in bed and there were no side rails noted on the bed.</p> <p>Review of the "Device Evaluation" dated 08/06/10 revealed the section labeled "side rail</p>	F 278	<p>3. The MDS staff was provided with additional re-education by the Assistant Director of Nursing (ADON)/Director of Nursing (DON) during the survey and on 11/18/2010 regarding the importance of accurate assessments of care areas and knowledge of residents status, needs, strengths, and areas of decline. The resident comprehensive assessments will be reviewed for accuracy during weekly CARE meetings ongoing.</p> <p>4. The MDS nurse and/or Unit manager will audit 5 comprehensive assessments to ensure accuracy 3X per week for the next 4 weeks. Any deficient practice will be corrected immediately. Audit findings will be forwarded to the DON, who will initiate further follow-up as indicated and present findings at the monthly Performance Improvement meeting for further evaluation.</p> <p>5. Compliance date 12/10/10</p>		

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F 278	<p>Continued From page 11</p> <p>evaluation/interventions attempted to date" was not checked to denote the resident had side rails.</p> <p>Review of the Comprehensive Plan of Care dated 08/07/10 revealed the resident had the potential for falls and the interventions included side rail while in bed as an enabler.</p> <p>Interview on 10/28/10 at 12:30 PM with the MDS Coordinator, revealed she had completed the Significant Change MDS Assessment dated 08/05/10. Continued interview revealed she must have observed side rails on the bed at the time she was completing the MDS Assessment. She further stated the "Device Evaluations" were completed by the Unit Managers.</p> <p>Interview on 10/28/10 at 1:45 PM with the Unit Manager assigned to Resident #7, revealed the resident had not had a side rail on the bed since she had been on the unit, and she had worked on the unit since 12/09. She further stated she had completed the "Device Evaluation" dated 08/08/10 and had not marked the resident as having a side rail on the bed. Further interview revealed the MDS Coordinator should have "caught it" while completing the MDS dated 08/05/10.</p> <p>Further review of the Significant Change MDS Assessment dated 08/05/10 revealed the facility assessed the resident as having no functional limitation in Range of Motion (ROM) or voluntary movement.</p> <p>Observation of the resident during a skin assessment on 10/27/10 at 10:00 AM with Licensed Practical Nurse (LPN) #4/Wound Nurse revealed the resident's left hand was closed.</p>	F 278		

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F 278	<p>Continued From page 12</p> <p>Further observation revealed the resident was unable to extend the left hand to full range of motion.</p> <p>Review of the Occupational Therapy Evaluation dated 12/02/09 revealed the resident had decreased left fine motor skills related to trigger finger.</p> <p>Observation of Resident #7 with the Occupational Therapist (OT) and Interview with the OT on 10/28/10 at 1:30 PM, revealed the resident had full ROM in the first and second digits of the left hand, and tightness and arthritic deformity in the third and digits of the left hand. Further interview with the OT on 10/28/10 at 5:00 PM revealed the resident did not have a contracture; however, had trigger finger which was an inflammation at the tendon sheath. She further stated a splint or ROM would not prevent the trigger finger from getting worse.</p> <p>Interview on 10/28/10 at 12:30 PM with the MDS Coordinator on 10/28/10 revealed she performed ROM on residents prior to completing the MDS to ensure there were no concerns related to ROM. She further stated she had completed the Significant Change MDS on 08/06/10 and had not noted limitations in ROM or voluntary movement of the resident's left hand.</p>	F 278		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable</p>	F 279		

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F 279	<p>Continued From page 13</p> <p>objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure Comprehensive Plans of Care were developed to meet the residents' medical and nursing needs for one (1) of twenty-six (26) sampled residents (Resident #7).</p> <p>The findings include:</p> <p>Review of Resident #7's medical record revealed diagnoses which included Infantile Cerebral Palsy and a History of Falls. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 08/05/10 revealed the facility assessed the resident as having no falls the past thirty (30) days or the past one hundred and eighty (180) days. Further review of the MDS revealed the facility assessed the resident as using bed rails for bed mobility and transfer.</p> <p>Observation of the resident on 10/26/10 at 1:25</p>	F 279	<p>1. Resident #7 is not using side rails on bed. The plan of care was corrected on October 27, 2010 by unit manager to reflect no side rails were being used.</p>	12/20/10
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F 279	<p>Continued From page 14</p> <p>PM revealed the resident was in bed and a bed alarm was in place. There were no side rails noted on the bed.</p> <p>Review of the "Device Evaluation" dated 08/08/10 revealed the section labeled "side rail evaluation/interventions attempted to date" was not marked to denote the resident had side rails.</p> <p>Review of the Comprehensive Plan of Care dated 08/07/10 revealed the resident had the potential for falls related to incontinence of bowel and bladder, required extensive to total assistance with bed mobility, toileting, and transfers, and was non-ambulatory. The interventions included side rail while in bed as an enabler.</p> <p>Interview on 10/28/10 at 12:30 PM with the MDS Coordinator, revealed she had completed the MDS dated 08/05/10. She further stated she completed the Care Plans on Admission, Quarterly, Annually, and with a Significant Change Assessment. She further stated the staff nurses were responsible for revising the Plans of Care between Assessments. Continued interview revealed she must have observed side rails on the bed at the time she was completing the 08/05/10 Significant Change MDS Assessment. She stated the MDS Coordinators did not complete the "Device Evaluation", and those forms were completed by the Unit Managers.</p> <p>Interview on 10/28/10 at 1:45 PM with the Unit Manager assigned to Resident #7, revealed she had been on the unit since 12/09, and the resident had not had a side rail on the bed since she had been on the unit. She stated she had completed the "Device Evaluation" dated 08/06/10 and had not marked the resident as</p>	F 279	<p>2. The nursing management team along with the interdisciplinary team reviewed and updated the residents' comprehensive care plans on or before 12/4/10 to reflect the current status of residents' care.</p> <p>3. The MDS nurse and nursing staff were provided with additional re-education by the ADON/ DON during survey and on 11/18/2010 regarding the importance of reviewing comprehensive care plans for accuracy to reflect resident's level of care.</p> <p>4. The MDS nurse and/or Unit Manager will conduct an audit of 5 residents' comprehensive care plans, matching care plans to identified needs via the comprehensive assessment, per week for 4 weeks to determine care plan reflects residents care needs. Deficient practice will be corrected immediately. Audit findings will be forwarded to the DON, who will initiate further follow-up as indicated and present findings at the monthly PI meeting. Frequency of audits will be determined based on findings and PI team recommendations.</p> <p>5. Compliance Date 12/10/10</p>	

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F 279	Continued From page 15 having a side rail on the bed. Further interview revealed the MDS Coordinator should have "caught it" when she completed the MDS dated 08/05/10.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(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 and record review it was determined the facility failed to review and revise the Comprehensive Care Plan for three (3) out of twenty-six (26) sampled residents (Resident #7, #13 and #20). Resident #7 had a Care Plan developed which stated the resident was to be assisted with meal set up and supervision for completion of the meals.	F 280			

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F 280	<p>Continued From page 18</p> <p>However, observation and interview revealed the resident was fed by staff. Resident #13's Care Plan indicated the use of weighted utensils and cup however, the Care Plan was not revised to show discontinuation of these devices. Resident # 20 had a Care Plan developed for an infection which interview revealed the resident no longer had.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of Resident #20's medical record revealed diagnoses which included Depressive Disorder, Constipation, Dysphagia, and Aphagia due to a Cerebrovascular Accident. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/18/10 revealed the resident was assessed by the facility as having Clostridium Difficile Infection. <p>Review of the Comprehensive Care Plan dated 09/26/10 revealed the facility had developed a Care Plan related to the resident's alteration in bowel elimination; diarrhea related to Clostridium Difficile infection. Interventions included to administer anti-diarrheal medication, record bowel movements and administer antibiotic as ordered.</p> <p>Review of the Medication Administration record for Resident #20 revealed no order for the use of an anti-diarrheal or antibiotic and was not receiving either medication per review of the resident's record.</p> <p>Interview with Registered Nurse (RN) #1, Unit Manager for the one-hundred (100) hall and this resident, on 10/28/10 at 10:30 AM revealed she was responsible for updating the Care Plan in this case because the antibiotic had been completed</p>	F 280	<ol style="list-style-type: none"> 1. Resident #7's care plan was updated by unit manager on 10/27/2010 to reflect that she requires to be fed by staff at each meal. Resident #13's care plan was updated 10/27/10 by unit manager to reflect that divided plate was the only adaptive eating equipment ordered. Resident #20's care plan was updated by unit manager on 10/28/10 to indicate resolution of C-diff. 2. The nursing management team and MDS nurse completed an audit of all resident plans of care, revised and updated as necessary to reflect current resident status on or before 11/23/10. Care plans were determined to be in substantial compliance 3. The nursing staff was provided with additional re-education by ADON/DON on 11/18/2010 to reinforce the importance of revising plans of care with any changes in resident orders/change in conditions. 4. The MDS nurse and/or Unit Manager will conduct an audit of 5 residents' comprehensive care plans per week for 4 weeks to determine care plan accurately 	12/10/10

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F 280	<p>Continued From page 17</p> <p>and the Infection resolved after the care plan was reviewed.</p> <p>2. Resident #13 was admitted to the facility on 08/02/10 with diagnoses which included Pressure Ulcer, Arthropathy Hand, Paraplegia, Depression and Chronic Obstructive Pulmonary Disease.</p> <p>Observation of Resident #13 on 10/26/10 at 5:15 PM, and again on 10/27/10 at 8:00 AM and 12:30 PM revealed the resident's meal was served on a divided plate, as ordered.</p> <p>Review of Resident #1's Physician orders dated 09/29/10, revealed the following order with a start date of 09/18/10, " Resident to have divided plate with meals". Review of Resident #13's Self Care Deficit Plan of Care (POC) revealed " Resident has range of motion (ROM) deficits in legs, feet, arms and left hand, has tremor to right hand and has order for weighted utensils, cup and divided plate". The POC was dated as reviewed on 08/26/10. Further review of the Physician orders revealed no order for weighted utensils or cup. Review of the resident's medical record revealed the resident was readmitted from the hospital on 09/18/10 and the POC had not been updated/revised to include Resident #13's current physician orders.</p> <p>Interview with the Minimum Data Set (MDS) Nurse/RN #5 on 10/28/10 at 2:25 PM revealed she completes the initial POC and updates the POC with significant change and quarterly assessments. RN #5 stated the Unit Manager and floor nurses were to update the POC for all other changes.</p> <p>Interview with the Unit Manager, RN #1 on 10/28/10 at 2:35 PM, revealed the floor nurses</p>	F 280	<p>reflects residents care needs. Deficient practice will be corrected immediately. Audit findings will be forwarded to the DON, who will initiate further follow-up as indicated and present findings at the monthly PI meeting. Frequency of audits after initial auditing will be determined based on findings and PI team recommendations.</p> <p>5. Compliance date 12/10/10</p>	

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F 280	<p>Continued From page 18</p> <p>were to update the residents POC at the time an order was received. RN #1 indicated she was unaware as to why the POC had not been updated, and did not know the weighted utensils and/or the cup was on the POC.</p> <p>3. Review of Resident #7's medical record revealed diagnoses which included Infantile Cerebral Palsy. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 08/05/10 revealed the facility assessed the resident as having severe impairment in cognitive skills for daily decision making and as being independent with eating.</p> <p>Review of the Comprehensive Plan of Care dated 12/15/09 and revised on 08/07/10 revealed the resident was at nutritional risk related to a diagnosis of Hypertension, polypharmacy, and had varied intakes. The interventions included assisting with meal set up as needed and supervising for completion.</p> <p>Observation of the resident on 10/26/10 at 6:20 PM revealed the resident was being fed by a Certified Nursing Assistant (CNA). Further observation of the resident on 10/27/10 at 8:20 AM revealed the resident was being fed per CNA #9.</p> <p>Interview on 10/27/10 at 10:00 AM with CNA #11 revealed the resident used to feed his/herself; however, the resident stopped feeding self about a month ago and now needed to be fed.</p> <p>Interview on 10/28/10 at 12:30 PM with the MDS Coordinator revealed she developed the Plans of Care with Quarterly and Comprehensive Assessments and at the time she completed the</p>	F 280		
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F 280	<p>Continued From page 19</p> <p>Significant Change MDS dated 08/05/10, the resident was feeding her/ himself. She further stated she was unaware the resident now needed to be fed, and the staff nurses were to revise the Plans of Care between Assessments.</p> <p>Interview on 10/28/10 at 1:45 PM with the Unit Manager assigned to Resident #7, revealed she had just talked with CNA #11 who had informed her the resident needed to be fed all the time. She further stated the aides should have informed the nurses so the Plan of Care could be updated to reflect the resident's decline in feeding status.</p>	F 280		
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 observation, record review and interview, it was determined the facility failed to follow written plans of care for two (2) of twenty six (26) sampled residents Resident #10 and #13). Resident #10 was care planned for the use of a Nosey cup and Resident #13's Plan of Care included to be up in a chair no more than three (3) hours.</p> <p>The findings include:</p> <p>1. Review of Resident #10's medical record revealed diagnoses which included Cerebral Vascular Accident and Aphasia.</p>	F 282	<p>1. Resident #10's nose cup was not reordered upon return from hospital on 9/27/2010. Resident # 10's plan of care was revised during survey by Unit Manager and nose cup discontinued. Resident #13's care plan was updated during survey and on 11/19/10 to reflect his non compliance with being in chair no more than 3 hours and that staff have educated him on risks and benefits of this decision.</p>	12/10/10

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F 282	<p>Continued From page 20</p> <p>Record review of Resident #10's Comprehensive Plan of Care interventions included the resident should have Nosey cups for all liquids, to increase the resident's independence in self feeding.</p> <p>Observation of evening meal service on 10/26/10 and 10/27/10 revealed Resident #10 was not provided Nosey cups for liquids. Review of the resident's meal service ticket indicated the need for the use of the Nosey cups.</p> <p>Interview with the Dietary Manager on 10/27/10 at 5:15 PM revealed it was dietary staffs' responsibility to read the meal service ticket and ensure Resident #10 had the adaptive utensils.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 10/26/10 at 3:30 PM revealed Resident #10's Care Plan intervention for the use of the Nosey cups should have been followed by all staff, at all times.</p> <p>2. Review of Resident #13's medical record revealed diagnoses which included Pressure Ulcer, Arthropathy Hand, Paraplegia, Depression and Chronic Obstructive Pulmonary Disease.</p> <p>Review of Resident #13's Skin Plan of Care (POC) revealed the resident was bedfast related to pressure ulcers. The POC indicated an intervention that "the resident may be up in Geri chair for maximum of two (2) hours per day, per the Physician's orders".</p> <p>Observation of Resident #13 on 10/26/10 at 1:15 PM, revealed the resident was sitting up in a reclined Geri-chair. Continued observations on</p>	F 282	<p>2. The nursing management team along with the interdisciplinary team completed an audit of all resident care plans to ensure implementation of interventions and that services are provided by qualified persons in accordance with written plan of care on or before 12/4/10. We determined that no other residents were affected.</p> <p>3. The nursing staff was provided with additional re-education by the ADON/DON on 11/18/2010 to reinforce the importance of revising and following plans of care with any changes in resident orders/ resident conditions.</p> <p>4. The MDS nurse and/or Unit Manager will conduct an audit of 5 residents' comprehensive care plans per week for 4 weeks to determine care plan reflects residents care needs and that care plan is revised as needed and being followed. The audit will consist of reviewing the care plan and assessing resident to ensure interventions are in place. Deficient practice will be corrected immediately. Audit findings will be forwarded to the DON, who will initiate further follow-up as indicated and present findings at the monthly PI meeting. Frequency of audits will be determined based on findings and PI team recommendations.</p> <p>5. Compliance date 12/10/10</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/28/2010
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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F 282	<p>Continued From page 21</p> <p>10/26/10 at 2:45 PM, 3:15 PM, 4:00 PM, 5:00 PM, 5:15 PM and again on 10/27/10 at 12:30 PM, 1:30 PM, 2:30 PM, 3:30 PM, 4:30 PM and 5:30 PM revealed Resident #13 Plan of Care failed to be implemented related to the length of time he/she was to be sitting up in the Geri chair.</p> <p>Review of Resident #13's Physician orders dated 09/29/10, revealed the following order with a start date of 07/13/10, may sit in motorized wheelchair for three (3) hours maximum of two (2) times per day.</p> <p>Interview with the Minimum Data Set (MDS) RN #5 on 10/28/10 at 4:00 PM, revealed she had spoken with the physician and received orders for the Geri chair, max 3 hours a day. She indicated she would update the POC, right away.</p> <p>Interview with the Unit Manager, RN #1 on 10/28/10 at 4:30 PM, revealed she was not aware the resident's POC stated to only be up two (2) hours a day. She further stated it should be on the State Registered Nurse Aide (SRNA) POC and she would get it updated.</p>	F 282		
F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure medications were available and administered to one (1) of twenty-six (26) sampled residents, Resident #22, who was admitted at 1:30 PM on</p>	F 333	<p>1. Resident #22 was discharged from facility on 2/29/10 and readmitted on 3/5/2010 with no medication availability issues.</p> <p>2. An audit of all medication records was completed by Unit managers and ADON</p>	12/30/10

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F 333	<p>Continued From page 22 12/10/09 and did not receive ordered medication until 4:00 PM on 12/11/09.</p> <p>The findings include:</p> <p>Review of Resident #22's medical record revealed the resident was admitted to the facility on 12/10/09 at 1:30 PM with diagnoses of Muscular Sclerosis, Hypertension, Hemiplegia, Seizure Disorder, Anxiety Disorder, Bi-polar Disorder, Urine Retention and Muscle Weakness.</p> <p>Interview with the Assistant Director of Nursing (ADON), Registered Nurse (RN) #2, on 10/28/10 at 10:00 AM revealed Resident #22 transferred from home health care and the facility did not receive a definite order of medications prescribed for the resident until 3:30 PM on 12/10/09. At 3:37 on 12/10/09 PM, the facility faxed the order to the pharmacy. The ADON revealed that his shift had ended at 3:00 PM and he left the facility, transferring his duties to the next nurse on duty. RN #2 revealed that the medications did not arrive to be administered at the 4:00 PM medication pass because they were ordered so late. The medications missed at 4:00 PM were the following: Coreg 3.125 MG, Kepra 1000 and Kepra 500 MG, Naproxen 500 MG and Zanaflex 4 MG.</p> <p>Interview with the ADON on 10/29/10 at 10:10 AM revealed that Resident #22's medications did not arrive on 12/10/09 and no one called the pharmacy to check on them. The ADON revealed the resident also missed his/her medications at 8:00 AM on 12/11/09: Aspirin 81 MG, Coreg 3.125 MG, Ferrous Sulfate 325 MG, Flonase 50 MG, Kepra 1000 MG and Kepra 500 MG, Naproxen 500 MG, Omeprazole 20 MG,</p>	F 333	<p>on March 3, 2010. Medication records of current residents for November and December 2010 were audited with no significant medication errors noted on 12-10-10.</p> <p>3. The Nursing staff were re-educated by the ADON/DON on 11/18/2010 regarding expectation for follow-up with pharmacy, pulling initial dosage of medication from E-box, protocol of calling pharmacy to alert them of admission after 1 PM and documentation of contact made with pharmacy. Education also included contacting nurse manager for untimely delivery of medications. Pharmacy logs are being maintained on each unit to communicate and track needs from the pharmacy. This log will be reviewed daily by a nurse supervisor to ensure that items needed from the pharmacy are received timely.</p> <p>4. The Nurse Managers will audit medication availability and pharmacy logs for 3 new admissions per week for 4 weeks. Audit findings will be forwarded to the DON, who will initiate further follow-up as indicated and present findings at the monthly PI. Frequency of audits will be determined based on findings and PI team recommendations.</p> <p>5. Compliance Date 12/10/10</p>	

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F 333	<p>Continued From page 23</p> <p>Simvastin 40 MG, Zanaflex 4 MG, Fluoxetine 20 MG and Hydrochlorothiazide 12.5 MG.</p> <p>The ADON revealed after the medication pass on 8:00 AM on 12/11/09, with no medications administered to Resident #22, RN #3 ordered Resident # 22's medications to be delivered "stat" from the pharmacy.</p> <p>Record Review of the Pharmacy Requisition Report revealed the medications for Resident #22 were received from the facility on 12/10/09 at 3:38 PM</p> <p>Record review of the Shipment Summary revealed the medications were delivered to the facility on 12/11/09 at 2:20 PM.</p> <p>Record review of the 12/11/09 Medication Administration Report (MARS) revealed that Resident #22's medications were administered at 4:00 PM and 8:00 PM on 12/11/09.</p> <p>Interview with the ADON on 10/28/10 at 10:15 AM revealed he did not know why no one followed up and reordered Resident #22's medications "stat" on 12/10/09 when they were not available for the 12/10/10 4:00 PM medication pass. He did not know why RN #3 waited until 10:00 AM on 12/11/10 to order the medications "stat" for Resident #22. When asked what happened that the resident did not get his/her medications until approximately 26 hours after admission, the ADON stated "there must have been a breakdown" with the pharmacy.</p> <p>Record Review of facility policy regarding medication not available revealed the following directives:</p>	F 333		

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F 333	Continued From page 24 Upon discovery that a medication is unavailable, the licensed nurse should take action at once and not wait until the med pass is completed. The nurse should call the pharmacy and speak to a Registered Pharmacist to determine the status of the order. If not ordered, the nurse should place the order re-order to be sent with the next scheduled delivery. If the next available delivery causes delay or missed dose in the medication schedule, take the medication from the emergency stock supply to administer the dose. If the medication is not available in the emergency stock supply, notify the pharmacist and arrange for an emergency delivery. The facility failed to follow their policy regarding unavailable medications.	F 333		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to provide special eating utensils and equipment for one (1) of twenty six (26) residents, Resident #10. The findings include: Resident #10 was admitted on 07/01/05 with diagnoses that included: Diabetes, Cerebral Vascular Accident, Aphasia, an Depression and Congestive Heart Failure. Review of the Significant Change Minimum Data Set Assessment (MDS) dated 09/17/10 revealed	F 369	1. Resident #10 was reassessed by Occupational therapy on 10/28/10 and nose cup was deemed unnecessary at this time and removed from orders and resident tray card.	12/10/10

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F-369	<p>Continued From page 25</p> <p>the facility assessed Resident #10 as having modified independence related to cognition. Review of an Annual Assessment dated 04/26/10 revealed the facility assessed Resident #10 as having no issues with his/her cognition/decision making skills. The facility assessed the resident as needing extensive assistance with eating.</p> <p>Review of Physicians Orders dated 09/03/10 revealed an order for Speech Therapy to evaluate and treat as indicated for Dysphagia.</p> <p>Review of the Comprehensive Plan of Care dated 09/27/10 revealed a plan had been developed related to the residents Risk for alteration in fluid balance related to: decreased independent access to fluids and not consuming all liquids provided. The Plan of Care indicated the resident was on diuretics and had a diagnosis of Congestive Heart Failure. The goal for meeting this focus included the use of Nosey cups for all liquids.</p> <p>Observation of evening meal on 10/26/10 and 10/27/10 revealed Resident #10's meal ticket indicated this resident was to have Nosey cups for liquids. During observations, during both of these meals, revealed Resident #10 failed to be provided the Nosey cups. Resident #10 was observed during both the above meals to be drinking from regular cups without difficulty.</p> <p>Review of the Medical Nutrition Therapy Assessment dated 09/09/10 and signed by Registered Dietician (RD) on 09/17/10 revealed the use of the Nosey cups, for Resident #10. Review of Interdisciplinary Communication to Nutrition Services dated 09/09/10 and signed by LPN #1 revealed the request for Nosey cups for</p>	F 369	<p>2. The Dietary Manager/Dietician will audit residents with adaptive equipment orders to determine adaptive equipment is available for residents to use by 12/6/10. All equipment will be available and accurately reflected in orders, on tray cards and in use by 12/6/10.</p> <p>3. During the survey on 10/27/10 dietary staff were re-educated by dietary manager on the importance of providing adaptive equipment per physician orders and reporting refusals of adaptive equipment to responsible nursing staff. Additional re-education re-enforcing adaptive equipment use and providing equipment on tray will be provided for dietary staff by Administrator and Dietician on or before 11-30-2010. Nursing staff were provided with additional re-education on 11/18/2010 by DON/ADON regarding the importance of checking tray tickets for adaptive equipment notations and requesting dietary to provide if not on tray.</p> <p>4. The Dietary Manager/Dietician will audit all residents with adaptive</p>	

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F 369	Continued From page 28 all meals, to increase the resident's independence with self feeding. Interview with the Dietary Manager on 10/27/10 at 5:15 PM revealed it was all Dietary staffs' responsibility to make sure recommended adaptive equipment was made available to residents. She further stated that Resident #10 had told staff numerous times he/she no longer wanted the Nosey cups and was not going to drink out of them. However, observations, noted above, revealed staff failed to offer the Nosey cups to the resident.	F 369	equipment orders to determine if adaptive equipment is available for resident to use on trays and orders remain active and update tray cards as indicated 3X week for a total of 6 meals per week for 6 weeks. Audit findings will be forwarded to the Administrator, who will initiate further follow-up with nursing as indicated and present findings at the monthly PI meeting. Frequency of audits after initial auditing will be determined based on findings and PI team recommendations.	
F 371 SS=E	483.35(l) 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 prepare, store and distribute food under sanitary conditions. Observation revealed a mixer to be stored dirty, five (5) hotel pans stored wet, improper glove usage and hand washing, improper wearing of hairnets, and fans with dust buildup on them. The findings include:	F 371	5. Compliance Date 12/10/10	

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F 371	<p>Continued From page 27</p> <p>1. Observation on 10/26/10 at 10:20 AM revealed the mixer was stored covered with crumbs in the bottom of the bowl.</p> <p>Interview, with the Dietary Manager on 10/26/10 at 10:20 AM, revealed the mixer should not be stored in this manner because it was not sanitary.</p> <p>2. Observation on 10/26/10 at 10:23 AM revealed five (5) pans stored wet.</p> <p>Interview with the Dietary Manager on 10/26/10 at 10:23 AM revealed the pans should not be stored wet because it could cause bacteria to grow.</p> <p>3. Observation on 10/26/10 at 4:35 PM revealed the Administrator entered the kitchen from the dining room without wearing a hairnet. He was observed to stand approximately three (3) feet inside the kitchen, during the trayline.</p> <p>Interview with the Administrator on 10/26/10 at 6:40 PM revealed he did not normally enter the kitchen without wearing a hair net. He further indicated there was a safe area to enter the kitchen without wearing a hairnet.</p> <p>Interview with the Dietary Manager on 10/26/10 at 6:23 PM revealed per the policy if you were in the kitchen you should wear a hairnet.</p> <p>Observation on 10/27/10 at 7:05 AM, a Dietary Aide was observed to enter the kitchen from the backdoor. She was then noted to enter the kitchen office, the storage room and walk through the back food preparation area. Observation revealed the Aide was not wearing a hairnet.</p>	F 371	<p>1. Mixer was cleaned and stored and all pans were rewashed and allowed to dry completely on 10/26/10 by dietary manager. No specific residents were identified.</p> <p>2. Sanitation rounds were conducted by the Administrator on 10-26-10 with no negative outcomes or other issues identified.</p> <p>3. During survey the dietary staff were re-educated by Registered Dietician on 10/26/10 regarding the importance of storing, preparing, distributing and serving food under sanitary conditions. Additional re-education will provided by Dietician for dietary staff on or before 11/30/10 regarding storing kitchen equipment in a clean and sanitary manner; properly air drying kitchen equipment before storage; proper glove use and hand washing. The Dietician re-educated the dietary staff and Administrator on 11-24-10 regarding properly restraining hair by the use of a hairnet in all areas of the kitchen. Fans were added to cleaning schedule.</p> <p>4. Administrator/Dietary Manager and/or Dietician will conduct audit of kitchen for sanitary practices 3X/weeks for 4 weeks and immediately correct non compliances issues if found. The audit findings will be forwarded to the Administrator, who will initiate further follow-up as indicated and present findings at the monthly PI</p>	12/10/10

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F 371	<p>Continued From page 28</p> <p>Interview with the Dietary Manager on 10/27/10 at 10:15 AM revealed the Dietary Aide should have had a hairnet in place. She further indicated the staff member had only been working at the facility for a short period of time and stated I think she needs more training.</p> <p>Review of the facility's policy titled Staff Attire states, the Nutrition Services Director ensures that all staff members have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained.</p> <p>4. Observation on 10/26/10 at 5:05 PM revealed Dietary Aide #7 touched the door knob for the dining room door, took a plate which was handed back into the kitchen from the resident dining area, he then handed the plate to the Dietary Manager. Dietary Aide #7 went back to setting up resident trays on the trayline. Dietary Aide #7 was not observed to wash his hands or change his gloves after this occurrence.</p> <p>Interview with Dietary Aide #7 on 10/26/10 at 6:20 PM revealed he should have changed his gloves and washed his hands after touching the door knob and the plate from the dining area.</p> <p>Observation on 10/26/10 at 5:40 PM revealed Dietary Aide #8 took her gloves off and used her bare hands to lift the garbage can lid to dispose of the gloves. She was then observed to place new gloves on her hands without washing them and returned to preparing food for the resident trayline.</p> <p>Interview with Dietary Aide #8 on 10/26/10 at 6:21 PM revealed she should have washed her hands before putting on new gloves. She further</p>	F 371	<p>meeting. Frequency of audits after initial auditing will be determined based on findings and PI team recommendations</p> <p>5. Compliance Date 12/10/10</p>	

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F 371	Continued From page 29 Indicated she did not realize she had done this. 5. Observation on 10/26/10 at 5:30 PM revealed one (1) tall floor standing fan and two (2) large fans mounted on the walls. Observation revealed one of the fans located in the dishwashing area, and the other fan was located above the area where the tray carts were stored. Further observation revealed a substantial dust build up on the metal casings of the fan. Further investigation on 10/26/10 at 5:55 PM revealed the substance on the metal casing of the fan above the tray cart storage was sticky and black. Interview with the Dietary Manager on 10/26/10 at 5:55 PM revealed maintenance was responsible for cleaning the fans in the kitchen. Interview with the Maintenance Director on 10/28/10 at 3:15 PM revealed he had planned to clean the fans at the end of each month and he believed the fans were last cleaned at the end of September. The facility was unable to provide documented evidence of when the fans were last cleaned.	F 371		
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 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;	F 441	1. No resident was cited as affected by this practice. 2. The facility ADNS conducted infection control rounds of the facility on 10-26-10. The ADNS reviewed infection control reports / rounds for October and November and no other residents were noted to be affected.	12/30/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/28/2010
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR L8C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X6) COMPLETION DATE
F 441	<p>Continued From page 30</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to establish and maintain an infection control program to help prevent the development and transmission of disease and infection regarding infection control during the medication pass. Improper hand washing, touching medications with ungloved hands and cleaning the glucometer with alcohol preps, not 1:10 bleach, per the facility's policy.</p> <p>The findings include:</p>	F 441	<p>3. The center maintains an infection control program and system to monitor and investigate causes of infection and manner of spread. This is reviewed by the DNS at least monthly to determine actions needed to sustain compliance. Licensed Nurses were re-educated on 11/18/2010 by DON/ADON on general infection prevention/control policy and procedures including medication pass and sanitation policy to be used for glucose meters between residents. Nurse # 4 was provided with re-education and counseling on 10/27/10 and a medication pass audit was done by ADON regarding the importance of washing hands before and after gloving, between resident care procedures prior to applying new gloves, removing pills onto medication cups, and sanitizing glucose meters with 1/10 bleach solution between residents. Nurse #4 Followed correct infection control practices during medication pass audit with ADON on 10/27/10.</p> <p>4. The ADON will complete 3 audits per week on licensed staff that will include compliance with infection control program including but not limited to washing hands, proper gloving procedure, proper pill pass procedure and sanitizing glucose meters for 4 weeks. Any deficient practice will be corrected</p>		

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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F 441	<p>Continued From page 31</p> <p>Observation of the medication pass on 10/26/10 at 4:05 PM revealed Registered Nurse (RN) #4 was pushing the medication into his hand from the medication card and then placing the medication into the medication cup. RN #4 then entered unsampled Resident A's room and administered the medications. This nurse then applied gloves and completed a blood sugar finger stick (FS), removed his gloves and returned to the medication cart. The RN cleaned the glucometer (FS machine) with a dispatch wipe (10% bleach) and started preparing another resident's medication using the same technique to remove the medication from the medication card. RN #4 entered unsampled Resident B's room, administered the medication, put gloves on and completed a FS. He then removed the gloves, left the room, returned to the medication cart, drew up the required insulin for the sliding scale coverage. RN #4 then returned to the resident's room, applied gloves, administered the insulin, removed his gloves and returned to the medication cart. RN #4 then cleaned the glucometer with an alcohol wipe. RN #4 never washed his hand before preparing the medication, after removing gloves or between residents.</p> <p>Interview with RN #4 on 10/26/10 at 4:20 PM, revealed he had not washed his hands at any time during the observed medication pass. He continued stating you should wash your hands anytime you remove gloves or leave a resident's room. When asked about touching the medication with bare hands he stated, "I usually pop the pills out in my hand to prevent them from flying across the room, I guess I shouldn't touch them".</p>	F 441	<p>immediately. Audit findings will be forwarded to the DON, who will initiate further follow-up with nursing as monthly PI meeting. Frequency of audits will be determined based on findings and PI team recommendations.</p> <p>5. Compliance Date 12/10/10</p>	
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F 441	Continued From page 32 During further interview with RN #4 on 10/28/10 at 1:30 PM, he revealed after the first cleaning of the glucometer there was no dispatch wipes left in the medication cart and the alcohol preps were all he had to clean the glucometer. He further stated he had completed six (6) more blood sugar checks and had cleaned the glucometer with the alcohol preps. Interview with the Director of Nursing (DON) on 10/28/10 at 1:45 PM, revealed the facility's procedure for cleaning the glucometer's was to wipe the machine's off with the dispatch wipes. The DON indicated hands were to be washed any time you remove gloves, when leaving a resident's room or any time your hands may be dirty. Review of the Manufacturer's guidelines recommend 10% bleach, 70% alcohol or 10% ammonia. However, the facility's policy for cleaning the glucometer revealed, the facility staff was to clean and disinfect only with 1:10 bleach (10%) solution in the form of wipes or towelettes. Observation of other staff members on the other units revealed the correct procedure was used to clean the glucometer.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	1. Resident # 7's medical record is accurate and complete as of 10-28-10. 2. Medical Records personnel conducted an audit of resident charts for completeness, accuracy of documentation; accessibility and organization on or before 12/8/10 and no other residents were noted to be affected.	12/10/10

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F 514	<p>Continued From page 33</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices for one (1) of twenty-five (25) sampled residents (Resident #7).</p> <p>The findings include:</p> <p>Review of Resident #7's medical record revealed diagnoses which included Infantile Cerebral Palsy.</p> <p>Interview with the Assistant Director of Nursing on 10/28/10 at 8:35 AM revealed he had found parts of Resident #7's medical record in an unsampled resident's medical record. Review of the records obtained from the unsampled resident's medical record revealed there were two skin assessments dated 08/26/10 and 09/17/10, and a Plan of Care dated 08/26/10 for Resident #7. He further stated the unsampled resident had a similar name and the records must have inadvertently been filed in the wrong chart. Continued interview revealed there was no name alert system in place to ensure staff were aware of residents who had the same last name or similar last names.</p>	F 514	<p>3. Medical records personnel and nursing staff were provided with reeducation on the importance of filing resident information in correct medical record on 11/18/2010 by ADON/DON. Education included utilizing medical record # identifiers, middle initials and nicknames to differentiate residents with similar last names and to ensure residents documents are complete, accuracy of documentation, accessibility and organization of medical record.</p> <p>4. Medical Records personnel will conduct random audits for completeness, accuracy of documentation, accessibility and organization of medical records. Audits will be conducted on 5 resident's medical records 3X/week for the next 4 weeks and immediately correct any deficient practice identified. Audit findings will be forwarded to the ADON/DON, who will initiate further follow-up as indicated and present findings at the monthly PI meeting. Frequency of audits will be determined based on findings and PI team recommendations.</p> <p>5. Compliance Date 12/10/10</p>	
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	F 518		

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F 518	<p>Continued From page 34</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure staff were knowledgeable of emergency procedures related to inclement weather.</p> <p>The findings include:</p> <p>Observation on 10/26/10 at 12:05 PM revealed an overhead announcement was made for a "Code Black" Tornado Warning. Staff were observed to check the windows, and remove items from the window area in the resident rooms. Further observation revealed some staff on the 100 Hall were closing resident doors and other staff were leaving resident doors open.</p> <p>Interview on 10/26/10 at 12:10 PM with Licensed Practical Nurse (LPN)#5/Unit Manager of the 100 Hall, revealed staff were to remove any items around the windows and ensure residents were not close to the windows in the resident rooms. She stated the residents were to remain in their rooms and were not to be brought into the hallways.</p> <p>Interview on 10/26/10 at 12:15 PM with Registered Nurse (RN) #8, who was assisting residents on the 100 Hall revealed the residents were to be accounted for, items were to be</p>	F 518	<ol style="list-style-type: none"> 1. No resident was affected by this citation. 2. Residents had the potential to be affected, but none were. 3. The facility assures that all employees are trained in emergency procedures during initial orientation; as well as re-educating employees on annual basis to review all emergency procedures and drills. The staff was provided with additional re-education on 11/18/2010 by ADON/DON. Maintenance Director will conduct a tornado drill on or before 12/6/10. 4. The maintenance director will conduct tornado drills for 3 consecutive months and correct deficient practice immediately. Result will be forwarded to the Administrator who will report findings to PI monthly meeting. Further drills will be determined by the PI team after results discussed. 5. Compliance Date 12/10/10 	12/10/10

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F 518	<p>Continued From page 35</p> <p>removed from the window sills, and the blinds and curtains were to be pulled in resident rooms during a tornado warning. She further stated, the resident room doors were to be shut; however, the residents were not to be brought out of the rooms and into the hallways.</p> <p>Further observation on 10/26/10 at 12:20 PM revealed staff were assisting residents into the hallways and shutting resident room doors on the 100 Hall.</p> <p>Further interview on 10/26/10 at 12:20 PM with LPN #5 revealed she had "double checked" with the Assistant Director of Nursing (ADON) on the procedure for a Code Black and found out the residents were to be moved to the hallways if the residents were ambulatory, and non-ambulatory residents were to have the beds moved away from the window. She further stated the residents doors were to be shut. Further interview revealed she had attended a recent inservice at the facility related to emergency procedures for weather, but did not remember the correct procedure for the "Code Black".</p> <p>Continued interview on 10/26/10 at 12:30 PM with RN #8, revealed she was new to the facility and had been employed for five (5) months. She stated she had an inservice related to weather emergencies on orientation; however, was unaware she was to bring residents into the hallway for a "Code Black" until she checked with her Unit Manager.</p> <p>Interview on 10/28/10 at 4:00 PM with the Assistant Director of Nursing (ADON), revealed he taught emergency procedures for weather during orientation to all new employees. He</p>	F 518			

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F 518	<p>Continued From page 36</p> <p>further stated employees were to complete a program on the computer related to emergency procedures every quarter. The ADON indicated he had witnessed staff were not knowledgeable of what to do when the tornado warning was called and he completed another inservice related to emergency procedures for weather on 10/28/10.</p> <p>Review of the facility's policy entitled "Tornado Procedure", revealed during a Tornado Warning residents were to be moved into the hallways, closets, and away from the windows, and the resident room doors were to be closed. Further review of the Policy entitled "Code Black", revealed Code Black was a tornado warning and the residents who were not bed bound were to be moved to the hallway. Further review of the Policy revealed bed bound residents were to be moved close to the door, the privacy curtain was to be pulled, windows were to be closed, and items were to be removed from the windowsill.</p>	F 518		
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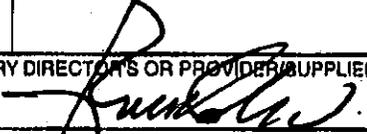
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 10/26/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F".	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bridgepoint Care & Rehabilitation Center does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure a combustible canopy, located at the rear of the facility, was sprinkler-protected, according to NFPA standards. The deficiency affected staff located in the Kitchen area. The findings include: Observation on 10/26/2010 at 11:32 AM, with the Director of Maintenance, revealed a canopy of combustible construction (wood) approximately eleven (11) feet by six (6) feet in size, located at the rear loading dock near the kitchen of the facility, was noted not to be sprinkler-protected. Canopies constructed of combustible material must be sprinklered to prevent the spread of fire. Interview on 10/26/2010 at 11:32 AM, with the Maintenance Director, revealed he was unaware the canopy was not sprinklered.	K 012		

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DEC 28 2010

12/17/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X8) DATE 12/17/10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 012	Continued From page 1. Reference: NFPA 13 (1999 Edtition).	K 012	4. The Maintenance Director will complete rounds on a monthly basis to ensure the facility is sprinkler – protected according to NFPA standards. Any deficient practice will be corrected. The results of rounds will be forwarded to the Administrator and discussed in performance improvement committee monthly for 3 months to ensure compliance.	
K 018 SS=D	5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of resident room doors, according to NFPA standards. The	K 018	5. Compliance Date 12-10-10 K 018 1. The trash can obstructing the closing of room #120 was repositioned on 10/26/10. 2. Rounds completed on 11/16/10 by center maintenance personnel of the center revealed no other obstructions impeding the closing of fire doors. No residents were negatively impacted. 3. Staff were re-educated by the DON on 11/18/20 regarding impediments to the closing of fire doors. 4. The Maintenance Director will complete rounds weekly times 4 weeks, then monthly times 2 months to ensure no fire door is blocked. Any deficient practice identified will be corrected immediately. The results of rounds will be forwarded to the Administrator and discussed in Performance Improvement committee for 3 months to ensure compliance. 5. Compliance date 12/10/10.	12/10/10

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K 018	Continued From page 2 deficiency affected one (1) resident and one (1) of six (6) smoke compartments. The findings include: Observation on 10/26/2010 at 1:07 PM revealed a trash can in resident room #120 was positioned so that it prevented the closing of the door. The observation was confirmed with the Maintenance Director, who was present at that time. Interview on 10/26/2010 at 1:07 PM, with the Maintenance Director, revealed the trash can was used to hold the door open. Reference: NFPA 101 (2000 edition) 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018			
K 025 99=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two	K 025	K 025 1. The doors near room # 101 were adjusted so as to seal on 11/16/10 by center maintenance personnel. 2. Rounds were completed at facility on 11/16/10 by center maintenance personnel. No other doors were identified to not seal. No residents were negatively impacted. 3. The Maintenance Director was re-educated by Administrator on 10/28/10 regarding applicable sections of the NFPA fire code pertaining to smoke barriers and sealing of doors. 4. The Maintenance Director will complete rounds weekly times 4 weeks, then monthly times 2 months to ensure doors have adequate seals. Any deficient practice identified will be corrected immediately. The results of rounds will be forwarded to the Administrator and discussed in performance improvement committee for 3 months to ensure compliance. 5. Compliance date 12/10/10.	12/10/10	

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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K 025	<p>Continued From page 3</p> <p>separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors were maintained according to NFPA standards. The deficient practice affected two (2) of six (6) compartments, staff and approximately seventeen (17) residents.</p> <p>The findings include:</p> <p>Observation on 10/26/2010 at 11:45 AM revealed the cross corridor doors near room number 101 did not have an adequate seal due to the Magnetic lock arm striking the wall above the doors. The observation was confirmed with the Maintenance Director, who was present during the observation. Cross corridor doors must seal to resist the passage of smoke.</p> <p>Interview on 10/26/2010 at 11:45 AM, with the Maintenance Director, revealed he had not noticed the doors were not sealing.</p> <p>Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving Only the minimum clearance necessary for proper operation And shall be without undercuts, louvers, or grilles.</p>	K 025		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/26/2010
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042	
(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)	(X8) COMPLETION DATE
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors, to hazardous areas were equipped with a self-closing device and were resistant to the passage of smoke.</p> <p>The findings include:</p> <p>Observation on 10/26/2010 at 2:06 PM, with the Director of Maintenance, revealed the corridor doors to the Maintenance work shop, housekeeping supply room, medical supply room failed to have a door self-closing device. Further observation revealed these doors had gaps, in the doors, preventing the doors from resisting the passage of smoke. Door closing devices are required on doors to rooms deemed to be a hazardous area. Doors in hazardous locations must also resist the passage of smoke.</p> <p>During an interview on 10/26/2010 at 2:06 PM with the Director of Maintenance he revealed he</p>	K 029	<p>K 029</p> <ol style="list-style-type: none"> The doors to the maintenance work shop, housekeeping supply room and medical supply room have been equipped with self-closing devices and gaps repaired to resist passage of smoke on 11/18/10 by center maintenance personnel. Rounds were completed at facility on 11/18/10 by center maintenance personnel and no other doors were noted to need self-closing devices or gaps repaired. No residents were negatively impacted. The Corporate Life Safety and Construction Director re-educated the Administrator and Maintenance Director on the applicable sections of the NFPA fire code pertaining to door closures and smoke seals and what is considered a hazardous area on 11/18/10 The Maintenance Director will complete rounds weekly times 4 weeks, then monthly times 2 months to ensure identified doors have self closing devices and no gaps. Any deficient practice identified will be corrected immediately. The results of rounds will be forwarded to the Administrator and discussed in performance improvement committee for 3 months to ensure compliance. Compliance date 12/10/10 	12/10/10

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 029	<p>Continued From page 5</p> <p>was unsure which rooms were considered hazardous areas, which would require a door closing device.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops; used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. <p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the</p>	K 029		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/26/2010
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 029	Continued From page 6 door.	K 029		
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained, according to NFPA standards. The deficiency affected all staff in the Kitchen area.</p> <p>The findings include:</p> <p>Observation on 10/26/2010 at 11:35 AM revealed a sprinkler head located in a storage room, located on the dock area, was located to close to the wall. Sprinkler heads must be located a minimum of four (4) inches from the wall to produce an affective spray pattern. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/26/2010 at 11:35 AM, with the Maintenance Director, revealed he had not noticed the sprinkler heads location until the day of the survey.</p> <p>Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p>	K 062	<p>K 062</p> <ol style="list-style-type: none"> 1. The sprinkler will be relocated by a local contractor on 12/7/10 in a storage room located on the dock area near the kitchen as required by the Life Safety Code. 2. Inspection of the center by center maintenance personnel on 11/18/10 did not reveal any other areas not meeting the requirements of the Life Safety Code concerning sprinklers. No residents were negatively impacted. 3. Requirements of the Life Safety Code pertaining to sprinkler placement were reviewed on 11/18/10 by the Corporate Life Safety and Construction Director with the center Maintenance Director and administrator. 4. The Maintenance Director will complete rounds monthly times three months to ensure sprinkler placement. Any deficient practice identified will be corrected. The results of rounds will be forwarded to the Administrator and discussed in performance improvement committee for 3 months to ensure compliance. 5. Compliance date 12/10/10 	12/10/10

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042	
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K 076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure oxygen supply areas were maintained according to NFPA standards. The deficiency affected one (1) smoke compartment, staff, and twenty four (24) residents.</p> <p>The findings include:</p> <p>Observation on 10/26/2010 at 12:10 PM revealed the oxygen supply room contained one (1) light switch located three (3) feet from the floor level and one (1) electrical outlet located one (1) foot from floor level. The observation was confirmed by the Maintenance Director. Electrical switches and outlets must be located a minimum of five (5) feet from the floor to prevent against physical damage.</p> <p>Interview on 10/23/2010 at 12:10 PM revealed the</p>	K 076	<p>K 076</p> <ol style="list-style-type: none"> The light switch and electrical outlet cited in the oxygen supply room will be relocated to meet standard of 5 ft from floor on 12/7/10 by a local contractor. Rounds of the center completed by center maintenance personnel on 11/18/10 did not reveal any other switches or outlets not meeting NFPA standards. No residents were negatively impacted. The Corporate Life Safety and Construction Director re-educated the Maintenance Director and Administrator on the applicable sections of the NFPA Fire code pertaining to electrical switches and outlets on 11/18/10. The Maintenance Director will complete rounds weekly times 4 weeks, then monthly time for 2 months to ensure electrical switches and outlets are at least 5 feet from floor. Any deficient practice identified will be corrected immediately. The results of rounds will be forwarded to the Administrator and discussed in performance improvement committee for 3 months to ensure compliance. Compliance date 12/10/10. 	12/10/10

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042	
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K 078	<p>Continued From page 8</p> <p>Maintenance Director was not aware the electrical switches and/or the electrical outlets locations did not meet the requirements for the Life Safety Code.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>4-3.1.1.2 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage.</p> <p>8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p>	K 078		

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042	
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K 076	Continued From page 9	K 076		
K 147 SS=F	<p>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure Electrical panels were maintained, according to NFPA standards. This deficient practices affected three (3) of six (6) smoke compartments, staff and approximately eighty-three (83) residents.</p> <p>The findings include:</p> <p>Based on observation and interview, the facility failed to guard against an electrical hazard by not securing an electrical panel box on the 100 front corridors, 200 front corridors and 300 front corridor of the facility.</p> <p>Interview on 10/26/2010 at 11:58 AM, with the Maintenance Director, revealed he was unaware the electrical panels should be secured.</p> <p>Reference: NFPA 70 (1999 Edition), 110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or</p>	K 147	<p>K 147</p> <p>1. All electrical panel boxes on the 100 front corridors, 200 front corridors and 300 front corridors will be secured by locks installed by a local vendor on 12/7/10.</p> <p>2. Rounds were completed by center maintenance personnel on 11/18/10 and did not reveal any other electrical panels in common areas not meeting NFPA standards. No residents were negatively impacted.</p> <p>3. The Corporate Life Safety and Construction Director re-educated the Maintenance Director and Administrator on 11/18/10 regarding the applicable sections of the NFPA Fire code pertaining to maintenance of electrical panels.</p> <p>4. The Maintenance Director will complete rounds weekly times 4 weeks, then monthly times 2 months to ensure electrical panels are secured. Any deficient practice identified will be corrected immediately. The results of rounds will be forwarded to the Administrator and discussed in performance improvement committee for 3 months to ensure compliance.</p> <p>5. Compliance date 12/10/10.</p>	12/10/10

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODBPOINT DRIVE FLORENCE, KY 41042
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K 147	<p>Continued From page 10</p> <p>permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means:</p> <p>(1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons.</p> <p>(2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them.</p> <p>(3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons.</p> <p>(4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface.</p> <p>(B) Prevent Physical Damage. In locations where electric equipment is likely to be exposed to physical damage, enclosures or guards shall be so arranged and of such strength as to prevent such damage.</p> <p>(C) Warning Signs. Entrances to rooms and other guarded locations that contain exposed live parts shall be marked with conspicuous warning signs forbidding unqualified persons to enter.</p>	K 147		