

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 CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/22/2012
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NAME OF PROVIDER OR SUPPLIER  BRADFORD SQUARE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601
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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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F 000	INITIAL COMMENTS  An Abbreviated Survey was initiated on 08/19/12 and concluded on 06/25/12. Complaint #KY00018489 was unsubstantiated with no deficiencies. Complaint #KY00018490 was substantiated with no deficiencies. Complaint #KY00018501 was substantiated and deficient practice was identified at 483.60 Pharmacy Services.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Bradford Square Care &amp; Rehabilitation Center</b> 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 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, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	F431 1. Medication cart labeled R4 was locked immediately on 6/21/12 by the licensed nurse. Re-education was completed with LPN#1 on 6/21/12 by the Director of Nursing.  2. An audit of the facility's medication carts was completed on 6/21/12 to determine carts were locked by the Director of Nursing. No other unlocked medication carts were identified.	6/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sue Shue</i>	TITLE <i>Administrator</i>  (X8) DATE <i>7/11/12</i>
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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 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: 07/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/22/2012
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NAME OF PROVIDER OR SUPPLIER  BRADFORD SQUARE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 UB 127 SOUTH FRANKFORT, KY 40601
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F 431	<p>Continued From page 1</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure all medications were under the direct observation of the person administering the medications or locked in the medication storage cart.</p> <p>The findings include:</p> <p>Review of facility policy 5.8 "Storage and Expiration Dating of Medications, Biological, Syringes and Needles", with a revision date of 08/09/11, revealed all medications were to be stored in a locked cart or locked medication room, and inaccessible by residents and visitors.</p> <p>Observation, on 06/21/12 at 5:00 PM, revealed two (2) medication carts labelled L4 and R4 were located in the residential hall on the 400 Unit. Continued observation revealed the L4 medication cart was locked; however, the R4 cart was unlocked with the drawers facing outward into the hall. Further observation revealed no staff were in sight.</p> <p>Subsequent observation, on 06/21/12 at 6:05 PM, revealed Licensed Practical Nurse (LPN) #1 exited a resident room and returned to the</p>	F.431	<p>3. Licensed Nurses were re-educated to medication and treatment carts being locked unless carts are in direct line of sight of the licensed nurse by the Director of Nursing and Assistant Director of Nursing on 6/21/2012 through 6/29/2012.</p> <p>4. Administrator/Unit Managers/ Director of Nursing and/or Assistant Director of Nursing will monitor medication and treatment carts 5 times weekly times 1 month; 3 times weekly times 1 month; then weekly times 1 month to validate that medication and treatment carts are locked. These findings will be submitted to the Performance Improvement Committee monthly x 3 months for further review and recommendation.</p>	

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:  185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/22/2012
NAME OF PROVIDER OR SUPPLIER  BRADFORD SQUARE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601		
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F 431	Continued From page 2 medication carts. Interview with the nurse at that time revealed she was finished with the R4 cart and was working off the L4 cart. She confirmed the R4 cart was unlocked. She stated she knew it was supposed to be locked and she thought it was locked.  Interview with the Director of Nursing Services (DNS), on 08/21/12 at 3:30 PM, revealed the medication cart should have been locked if not in direct sight of the nurse.	F 431			