

RECEIVED

MAR 7 - 2011

PRINTED: 02/24/2011
FORM APPROVED
OMB NO: 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE COMPLETION DIVISION OF HEALTH CARE FACILITIES A. BUILDING _____ B. WING _____	OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES	(X3) DATE SURVEY COMPLETED C 02/17/2011
--	--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bradford Square Care & Rehabilitation Center does not admit that the deficiency 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."</p> <p>F309</p> <ol style="list-style-type: none"> Resident #1 and # 4's physician 3/5/11 was notified by the Director of Nursing Services on 2/17/2011. No change in plan of care noted. The treatments for resident # 1 and # 4 were completed as ordered by the Director of Nursing Services on 2/17/2011. Other resident's treatments were re-assessed by the 	
F 309 SS=E	<p>An abbreviated survey investigating KY00015937 was initiated on 02/16/11 and concluded on 02/17/11. KY00015937 was substantiated and a deficiency was cited at 483.25 Quality of Care, F 309 at a scope and severity of an "E".</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and 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 ensure wound care treatments were completed as ordered by the physician for two (2) of the nine (9) sampled residents (Resident #1 and #4). In addition, the facility failed to ensure physician ordered biologicals necessary for wound care treatments were available and labeled on three (3) of the four (4) treatment carts.</p> <p>The findings include: The facility did not provide a policy on provision of biologicals or monitoring the treatment carts for accuracy of the treatments.</p> <p>Observations of the 100, 200, 300 and 400 hall treatment carts on 02/17/11 at 3:00am revealed three of the four carts missing 40 biologicals.</p>	F 309		

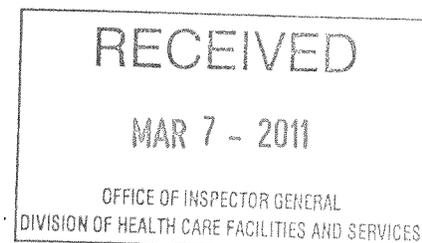
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Jones, NHA TITLE: NHA (X6) DATE: 3/3/11

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.

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

PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2011	
NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601		
(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 309	<p>Continued From page 1</p> <p>Comparison of the current treatment records to the biologicals in the 200 hall cart revealed Ammonium Lactate times four, Calmoseptine times one, Nystatin powder times five, Lidocaine times one, Donavex times one, Triple Antibiotic times two, Calazine times three, and Zinc Oxide times one missing from the cart. Two tubes of triple antibiotic did not have the required label attached.</p> <p>A comparison of the treatment records to the biologicals on the 300 hall cart revealed Skin Prep times one, Sodium Chloride times one, Nystatin times two, Thermacare times one, Tucks times one, Epsom Salts times one, Aspercreme times one, and Albuterol times one, not on the cart.</p> <p>The treatment cart on the 400 hall when compared to the treatment records revealed Lidocaine times three, Nystop times three, Albuterol times one, Atrovent times one, Calzime times one, Calmoseptine times two, Bacitracin times one, Biofreeze times one and Lidocaine times one, not on the treatment cart.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 02/17/11 at 3:15am revealed the biologicals could not be located on the carts and should have been called to the pharmacy. In addition, these biologicals were not available in stock. The LPN stated the treatments could not be done as ordered by the physician if the biologicals were not on the carts.</p> <p>Interview with LPN #2 on 02/17/11 at 4:30am revealed the pharmacy would be called if the biologicals were missing from the cart. The LPN</p>	F 309	<p>Director of Nursing on 2/18/2011. The treatment carts were audited by the Director of Nursing and nursing management team on 2/17/11. Identified biologicals were ordered and received by facility on 2/18/11.</p> <p>3. LPN #1 was re-educated by the Director of Nursing on 2/17/11 regarding following physician treatment orders. The nursing staff will be re-educated by the Director of Nursing and/ or Assistant Director of Nursing regarding the pressure ulcer program and protocol, availability and re-ordering of biologicals and following physician orders related to wound treatments. Education will be completed on or before 3/4/2011.</p> <p>4. The Unit Managers and Assistant Director of Nursing will conduct weekly treatment cart audits to ensure all biological for treatments are available for 4 weeks, then monthly. The Assistant</p>	



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

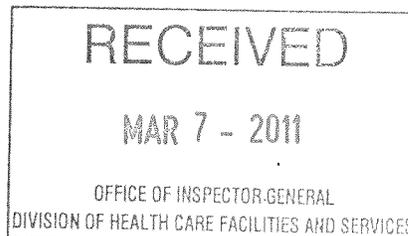
PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601
--	---

(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 309	<p>Continued From page 2</p> <p>could not express if the missing biologicals had been called to pharmacy. In addition, the treatments could not be completed as ordered if the biologicals were not on the cart. The LPN confirmed the items were not available in stock.</p> <p>Interview with the Director of Nursing (DON) on 02/17/11 at 2:00pm revealed 11-7am shift does not do treatments. The DON was not aware the treatments were not getting done because biologicals were not on the treatment carts. The facility does not keep a par level of biologicals in the facility. The orders are placed based on the physician's order at the time. The facility uses the standard system of the physician orders drugs and biologicals, nurses are responsible for appropriate treatment and being available. The nursing staff had not reported to DON any concerns with treatments. The DON further stated the holes in treatment records had been audited however, could not say how long ago.</p> <p>Interview with the Administrator on 02/17/11 at 2:50pm revealed she had not received any complaints from residents, families or staff that treatments were not getting done. She indicated the DON and unit managers are responsible for care and services to the residents.</p> <p>Record review of the facility's policy for Skin Care & Pressure Ulcer Management stated the main objectives were: 1. prevention of pressure ulcers in residents identified at risk; 2. early identification of pressure ulcers with documentation of changes in condition; 3. standardized treatment and interventions that promote pressure ulcer healing and prevent infection, and 4. evaluation of the effectiveness of interventions.</p>	F 309	<p>Director of Nursing Services will complete 2 treatment observations weekly for 4 weeks then monthly. The Director of Nursing Services will review findings with the Performance Improvement committee monthly.</p> <p>5. Completion date is 3/5/2011.</p>	
-------	---	-------	--	--



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

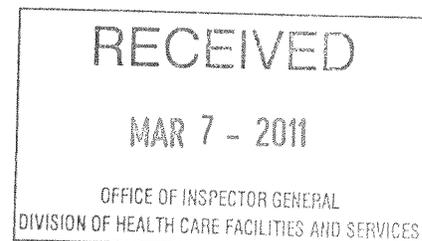
PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601
--	---

(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
--------------------	--	---------------	---	----------------------

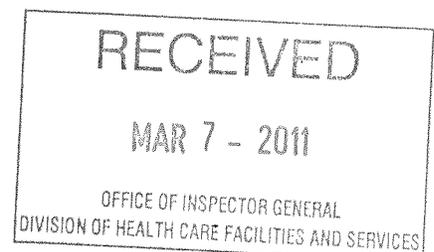
F 309	<p>Continued From page 3</p> <p>Record review of the care plan for Resident #1, dated 06/10/10, revealed an abscess to the right hip with tunneling which was surgically opened by The Wound Care Clinic on 06/01/10. Interventions included weekly skin assessments, wound care clinic appointments as ordered, and treatment to right hip as ordered.</p> <p>Record review of the Treatment Record, revealed the physician's order dated 01/26/11 stated the right hip wound was to be irrigated daily by insertion of a red rubber catheter into the right hip wound with 0.25% Dakins solution, then packed lightly with ¼ inch iodofoam gauze with a sterile tip, and secured with optifoam dressing. The treatment was not initialed by a nurse as completed on 02/09/11, 02/13/11, 02/14/11, and 02/15/11.</p> <p>Observation on 02/17/11 at 10:40am of the wound care treatment for Resident #1 to the right hip wound, revealed that LPN #1 irrigated the wound with 0.25% Dakins solution, then rolled a length of iodofoam gauze on the end of a sterile applicator, then pressed the rolled iodofoam gauze into the wound and secured the dressing with optifoam dressing.</p> <p>Interview on 02/17/11 at 10:40am with LPN #1 regarding the frequency of the right hip wound care for Resident #1 revealed the treatment is ordered to be done daily. LPN #1 stated it didn't appear the treatments were completed as ordered if the nurse neglected to sign the treatments after completed.</p> <p>Record review of Physician Orders dated 12/20/10, for wound care of Resident #4, revealed an order to apply compression wraps for</p>	F 309		
-------	--	-------	--	--



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

PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/17/2011
NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601		
(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 309	<p>Continued From page 4</p> <p>edema in the left lower extremity. The order stated: wrap legs with kerlix and start from toes then apply Setopress with 40mmHg pressure to be completed twice daily.</p> <p>Record review of treatment record for Resident #4, dated February, 2011, revealed the lower extremity compression wrap treatment for Resident #4 was not initialed by a nurse as completed on 02/15/11 at 0800 and 1600.</p> <p>Observation on 02/17/11 at 11:50am of the compression wrap treatment for Resident #4 revealed the vascular wounds were healed. LPN #1 stated the compression wraps were provided to promote venous return. LPN #1 applied Aquaphor to the left lower extremity and wrapped the extremity with a kerlix beginning at the knee, and ending at the toes, then applied a compression dressing over the kerlix beginning at the knee and secured the dressing at the toes.</p> <p>Interview on 02/17/11 at 3:05pm with the Director of Nursing (DON) revealed that the treatment records were audited. The DON stated that the treatments for Resident #1 and #4 were probably completed, but not signed by the nurse on the treatment record after completion. The DON stated that she needed to do some training regarding wound care techniques, and agreed the appropriate application of a compression dressing would always begin at the toes, then working toward the knee. The DON stated that the facility did not have a gauge to measure compression pressure.</p> <p>Interview on 02/17/11 at 3:05pm with the Administrator revealed that the treatment records were audited, but was not sure how often or when</p>	F 309		



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

PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601
--	---

(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 309	Continued From page 5 the records were last audited. The Administrator stated the treatments not signed as completed for Resident #1 and Resident #4 were a result of the same nurse on that hall who neglected to sign the treatment records.	F 309		
-------	---	-------	--	--

