

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

PRINTED: 12/16/2015
FORM APPROVED
OMB NO. 0938-0391

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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 R-C 12/16/2015 |
| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT 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) | {X5} COMPLETION DATE |
| {F 000} | INITIAL COMMENTS An offsite revisit was conducted, and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 12/15/15 as alleged. | {F 000} | | |

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

TITLE

(X6) DATE

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

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F 000 INITIAL COMMENTS

An Abbreviated Survey to investigate #KY00023956 and #KY00023979 was initiated on 11/03/15 and concluded on 11/06/15. #KY00023956 was unsubstantiated; however, related deficiencies were identified and cited. #KY00023979 was unsubstantiated without deficiency.

F 241 SS=E 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to promote care in a manner that maintained or enhanced each resident's dignity and respect, for one (1) of four (4) sampled residents (Resident #4), and for two (2) of four (4) unsampled residents (Unsampled Residents C and D).

Observation revealed the 300 hall shower room door was propped open and Unsampled Resident C was unclothed and sitting in the shower room, in full view of anyone who walked by in the hall.

In addition, staff failed to pull the privacy curtain during the provision of catheter care for Resident #4 and during a head to toe skin assessment, dressing change, and catheter care for Unsampled Resident D. The facility did not protect the residents from potential exposure to

F 000

The Bridge Point Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.

F 241

SRNA #2 and SRNA #3 will be re-educated by Nurse Practice Educator to provide privacy by closing doors and/or pulling privacy curtain while showering Resident C on or before December 14, 2015. Resident C has not experienced any negative outcome.

RN#2 will be re-educated by Nurse Practice Educator to provide privacy by pulling privacy curtain while providing catheter care for Resident #4 on or before December 14, 2015. Resident #4 has not experienced any negative outcome.

12/15/15

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Interim Administrator | (X6) DATE 12/2/15 |
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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 241 | <p>Continued From page 1</p> <p>other staff, residents or visitors in the hall if someone opened the door.</p> <p>The findings include:</p> <p>1. Review of the policy titled "Privacy Rights: Patient", revised 09/01/13 and provided by the Administrator, revealed it did not address the issue of protecting exposed residents from view of staff, other residents or visitors during the provision of care.</p> <p>Observation, on 11/06/15 at 9:35 AM, revealed the shower room door on the 300 hall was propped open with a shower chair. Continued observation revealed Unsampled Resident C was sitting unclothed in the shower room, in a chair facing the doorway to the hall. The resident was fully visible from the hall upon walking by the shower room. Further observation revealed State Registered Nursing Assistant (SRNA) #2 was standing behind Resident C in the shower room, and SRNA #3 was noted to push a shower chair out into the hall through the propped-open door.</p> <p>Review of the Brief Interview for Mental Status (BIMS), dated 09/11/15, revealed Resident C was unable to complete the interview which indicated the resident was severely cognitively impaired and not interviewable.</p> <p>Interview with SRNA #2, on 11/06/15 at 9:45 AM, revealed she acknowledged Resident C was exposed to passersby in the hall while the door was propped open. She stated she told SRNA #3 to pull the shower curtain before exiting the shower room, but SRNA #3 failed to do so. SRNA #2 further stated each resident had the right to privacy and dignity.</p> | F 241 | <p>RN #4 will be re-educated by Nurse Practice Educator to provide privacy by pulling privacy curtain while providing skin assessments, dressing change and catheter care for Resident D on or before December 14, 2015. Resident D has not experienced any negative outcome.</p> <p>RN #1 will be re-educated by Nurse Practice Educator to provide privacy by pulling privacy curtain while providing skin assessments, dressing change and catheter care for Resident D on or before December 14, 2015. Resident D has not experienced any negative outcome.</p> <p>Director of Nursing will be re-educated by Manager of Clinical Operations to provide privacy by pulling privacy curtain while providing skin assessments, and dressing change for Resident D on or before December 14, 2015. Resident D has not experienced</p> | |
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| F 241 | <p>Continued From page 2</p> <p>Interview with SRNA #3, on 11/06/15 at 10:10 AM, revealed she acknowledged Resident C was exposed to passersby in the hall while the shower room door was propped open. She stated, "I was not thinking about what I was doing", and explained she was more focused on getting the chair out of the room than on pulling the curtain because she had several tasks that needed to be performed at that time. Continued interview revealed SRNA #3 usually pulled the shower curtain in order to protect the residents from exposure to others.</p> <p>2. Observation of the catheter care and a skin assessment performed by Registered Nurse (RN) #2 for Resident #4, on 11/06/15 at 12:05 PM, revealed the resident's bed was positioned in front of the door to the hall, with the resident's perineal area facing the doorway during the catheter care. Continued observation revealed staff failed to pull the privacy curtain around the resident's bed prior to the procedures, which required the resident to be unclothed. During the procedure, RN #2 left the room to obtain additional equipment, leaving the resident positioned on his/her back with legs apart and groin exposed to anyone who entered the room or happened to see into the room when the nurse left and re-entered.</p> <p>Interview with RN #2, on 11/06/15 at 12:15 PM, revealed she never pulled the curtain when providing care for Resident #4 because everyone knew not to burst in. She stated the staff was aware the resident was straight catheterized (the insertion and removal of a urinary catheter to empty the bladder) four (4) times per day.</p> | F 241 | <p>SRNA #5 will be re-educated by Nurse Practice Educator to provide privacy by pulling privacy curtain while providing catheter care for Resident D on or before December 14, 2015. Resident D has not experienced any negative outcome.</p> <p>Director of Nursing completed observations rounds to ensure privacy curtains were being utilized appropriately on November 6, 2015 and no additional issues were identified.</p> <p>All residents of the facility have the potential to be affected.</p> <p>The facility ordered additional privacy curtains on November 24, 2015 and those privacy curtains will be installed on or before December 14, 2015.</p> | |
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F 241 Continued From page 3
Interview with Resident #4, on 11/06/15 at 12:20 PM, revealed staff did knock and then "barge in" during care. The resident stated "it just happened yesterday".

3. Observation of the head-to-toe skin assessment and a dressing change for Unsampld Resident D, performed by RN #1 and assisted by the Director of Nursing (DON) on 11/06/15 at 10:15 AM, revealed the procedure was conducted without pulling the privacy curtain around the resident's bed. The resident's bed was located in the center of the private room, in full view of the hall if the door to the room were opened.

Subsequent observation of catheter care for Resident D, performed by RN #1 and assisted by SRNA #5 on 11/06/15 at 2:45 PM, revealed staff failed to pull the privacy curtain around the resident's bed during the procedure. Continued observation revealed the resident's spouse was present in the room at the beginning of the procedure, but exited the room during the procedure, leaving the door to the hallway open, which left Resident D exposed to any staff, residents or visitors who may have been present in the hallway.

Interview with RN #1, on 11/06/15 at 3:00 PM, revealed she acknowledged she did not pull the resident's privacy curtain during the morning skin assessment and dressing change, or during the afternoon catheter care. She stated she did not routinely pull Resident #3's curtain during care because the resident was in a private room and not exposed to a roommate; however, RN #1 acknowledged the resident's privacy was not protected from passersby in the hall if the door

F 241 Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator or Nurse Managers will re-educate the nursing assistants and licensed nurses by December 14, 2015 on the need to pull the privacy curtain while providing care to residents to maintain and enhance resident dignity. Post-test will be completed to validate understanding by December 14, 2015. Staff not available during this time frame will be re-educated including posttest by Nurse Practice Educator or Nurse Managers upon return to work and to new hires during orientation.

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| F 241 | | F 241 | <p>Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator or Nurse Managers will re-educate the nursing assistants and licensed nurses by December 14, 2015 on the need to pull the privacy curtain while providing care to residents to maintain and enhance resident dignity. Post-test will be completed to validate understanding by December 14, 2015. Staff not available during this time frame will be re-educated including posttest by Nurse Practice Educator or Nurse Managers upon return to work and to new hires during orientation.</p> | |
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| F 241 | | F 241 | <p>Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator, Nurse Managers, Licensed Nurses or Manager on Duty will audit privacy curtain usage daily across all shifts times two weeks, then 3 times a week times 2 weeks, weekly times 4 weeks, monthly times 4 months then as determined by the monthly Quality Improvement Committee with corrective action upon discovery.</p> <p>The Director of Nursing or Nurse Practice Educator will submit a summary of the audits monthly times 6 months to the monthly Quality Improvement Committee consisting of Administrator, Director of Nursing, Medical Director, Social Service Director, Activity Director, Maintenance Director, Business Office Manager, and Dietary Supervisor monthly for any additional follow up and/or inservicing needs until the issue is resolved and ongoing thereafter.</p> | |
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| F 241 | Continued From page 4 were opened during a procedure which necessitated the resident being unclothed and therefore exposed. Interview with the Administrator, on 11/06/15 at 4:45 PM, revealed she did not recognize the failure to pull the privacy curtains to be a problem. She stated "no one walked in the room". Continued interview revealed the Administrator did not offer a response to the incident involving Unsamped Resident C being left sitting exposed in front of the open shower door on the 300 hall. Post-survey interview with the DON, on 11/10/15 at 3:20 PM, revealed it was her expectation for residents to not be exposed during the provision of care. She stated staff should utilize privacy curtains whenever providing care which required residents to be exposed, including skin assessments, dressing changes and catheter care. | F 241 | | | |
| F 364 SS=D | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed to ensure each resident received food at the proper temperature. | F 364 | Dietary Aide #2 was re-educated on proper food temperatures by Dietary Manager on or before November 20, 2015. An alternate tray was offered to resident who was to receive the scrambled eggs and strawberry shake on November 5, 2015, but resident declined. These food items were discarded. The resident has not experienced any negative outcome. | 12/15/15 | |

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| F 364 | Continued From page 5 A point-of-service temperature check revealed breakfast tray temperatures were not within the acceptable range. The findings include: Review of the facility's policy titled "Food Service Quality Indicators", revised 05/05/13, revealed food was to be served at temperatures appropriate for food safety and palatability. Review of the "Food Guide", revised 10/2009, revealed cold foods should be maintained at or below 41 degrees Fahrenheit, and hot foods at or above 135 degrees Fahrenheit. Observation of the breakfast meal service on the 200 hall on 11/05/15 at 7:55 AM, revealed Dietary Aide #2 checked the point-of-service temperatures on the last tray on the delivery cart. Continued observation revealed the scrambled egg temperature to be 90 degrees Fahrenheit, and the temperature of the Strawberry Shake was 52 degrees. Interview with the dietary aide at the time of the observation revealed she did not believe the egg temperature was accurate; she stated "you can't get a good measurement of eggs". Further interview revealed the Strawberry Shake should be between 35 and 38 degrees Fahrenheit. Interview with the Dietary Director, on 11/05/15 at 2:10 PM, revealed food temperatures were checked in the kitchen prior to putting on the tray line, and again halfway through the service. He stated no point-of-service temperatures on the resident units were checked. Continued interview revealed the egg temperature should be greater | F 364 | All residents of the facility have the potential to be affected including those residents who desire to eat their meals in their rooms. Dietary Manager tested temperatures at point of service on room trays during the breakfast meal on November 5, 2015 with no additional concerns identified. The Dietary Manager, Nursing Home Administrator or Dietician will re-educate the dietary aides and cooks on the need to serve hot and cold foods within acceptable temperate ranges for food safety and palatability by December 14, 2015. Staff not available during this time frame will be re-educated including posttest by Dietary Manager upon return to work and to new hires during orientation. | | |

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| F 364 | | F 364 | <p>The Dietary Manager, Nursing Home Administrator, Dietician, Cook, Manager on Duty or Nurse Manager will audit food temperatures at point-of-service on 5 trays at different meals each day daily times two weeks, 3 times a week times 2 weeks, weekly times 4 weeks, monthly times 4 months then as determined by the monthly Quality Improvement Committee with corrective action upon discovery. The Dietary Manager or Nursing Home Administrator will submit a summary of the audits monthly times 6 months to the monthly Quality Improvement Committee consisting of Administrator, Director of Nursing, Medical Director, Social Service Director, Activity Director, Maintenance Director, Business Office Manager, and Dietary Supervisor for any additional follow up and/or inservicing needs until the issue is resolved and ongoing thereafter.</p> | |
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| F 364 | Continued From page 6 than 145 degrees, and Strawberry Shake should be less than 40 degrees Fahrenheit at the point-of-service. He further stated he could not explain why the temperatures on the 200 hall were out-of-range. | F 364 | | |
| F 365 SS=D | 483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed to ensure food served was appropriate to each resident according to assessment, for one unsampled resident (Resident B). Resident B was served oatmeal for the breakfast meal when the resident's tray ticket revealed a dislike of oatmeal. The findings include: Review of the facility's policy titled "Meal Service", revised 03/16/15, revealed trays were to be checked for each meal to ensure trays were complete and accurate for resident preferences. Medical record review revealed Unsampled Resident B was initially admitted on 05/09/13 and | F 365 | Dietary Aide #1 re-educated by Dietary Manager on checking tray tickets on likes and dislikes on or before November 20, 2015. Resident B was offered an alternate food item to oatmeal which had been served on November 5, 2015, but resident declined. Tray card was updated to reflect appropriate preferences on November 30, 2015 due to resident requesting oatmeal for breakfast at times. All residents of the facility have the potential to be affected. | 12/15/15 |

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

PRINTED: 11/23/2015
FORM APPROVED
OMB NO. 0938-0391

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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 11/06/2015 |
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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT 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) | (X5) COMPLETION DATE |
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F 365 Continued From page 7
readmitted on 01/02/14. Review of the Brief Interview for Mental Status (BIMS), dated 09/06/15, revealed a score of 10, which indicated the resident was moderately cognitively impaired but interviewable.

Observation of the breakfast meal service, on 11/05/15 at 8:05 AM, revealed Unsampled Resident B was sitting up in bed with the breakfast tray on the overbed table in front of the resident. Continued observation revealed the meal had been consumed except for an uneaten bowl of oatmeal. Review of the meal ticket located on the tray revealed the resident had a "dislike" of oatmeal.

Interview with Resident B at the time of the observation revealed he/she preferred to receive corn flakes for breakfast. Resident B reported he was finished with the meal and would not be eating the oatmeal.

Interview with the Dietary Director, on 11/05/15 at 2:10 PM, revealed he had been in the position for about two and 1/2 months. He stated resident food "dislikes" were documented initially by the Activities Department. He further stated he had just become aware resident preferences were to be updated quarterly by the Dietary Director, but he had not yet completed any updates. Continued interview revealed tray tickets should be checked three (3) times prior to trays being served - by the cook and by two (2) other staff at the "top" of the tray line and the "bottom" of the tray line. He acknowledged the system failed when a resident received the wrong food. Further interview revealed the Dietary Director could not explain why Resident B received a "dislike", but felt it could be a matter of the resident's preferences

F 365 Dietary Manager completed an observation during meal service to ensure food was served as appropriate to each resident according to the tray card on November 5, 2015 with no additional concerns identified.

The Dietary Manager, Nursing Home Administrator, Dietician or Nurse Practice Educator will re-educate the dietary aides, cooks and nursing assistants by December 14, 2015 on need to ensure food is served according to each resident's preference and accurately reflected on the tray card. Staff not available during this time frame will be re-educated including posttest by Dietary Manager upon return to work and to new hires during orientation.

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| F 365 | Continued From page 8 not being updated. Interview with Dietary Aide #1, on 11/05/15 at 4:00 PM, revealed his responsibilities included checking tray tickets for likes and dislikes. He stated the kitchen was short-staffed at the present and "we do the best we can", but explained it was sometimes difficult to complete the checks when the dietary staff were so busy trying to get the meals served on time. He further stated the residents should be served food they liked. Interview with the Director of Nursing (DON), on 11/06/15 at 4:40 PM, revealed there were vacant dietary positions which had been posted for hiring purposes. She stated she was not familiar with all of the dietary processes within the kitchen and did not know the circumstances of how Resident B's "dislikes" were overlooked. Interview with the Administrator, on 11/06/15 at 4:45 PM, revealed she did not see it as a problem if only one (1) resident received the wrong food. | F 365 | Dietary Manager, Cook, Dietician, Nursing Home Administrator, Manager on Duty or Nurse Manager will audit trays to validate tray card compliance on 5 trays at different meals each day times two weeks, 3 times a week times 2 weeks, weekly times 4 weeks, monthly times 4 months then as determined by the monthly Quality Improvement Committee with corrective action upon discovery. The Dietary Manager or Nursing Home Administrator will submit a summary of the audits monthly times 6 months to the monthly Quality Improvement Committee consisting of Administrator, Director of Nursing, Medical Director, Social Service Director, Activity Director, Maintenance Director, Business Office Manager, and Dietary Supervisor monthly for six months for any additional follow up and/or inservicing needs until the issue is resolved and ongoing thereafter | | |