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

PRINTED: 01/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185170		12/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD SQUARE CARE AND REHABILITATION CENTER	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 A Standard Recertification Survey was initiated on 12/26/12 and concluded on 12/28/12. Deficiencies were cited with the highest scope and severity of an "E".	F 000	"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."	
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, group interview, interview with staff, record review, and review of the facility's policy, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect for three (3) of nineteen (19) sampled residents (Resident #12, 13, and 14) and three (3) residents who attended the Group Interview, and one (1) unsample resident. The facility failed to ensure staff knocked on residents' doors prior to entry or by knocking and immediately entering residents' rooms without permission when appropriate. This failure to enhance dignity was further evidenced during general survey observation and during the Group Interview. The findings include: Review of the facility policy titled "Resident's Rights", not dated, revealed each resident had the right to a dignified existence and	F 241	F241 1. Grievances were completed on Resident #13 and #14 on January 23, 2013 regarding staff not waiting for a response when knocking on doors. Grievances were resolved on January 24, 2013 after staff being re-educated on dignity (resident rights and knocking on doors and waiting for permission to enter). Both resident #13 and #14 stated that staff was now knocking and asking for permission to enter room and they were satisfied. Resident #12 was discharged from the Center on	2/10/13

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steve Shine — TITLE: Administrator — (X6) DATE: 2/7/13

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	Continued From page 1 self-determination. Further review of the policy revealed each resident had the right to be treated with kindness, dignity and respect. 1. Review of Resident #12's medical record revealed the facility admitted the resident on 10/02/12 with diagnoses which included Anxiety and a Traumatic Leg Fracture. Review of the quarterly Minimum Data Set (MDS) Assessment, completed 11/08/12, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) which indicated Resident #12 was cognitively intact. 2. Review of Resident #13's medical record revealed the facility admitted the resident on 12/19/12 with diagnoses which included Malaise and Fatigue. Review of the quarterly MDS Assessment, completed on 12/26/12, revealed Resident #13 had a BIMS of fourteen (14) out of fifteen (15) which identified the resident as being cognitively intact. 3. Review of Resident #14's medical record revealed the facility admitted the resident on 02/01/07 with diagnoses which included Hypertension and Non Insulin Dependant Diabetes. Review of the admission MDS, completed on 12/26/12, revealed Resident #14 had a BIMS of fifteen (15) out of fifteen (15) which identified Resident #14 as being cognitively intact. The Group Interview, which was conducted on 12/26/12 at 3:30 PM, revealed three (3) unsampled residents and Residents #12, #13 and #14 stated staff had routinely entered their rooms without knocking or had entered their rooms while	F 241	January 11, 2013. (Residents #12, 13 and 14 were not disclosed at exit briefing and were not identified until SOD received on January 15, 2013) 2. Resident Council was held on January 30, 2013 including a discussion of staff providing for a residents dignity by knocking on doors and waiting for a response prior to entry. At that time, residents reported an improvement in staff knocking on doors and waiting for response prior to entering their rooms. In addition, on February 7, 2013, the Social Services Director, and Unit Managers completed interviews with interviewable residents to validate continued improvement and compliance with promoting resident dignity, including knocking on doors and waiting for a response prior to entry. Any concerns noted will be addressed through grievances process, as appropriate. 3. Center Staff, nursing and non-nursing, were re-educated on caring 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 by the Assistant	

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F 241	Continued From page 2 they were knocking and had not waited for the residents to give their permission for the staff to enter their rooms. Further interview revealed the residents in the Group Interview felt this was not respectful of staff. Interview on 12/26/12 at 3:30 PM, in the Group Interview, Resident #14 revealed staff routinely did not wait for his/her permission before they entered his/her room. Resident #14 stated this made him/her feel uncomfortable at times because sometimes he/she was not presentable for staff to walk into his/her room. Resident #13 stated it also made him/her feel uncomfortable when staff entered his/her room without waiting for his/her permission to enter. Observation, on 12/27/12 at 11:00 AM, revealed Certified Nursing Assistant (CNA) #2 entered unsampled Resident A's room without knocking or introducing themselves. Interview, on 12/27/12 at 11:15 AM, with CNA #2 revealed she had been checking on the resident and forgot to knock and introduce herself before she entered the resident's room. She further stated she should have knocked and introduced herself to the resident before she entered the room. Observation, on 12/27/12 at 2:00 PM, revealed CNA #3 walked into Resident #12's room without waiting for Resident #12 to give his/her permission for her to enter his/her room. Interview with Resident #12, on 12/26/12 at 3:30 PM, in the Group Interview, revealed staff walked in on him/her before when he/she had to ask staff	F 241	Director or Nursing on January 9-16, 2013. Re-education included knocking on residents' doors prior to entry and waiting for permission prior to entering residents' room when appropriate. 4. Director of Nursing, Assistant Director of Nursing, Administrator, Resident Service Director, Social Service Director will monitor dignity of residents in the center though observation of rounds, to include staff knocking on door and waiting for permission to enter resident rooms 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks, then monthly. Any issues will be addressed immediately. Results will be reported to the Performance Improvement Committee monthly for further review and recommendation. Director of Nursing, Assistant Director of Nursing, Administrator, Resident Service Director, Social Service Director will complete resident interviews, consisting of at least 5 interviewable residents, 3 times weekly times 4 weeks; weekly times 4 weeks; and bi-weekly times 4 weeks, then monthly to validate	

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F 241	Continued From page 3 to wait before entering and the staff had already entered his/her room. Resident #12 further stated this made him/her feel uncomfortable and he/she felt this had been very disrespectful of the staff. Continued interview, on 12/27/12 at 2:25 PM, revealed CNA #3 did not wait for him/her to give his/her permission to enter the room. Observation, on 12/28/12 at 10:00 AM, revealed CNA #4 entered Resident #13's room while she was knocking and did not wait for Resident #13 to give his/her permission for her to enter. Interview with CNA #4, on 12/28/12 at 10:15 AM, revealed she had been answering Resident #13's call light; therefore, she did not wait for Resident #13 to give his/her permission for her to enter his/her room but she had knocked before she entered the resident's room. Further interview revealed even though she was answering a call light, she should not have entered the room before the resident gave his/her permission for her to enter the room. Interview with the Director of Nursing (DON), on 12/28/12 at 3:00 PM, revealed staff should always knock before entering a resident's room and wait for the resident to give their permission before they enter the resident's room. She further stated even if staff had been answering a resident's call light, they should still wait for the resident to give their permission before they entered the resident's room. Further interview revealed if a resident was cognitively impaired, staff was to still knock and identify themselves before they entered the resident's room. She further stated all residents should be treated with dignity and respect and if staff failed to knock before they	F 241	center is providing care that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Any issues will be addressed immediately. A summary of findings will be submitted to the Performance Improvement Committee monthly for further review and recommendation. Lastly, the Resident Services Director will continue to discuss the center providing for each resident's dignity in resident council meetings for the next 3 months (Feb, March and April). A summary of findings will be submitted to the Performance Improvement Committee monthly for further review and recommendation. The PIC will consist of, at a minimum, the Administrator, Director of Nursing and at least 3 other members of the Centers staff and the Medical Director at least Quarterly.	

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F 241	Continued From page 4 entered a residents room or failed to wait for the resident to give them permission to enter the residents room, this would be a violation of the resident's right to be treated with dignity and respect.	F 241		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy and review of the Standard Nursing Guidelines utilized by the facility, it was determined the facility failed to ensure proper treatment and special services, related to a gastrostomy tube, were provided for one (1) of nineteen (19) sampled residents (Resident #4). During a medication administration, on 12/26/12 at 4:00 PM, Licensed Practical Nurse (LPN) #2 was observed to administer medications via the gastrostomy tube without giving an air bolus for placement verification and without giving a fifty (50) milliliter flush prior to the medications being administered via the gastrostomy tube per the facility's policy. The findings include:	F 322	F322. 1. Resident # 4 was assessed by Licensed Nurse on December 28, 2012 to verify G-tube placement. Licensed Practical Nurse #2 was re-educated on Standard Nursing Guidelines to determine proper treatment and special services, related to gastrostomy tube by the Director of Nursing on December 26, 2012. 2. Residents who receive nutrition or medication administration via gastrostomy tube were assessed by the licensed nurse on January 24, 2013 to verify gastrostomy tube placement and for change of condition. No change in condition was noted. 3. Nurses were re-educated on Standard Nursing Guidelines to determine proper treatment and special services, related to gastrostomy tube by the Assistant Director of Nursing on January 9-16,	2/10/13

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F 322	Continued From page 5 Review of the facility's policy "General dose Preparation and Medication Administration", dated 05/01/10, revealed medications should be verified for correct medication, correct dose, correct route, correct rate, correct time for the correct resident. Additionally the facility's policy revealed it should be confirmed that the Medical Administration Record (MAR) reflected the most recent medication order. Review of the nursing guidelines utilized by the facility, "Clinical Nursing Skills & Techniques Sixth (6) Edition", revealed when administering medications via the Percutaneous Endoscopic Gastrostomy (PEG) tube, the tube must be flushed prior to and after the administration of a crushed medication to prevent the drug from adhering to the inside of the tube. Record review revealed the facility admitted Resident #4 on 10/27/10 with diagnoses which included Depressive Disorder, Dementia, Altered Mental Status, Hypertension, Diabetes, Hypothyroidism, Hyperlipidemia, and Gastrostomy Tube. Review of Resident #4's Physician's Orders, dated 11/30/12, revealed an order to verify placement of the Percutaneous Endoscopic Gastrostomy (PEG) tube with air prior to flushes, tube feeding or medication administration. Further review of the Physician's Order revealed the PEG tube should be flushed with 50 milliliters (ml) of water before and after medications were administered via the PEG tube. Observation of a medication pass, on 12/26/12 at 3:40 PM, revealed Licensed Practical Nurse (LPN) #2 administering medication to Resident #4 via a gastrostomy tube. LPN #2 aspirated for	F 322	2013. Re-education included verifying placement of the gastrostomy tube and proper flushing of the gastrostomy tube. 4. Director of Nursing, Assistant Director of Nursing and/or Unit Managers will perform clinical competency of gastrostomy tube weekly x4 wks, biweekly x 4wks, then monthly. A summary of findings will be submitted to the Performance Improvement Committee monthly for further review and recommendation.	

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F 322	Continued From page 6 stomach contents prior to administering the medications. After aspiration LPN #2 allowed the contents to flow back into the tubing then proceeded to administer the medications without prior giving an air bolus to check placement or flushing the tube with 50 ml of water per the Physician's order and the facility's policy. Review of Resident #4's Medication Administration Record (MAR) for December 2012, revealed the PEG placement should have been verified with an air bolus prior to medication administration. Further review revealed the PEG should have been flushed with 50 ml of water prior to and after the medication administration. Interview with Licensed Practical Nurse (LPN) #2, on 12/28/12 at 3:10 PM, revealed the policy for administering medications via the gastrostomy tube would be to check for tube placement by auscutting the abdomen for an air bubble. Further interview with LPN #2 revealed the tubing should have been flushed with fifty (50) ml of water prior to giving the medications. Interview with the Director of Nursing (DON), on 12/28/12 at 3:25 PM, revealed the facility's policy for gastrostomy tube placement would be to verify placement with an air bubble. Further interview revealed, the gastrostomy tubing should have been flushed with fifty (50) ml of water prior to the administration of any medications.	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	F323 1. Beautician was re-educated on January 2, 2013 on not leaving hazardous material unattended, storing hazardous materials in a	2/10/13

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F 323	Continued From page 7 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles Policy, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible. Observation of two (2) medication carts revealed the narcotic drawers were unlocked. Further observation revealed the facility's beauty shop was left unattended, with the door open and a resident under a hair dryer. The findings include: 1. Review of the facility's Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles Policy (#5.3- Revised 08/09/11) revealed after receiving controlled substances and adding to inventory, the facility should ensure that Schedule II-V controlled substances were immediately placed into a secured storage area (i.e. a safe, self-locked cabinet, or locked room, in all cases in accordance with Applicable Law) and locked. Further review revealed the facility should ensure that all controlled substances were stored in a manner that maintained their integrity and security. Observation, on 12/28/12 at 1:20 PM, revealed	F 323	locked area, and that residents are not left unattended in the beauty shop by the Administrator. A lock was placed on a drawer in the beauty shop for hazardous material by the Maintenance Director on December 26, 2012. Narcotic drawers were locked immediately on December 28, 2012 by the licensed nurse. Licensed Practical Nurse #3 was educated on December 28, 2012 by the Director of Nursing on proper storage of narcotics. 2. Residents residing in the Center have the potential for being affected and benefit from having the safest environment possible. 3. Beautician was re-educated on January 2, 2013 on not leaving hazardous material unattended, storing hazardous materials in a locked area, and that residents are not left unattended in the beauty shop by the Administrator. Nurses were re-educated on proper storage of narcotics under double lock by the Assistant Director of Nursing on January 9-16, 2013. 4. Administrator, Director of Nursing, Assistant Director of Nursing and/or Unit Managers will	

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F 323	Continued From page 8 the Narcotic drawer, of the 400R medication cart, was unlocked. Further observation, at 1:35 PM, revealed the Narcotic drawer, of the 400L medication cart, was also unlocked. Interview, on 12/28/12 at 2:00 PM, with Licensed Practical Nurse (LPN) #3 revealed the narcotics should have been double-locked. She stated she didn't realize the drawers were not shut, that she must not have shut the lid hard enough to latch. She further stated she did not make sure the lids were latched. Further interview revealed the narcotics in the drawers could be harmful to residents if they took them, that was a safety hazard for the residents. Interview, on 12/28/12 at 2:40 PM, with LPN #4 revealed narcotic drawers were to be locked and the carts also locked (double-locked) and it was a safety hazard if the drawers were not double-locked. Interview, on 12/28/12 at 2:50 PM, with LPN #5 revealed narcotics were to be double-locked and it was a safety hazard to the residents if they weren't. Interview, on 12/28/12 at 2:15 PM, with the Assistant Director of Nursing Services (ADNS) revealed the narcotic drawers were to be double locked, it was a safety hazard for the residents, there was no excuse why they were not locked. She further stated if the lids had been shut they would have locked. Interview, on 12/28/12 at 2:30 PM, with the Director of Nursing Services revealed the narcotic drawers should have been locked and the nurse	F 323	monitor to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents which will included monitoring of the beauty shop to determine that potential hazardous materials are not left unattended and narcotic storage are secure though observation rounds weekly times 4 weeks; bi-weekly times 4 weeks, then monthly. A summary of findings will be submitted to the Performance Improvement Committee monthly for further review and recommendation.	

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F 323	Continued From page 9 knew that. Further interview revealed the policy was not a new policy. She further stated the narcotic drawer was only single-locked and that was a safety hazard for the residents. 2. Observation, on 12/26/12 at 12:15 PM, revealed the facility's Beauty Shop was unattended, the door was open and a resident was sitting in his/her wheelchair under a hair dryer. Further observation revealed a can of Paul Mitchell Extra Body Sculpting Foam was on the countertop with a lable that stated: Extremely Flammable; Pressurized Container; Contents under Pressure; Keep out of Reach of Children; Avoid contact with eyes. Continued observation revealed the contents of an unlocked drawer was four (4) capped razors, one (1) uncapped razor, two (2) pair of scissors and one (1) pair of razor scissors. Interview, on 12/26/12 at 12:20 PM, with the Hair Dresser revealed staff was busy at lunch time and it was hard to get anyone to take residents back to their room. She stated the drawer had a lock; however, it was broken and it would not lock. Further interview revealed she did not realize if a product said to keep out of reach of children that it also had to be kept out of reach of the residents. She further stated she did not realize it was a safety hazard for residents to be left alone in the beauty shop, she thought it would be fine if they were under the hair dryer. Interview, on 12/27/12 at 10:30 AM, with LPN #4 revealed for the residents' safety, they should not be left alone in the beauty shop.	F 323		

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F 323	Continued From page 10 Interview, on 12/28/12 at 2:15 PM, with the Assistant Director of Nursing Services revealed the beauty shop door should not have been unlocked or open unless the Hair Dresser was present. She stated it was a safety hazard. Interview, on 12/28/12 at 2:30 PM, with the Director of Nursing Services revealed the beauty shop should not be left unattended, the door should be locked if the hair dresser had to leave the room. She further stated a resident should not be left unattended in the Beauty Shop.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	F431 1. Narcotic drawers were locked immediately on December 28, 2012 by the licensed nurse. Licensed Practical Nurse #3 was educated on December 28, 2012 by the Director of Nursing on proper storage of narcotics under double lock. 2. Residents residing in the Center have the potential for being affected. 3. Nurses were re-educated on storing narcotics under double lock by the Assistant Director of Nursing on January 9-16, 2013. 4. Narcotic Storage as well as drug records of controlled drug, proper labeling/storing of drug and biologicals will be monitored though observation weekly times 4 weeks;	2/10/13

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F 431	Continued From page 11 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles Policy revealed the facility failed to ensure controlled substance compartments were separately locked. Observation of two (2) medication carts revealed narcotic drawers were not double-locked. The findings include: Review of the facility's Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles Policy (#5.3- Revised 08/09/11) revealed after receiving controlled substances and adding to inventory, the facility should ensure that Schedule II-V controlled substances are immediately placed into a secured storage area (i.e. a safe, self-locked cabinet, or locked room, in all cases in accordance with Applicable Law) and locked. Further review revealed the facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security.	F 431	bi-weekly times 4 weeks and then monthly by Director of Nursing, Assistant Director of Nursing, Nurse Supervisor and/or Unit Manager. A summary of findings will be submitted to the Performance Improvement Committee monthly for further review and recommendation.	

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F 431	Continued From page 12 Observation, on 12/28/12 at 1:20 PM, revealed the Narcotic drawer, of the 400R medication cart, was unlocked. Further observation, at 1:35 PM, revealed the Narcotic drawer, of the 400L medication cart, was also unlocked. Interview, on 12/28/12 at 2:00 PM, with Licensed Practical Nurse (LPN) # 3 revealed the narcotics should have been double-locked. She stated she didn't realize the drawers were not shut, that she must not have shut the lid hard enough to latch. She further stated she did not make sure the lids were latched. Further interview revealed the narcotics in the drawers could be harmful to residents if they took them, that was a safety hazard for the residents. Interview, on 12/28/12 at 2:40 PM, with LPN #4 revealed narcotic drawers were to be locked and the carts also locked (double-locked) and was a safety hazard if the drawers were not double-locked. Interview, on 12/28/12 at 2:50 PM, with LPN #5 revealed narcotics were to be double-locked and was a safety hazard to the residents if they weren't. Interview, on 12/28/12 at 2:15 PM, with the Assistant Director of Nursing Services (ADNS) revealed the narcotic drawers were to be double locked, it was a safety hazard for the residents, there was no excuse why they weren't. She further stated if the lids had been shut they would have locked. Interview, on 12/28/12 at 2:30 PM, with the Director of Nursing Services revealed the narcotic	F 431		

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F 431	Continued From page 13 drawers should have been locked and the nurse knew that. Further interview revealed the policy was not a new policy. She further stated the narcotic drawer was only single-locked and that was a safety hazard for the residents.	F 431		

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 007/14/76 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected SMOKE COMPARTMENTS: Five (5) smoke compartments. COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (Wet SYSTEM) EMERGENCY POWER: Type II Diesel Generator. A life safety code survey was initiated and concluded on 12/27/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred (100) beds and the census was ninety-five (95) the day of the survey. Deficiencies were cited with the highest	K 000	"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." RECEIVED JAN 25 2013 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacie Shine	Administrator	1/25/13

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 000	Continued From page 1 deficiency identified at "F" level.	K 000	K025	
K 025 SS=E	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 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, forty-six (46)l residents, staff and visitors. The facility is licensed for one hundred (100) beds and the census was ninety-five (95) the day of the survey. The findings include: Observation, on 12/27/12 between 9:30 AM and 2:00 PM, revealed the smoke barriers for the Hallways #1 and #4 had penetrations not sealed around where conduit penetrated the walls also noted was the grout was missing in about 4-5 blocks. Smoke barriers are to be sealed with a material that is equal or greater than existing	K 025	1. The Maintenance Director sealed the identified penetrations with smoke resistive caulk in the smoke barrier walls on the 100 Hall and 400 Hall where the conduit penetrated the wall and grout was missing as of January 16 , 2013 . 2. Other smoke barrier walls were visually inspected throughout the facility by the Maintenance Supervisor on January 11 and 16, 2013 to determine proper requirements are met regarding smoke barrier walls in accordance with NFPA Standards 3. Maintenance Director was re-educated on Life Safety Code Standards regarding smoke barriers walls on January 10, 2013 by the Administrator. 4. Maintenance Director will monitor smoke barrier walls monthly for 3 months to determine smoke barrier walls have not been penetrated and blocks are sealed with grout. A summary of findings will be submitted to the Performance Improvement Committee monthly x	2/9/13

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K 025	Continued From page 2 material or fire rated. Penetrations in smoke barriers must be sealed to prevent the spread of smoke during a fire. The observations were confirmed with the Maintenance Director. Interview, on 12/27/12 at 12:40 PM in the main Hallway, with the Maintenance Director revealed he was not aware of those penetrations. Reference: NFPA 101 (2000 edition) 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that	K 025	3 months for further review and recommendation.	

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K 025	Continued From page 3 is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards. The findings include: Observation on 12/27/12, between 9:30 AM and 2:00 PM, with the Maintenance Director revealed	K 029	K029 1. The Medical Record office door and kitchen storage door were closed immediately during surveyor's inspection of Life Safety on December 27, 2013. 2. Other doors were visually inspected throughout the facility by the Maintenance Supervisor and Life Safety Surveyor on December 27, 2012 to determine proper requirements were met regarding closing of doors to the facility in accordance with NFPA Standards, with no other concerns identified. 3. Maintenance Director, Medical Record Director and Dietary staff were re-educated on Life Safety Code Standards regarding proper separation of a hazardous area from other areas of the facility to include	2/9/13

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K 029	Continued From page 4 the door leading into the dry bulk food storage room in the kitchen did have a self-closing device installed per the NFPA Life Safety Code but further investigation revealed the door was being held open by a bungee cord. The amount of combustibles stored in the dry bulk storage room required the room to be considered a storage area and, as such, required a door closing device and should be kept closed at all times. Interview on 12/27/12, at 11:01 AM, with the Maintenance Director and Dietary Manager in Hallway #1 revealed they were unaware of the above noted requirements. The Administrator also acknowledged during the exit interview conducted on 12/27/12, at 2:15 PM that she was unaware of these requirements. Observation on 12/27/12 between 9:30 and 2:00 PM revealed the door of the Medical Records storage room was being held open by an unapproved hold open device. Interview on 12/27/12 at 11:10 AM in the Medical Records room with the Maintenance Director revealed he thought the device was allowed by the code. Reference: NFPA 101 (2000 Edition). 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	K 029	maintaining closure of dry storage door in kitchen and Medical Records storage door on January 10 - 16, 2013 by the Administrator. 4. Maintenance Director will monitor doors of the facility weekly times 4 weeks; bi-weekly times 4 weeks and monthly times one month to determine proper separation of a hazardous area from other areas of the facility and determine door are properly closed. A summary of findings will be submitted to the Performance Improvement Committee monthly x 3 months for further review and recommendation.	

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K 029	Continued From page 5 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: (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. 7.2.1.8 Self-Closing Devices. 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.	K 029		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 062	K062 1. Sprinkler heads in the therapy room will be moved on or before February 8, 2013 to determine 4 inch clearance from wall. Wires were removed from sprinkler pipes on hall 100, 400 and main hallway as of January 16, 2013 by Maintenance Director.	2/9/13

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K 062	Continued From page 8 determined the facility failed to ensure sprinkler heads were maintained, according to National Fire Prevention Association (NFPA) standards. The findings include: Observation on 12/27/12 between 9:30 AM and 2:00 PM revealed three (3) sprinkler head located in the Physical Therapy Room was located too close to the wall, less than four (4) inches. The observation was confirmed with the Maintenance Director. Interview, on 12/27/12 at 12:05 PM, with the Maintenance Director, revealed he thought all sprinkler heads that were too close to the walls had been identified. Observation on 12/27/12 between 9:30 AM and 2:00 PM revealed various wires hanging across sprinkler piping in attic of Hallways #1 and #4 and Main Hallway. This practice had the potential to affect all five (5) smoke compartments, all residents and staff. The facility was licensed for one hundred (100) beds and the census was ninety-five (95) the day of the survey. Interview on 12/27/12 with the Maintenance Director at 12:30 PM in the Main Hallway revealed he was unaware of this requirement. 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.	K 062	2. Other sprinklers and pipes were visually inspected throughout the facility by the Maintenance Supervisor on January 11 - 22, 2013 to determine proper requirements are met regarding sprinklers in accordance with NFPA Standards. Any other sprinkler or pipes noted to be out of compliance will be corrected on or before February 8, 2013. 3. Maintenance Director was re-educated on Life Safety Code Standards regarding sprinkler systems by the Administrator on January 10, 2013. 4. Maintenance Director will monitor sprinkler system and pipes monthly to determine sprinkler system is maintained properly per NFPA Standards. A summary of findings will be submitted to the Performance Improvement Committee monthly x 3 months for further review and recommendation.	

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K 062	Continued From page 7 Reference: NFPA 25 (1998 edition) 2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation, policy review, and interview it was determined the facility failed to ensure decorations used by the facility were noncombustible. The deficiency had the potential to affect five (5) of five (5) smoke compartments, ninety-five (95) residents, staff and visitors. The findings include:	K 073	K073 1. Combustible decorations on residents room doors (102,113,205, 206,208,209,218,303,304,306,307, 312,401,403,404,406,409,411,412) were treated with fire retardant spray or removed on January 18, 2013 by the Maintenance Supervisor or family member. A policy on treating combustible decorations in order to prevent the spread of fire was implemented on January 23, 2013 by the Performance Improvement Committee.	2/9/13

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185170	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD SQUARE CARE AND REHABILITATION CENTER	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
K 073	Continued From page 8 Observation, on 12/27/12 between 9:30 AM and 2:00 PM, with the Maintenance Director, revealed combustible decorations on resident room doors (102,113,205,206,208,209,218,303,304,306,307, 312,401,403,404,406,409,411,412. Further observation revealed there was not a written policy on combustible decorations. Combustible decorations must be treated to prevent the spread of fire. The observation was confirmed with the Maintenance Director. Interview, on 12/27/12 at 2:15 PM, with the Maintenance Director, revealed the facility does spray the decorations with a flame retardant spray but does not have a written policy and do not document the decorations. Reference: NFPA 101 (2000 edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present.	K 073	2. Rounds were conducted in the center and decorations were either removed or treated with fire retardant spray on January 18, 2013 in accordance with NFPA Standards by the Maintenance Director or Activity Director. 3. Maintenance Director, Activity Director and Activity Assistant were re-educated on Life Safety Code Standards regarding combustible decorations in the facility on January 15, 2013 by the Administrator. Maintenance Director will spray any combustible decoration when brought into the facility with fire retardant spray. Maintenance Director will also keep documentation of combustible decorations treated. 4. Maintenance Director will monitor doors and facility for combustible decorations weekly times 4 weekly, bi-weekly times 4 weeks and monthly times 2 months. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation.	