

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

PRINTED: 12/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2011
--	--	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS A Standard Recertification and Abbreviated Survey investigating ARO#KY00017345 was conducted 11/15/11 through 11/18/11. Deficiencies were cited with the highest Scope and Severity of a "F". ARO#KY00017345 was unsubstantiated with no deficiencies cited.	F 000		
F 248 SS=D	489.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review it was determined the facility failed to ensure an ongoing program of activities designed to meet the interests and well-being of each resident. The facility failed to ensure one (1) of twenty (20) sampled residents, (Resident #10) had activities that were compatible with the resident's interests, special needs, abilities, and preferences. Resident #10's activity preferences included music, keeping up with the news, doing things with groups of people, participate in religious services, and going outside to get fresh air when the weather was good. The resident's activities care plan did not include any interventions with these individual preferences. Review of the resident's Program Participation Record for October 2011 and November 2011 revealed the resident rarely participated in activities and was not getting one to one activities	F 248	F248 1. Resident #10 was re-assessed by the Activity Director on 11/21/11 and care plan updated as indicated. A hearing amplifier purchased on 12/15/11 to utilize during activities. 1-1 activities were provided per plan of care effective 11/21/11 and ongoing. 2. Current residents were reviewed starting on 11/29/11 and completed as of 12/14/11 by the Activity Director and plan of care updated as indicated by the activity assessment. A master list has been implemented by the Activity Director to identify customers on 1-1 activities and frequency of visits.	

RECEIVED
DEC 16 2011
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michelle Dover</i>	TITLE <i>Administrator</i>	(X5) DATE <i>12/16/11</i>
--	-------------------------------	------------------------------

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: 12/06/2011
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 11/18/2011
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)	(X6) COMPLETION DATE
F 248	<p>Continued From page 1</p> <p>twice weekly. In addition, the facility failed to provide for the special needs of the resident, who was hard of hearing, to enhance participation in activities.</p> <p>The findings include:</p> <p>Review of the facility's policy: Care and Services, dated January 2008, revealed the facility was to provide residents with the necessary care and services to maintain his/her highest level of practicable functioning in an environment that enhances each resident's quality of life.</p> <p>Record review revealed Resident #10 was admitted by the facility, on 09/16/10, with diagnoses which included Depression and Alzheimer's Disease. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/18/11, revealed the resident's ability to hear was severely impaired and the resident had a hearing aid. Further review of the MDS for Activity Preferences revealed the following activities were identified as very important: listen to music, keep up with the news, do things with groups of people, go outside to get fresh air, and participate in religious services or practices.</p> <p>Interview, on 11/18/11 at 1:40 PM, with Registered Nurse (RN) #6/MDS Coordinator, revealed the resident was hard of hearing and had a hearing aid. When informed the resident no longer had a hearing aid because the family had taken it to get repaired, RN #6 stated if the hearing aid was broken it would be up to the family to get it repaired. The family had not mentioned anything about the hearing aid or wanting the resident to have one.</p>	F 248	<p>3 Re-education by the Administrator to the Activity Director and Assistant on 12/13/11 regarding programming and providing of activities designed to meet the interests of each resident.</p> <p>4. The Activity Director and Administrator will review five resident's activity assessments and observe participation of activities weekly for four weeks then monthly times two months to determine interests and needs of the resident are met. Findings will be reported by the Activity Director to the Performance Improvement Committee for review and recommendations.</p> <p>5. Date of completion:</p>	12/22/11

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

PRINTED: 12/06/2011
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 11/18/2011
--	--	--	---

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)	(X6) COMPLETION DATE
F 24B	<p>Continued From page 2</p> <p>Record review of the resident's activity care plan, revised on 09/20/11, revealed the resident was unable to self initiate activities, needed reminders, and transportation to and from activities. In addition, it noted the resident was hard of hearing, enjoyed music and conversation with staff. The goals included receiving one (1) on one (1) activities twice (2) a week and to keep the resident active in facility life. Review of the interventions revealed no individual preferences listed. Interventions included: introducing the resident to other residents with the same interest; alert the resident about activities he/she has interest; receive one (1) on one (1) activities on a weekly basis; activity calendar in room; remind and invite to activities of choice; to provide transportation to activities of choice; and in room visits for conversation as tolerated.</p> <p>Further record review of Resident #10's Program Participation Record for October 2011 revealed: only one (1) visit (October 14 th) was documented under the one (1) on one (1) activities section, and the resident participated in only one facility program activity (Helping Hands) on October 4 th. There was no documentation the resident declined to participate in the other facility activities, including music. The Program Participation Record for November 2011 revealed only one (1) visit was documented under the one (1) on one (1) activities section. There was no documentation showing the resident participated in any other activities listed and there was no documentation the resident declined to participate.</p> <p>Observations of Resident #10, on 11/16/11 at</p>	F 24B		

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

PRINTED: 12/06/2011
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 11/18/2011
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)	(X6) COMPLETION DATE
F 248	<p>Continued From page 3</p> <p>9:10 AM, 10:20 AM, 11:35 AM, 12:35 PM, and 2:00 PM revealed the resident was awake in her room. The resident was not taken to any group activities scheduled and there was no music or TV on in the resident's room. Further observation, on 11/17/11 at 2:35 PM, revealed the resident was in his/her room while the facility had a music activity going on.</p> <p>Interview, on 11/17/11 at 2:40 PM, with Certified Nursing Assistant (CNA) #11, regarding the resident participating in the music activity, revealed she did not ask the resident if he/she wanted to attend the activity. Further interview revealed, she did try to get the resident to activities when the resident was out of bed. CNA # 11 stated Resident #10 only attended about one activity a month. CNA #11 further stated the resident got individual activities in his/her room, but did not know what specific activities the resident got or how often. When asked how the resident spent his/her days, CNA #11 stated the resident looked out the window, talked to his/her doll, and talked with CNA's when in his/her room for care. Further interview regarding the resident being hard of hearing revealed the resident did hear better with the hearing aide.</p> <p>Interview, on 11/18/11 at 2:10 PM, with CNA #12 who cared for Resident #10, regarding activities, revealed the CNA was not aware the resident attended any religious services or listened to music. In addition, the resident did not attend alot of group activities. The CNA did not assist the resident with one (1) on one (1) activities, this was done by activities staff. Further interview revealed, the resident liked to talk and communicate with staff and at one time the</p>	F 248		

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

PRINTED: 12/06/2011
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 11/18/2011
--	--	--	---

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 248	Continued From page 4 resident had a set of headphones with a microphone that would allow the resident to hear them better. Interview, on 11/18/11 at 2:20 PM, with the Activities Assistant (AA), revealed the resident loved to talk to people, but had a hard time hearing. The resident used to have a device with headphones and a microphone which helped the resident hear much better, but did not know what happened to that device. The AA further stated it had been awhile since Resident #10 attended group activities regularly and now most of the activities were individualized in the resident's room. Interview with the AA further revealed only Activities Staff conduct the one (1) on one (1) activities and they did not have any set activities.	F 248		
F 281 SS=D	489.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services provided meet professional standards of quality for three (3) of twenty (20) sampled residents, (Resident #11, #12 and #13). The facility failed to ensure Physician's Orders were followed for Resident #11 related to EZ	F 281		

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

PRINTED: 12/08/2011
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 11/18/2011
NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1046 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 281	<p>Continued From page 5</p> <p>Wrap to the oxygen tubing. Also, Physician's Orders were not followed for Resident #11 and Resident #12 related to sliding Sliding Scale Insulin (Insulin.</p> <p>In addition, the facility failed to ensure Physician's Orders were followed for Resident #13 related to oxygen.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of Resident #11's medical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease and Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/23/11, revealed the facility assessed the resident as having severe impairment in cognitive skills for decision making and as requiring limited to total assistance with Activities of Daily Living (ADL's). Further review revealed the facility assessed the resident as receiving oxygen therapy. <p>Review of the 11/11 Physician's Orders revealed orders for EZ Wraps to the oxygen tubing behind ears to prevent tube rubbing every shift. Further review revealed orders for oxygen at two (2) liters per nasal cannula.</p> <p>Observation, on 11/16/11 at 10:00 AM, of a skin assessment revealed the resident had oxygen at 2 liters per nasal cannula and the EZ Wraps to the oxygen tubing were not in place. There was no skin breakdown behind the resident's ears. Further observation, on 11/16/11 at 11:00 AM, 12:45 PM, and 11/17/11 at 10:00 AM revealed the resident had oxygen at 2 liters per nasal cannula and the EZ Wraps to the oxygen tubing were not</p>	F 281	<p>F 281</p> <ol style="list-style-type: none"> 1. E-Z wrap was placed on oxygen tubing on resident #11 on 11/18/11 by a licensed nurse. No skin breakdown was noted. The physician of Resident #11 was notified of the Sliding Scale Insulin not administered as ordered on 11/17/2011 by a licensed nurse with no new orders noted. The oxygen for resident #13 was set at 2Liters/minute and the nasal cannula placed in the residents nares and assessed by a licensed nurse and the physician notified on 11-18-11. No change in condition was identified. 2. Current Physicians orders will be reviewed as of 12/21/2011 by the Director of Nursing Services, Assistant Director of Nursing Services and Unit Managers to determine that physician orders are followed. Any concerns identified will be addressed. 	

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

PRINTED: 12/08/2011
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 11/18/2011
--	--	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281	<p>Continued From page 6 In place.</p> <p>Interview, on 11/17/11 at 10:00 AM, with Certified Nursing Assistant (CNA) #11 revealed she was assigned to the resident and she verified the EZ Wraps were not on the resident's oxygen tubing. She stated, she was unsure if the resident was to have the EZ Wraps. She further stated, she checked the CNA Care Plan at the beginning of each shift for a reference for devices needed. Review of the CNA Care Plan, dated 11/11, revealed interventions for EZ Wrap to the oxygen tubing.</p> <p>Interview, on 11/17/11 at 10:05 AM, with Licensed Practical Nurse (LPN) #7 revealed she was assigned to the resident and was unaware the EZ Wraps were not on the resident's oxygen tubing as she had not completed treatments yet for this resident. She stated the resident had the EZ Wraps in place prior to being transferred to the hospital on 11/15/11 and the staff must not have been reapplied them after return. She further stated the Treatment Administration Record (TAR) dated 11/11 had the intervention for the EZ Wraps and the nurses were to ensure the device was in place and sign the TAR to verify this. Review of the TAR revealed the EZ Wraps were signed on night shift 11/16/11 to indicate the EZ Wraps were in place.</p> <p>2. Further review of Resident #11's Physician's Orders revealed orders for Novolin R (Insulin Regular Human) 100 Unit/Milliliter (ML) Solution Subcutaneous (SQ) before meals (AC) and at night (HS) everyday: Sliding Scale (SS) AC and HS: 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-400=6 units, and greater than 400 call</p>	F 281	<p>3. Licensed nursing staff have been re-educated as of 12/12/11 by the Assistant Director of Nursing regarding following Physicians orders and the Care and Services Policy.</p> <p>4. The Director of Nursing Services, Assistant Director of Nursing Services and or the Unit Managers will conduct 5 audits/week times 1 month, then weekly for 1 month, then monthly times 1 month to determine that physician's orders are followed. A summary of these findings will be submitted monthly x3 months to the Performance Improvement Committee for further review and recommendation.</p> <p>5. Date of completion:</p>	12/22/11
-------	--	-------	---	----------

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

PRINTED: 12/08/2011
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 11/18/2011	
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 281	<p>Continued From page 7 Physician.</p> <p>Review of the Medication Administration Record (MAR) dated 11/11 revealed the resident's finger stick blood sugar (FSBS) on 11/05/11 at 6:00 AM was 198. The MAR was marked as "0" SS Insulin administered. On 11/06/11 at 11:30 AM the residents FSBS was 171 and at 5:30 PM the resident's FSBS was 182. The MAR was marked as "0" SS Insulin administered. On 11/07/11 at 6:00 AM the residents FSBS was 153 and at 11:30 AM the residents FSBS was 185. The MAR was marked as "0" SS Insulin administered. On 11/11/11 at 6:00 AM the resident's FSBS was 154 and at 5:30 PM the resident's FSBS was 185. The MAR was marked as "0" SS Insulin administered. On 11/14/11 at 6:00 AM the resident's FSBS was 154 and at 11:30 AM was 188. The MAR was marked to indicated the resident received "0" SS Insulin. There was no documented evidence the resident received the SS Insulin as ordered.</p> <p>Interview, on 11/17/11 at 3:40 PM, with the Unit Coordinator/Licensed Practical Nurse (LPN) #8, revealed she checked the MARs every day to ensure the nurses were initialing medications as administered. She further stated she randomly checked the MARs to ensure Sliding Scale Insulin was administered as ordered. She stated she was unaware the nurses were not administering the correct dose of SS Insulin. She stated the resident was a "brittle diabetic" and the nurses should administer the SS Insulin as ordered unless they received a clarification order from the Physician.</p> <p>Interview, on 11/17/11 at 4:00 PM, with LPN #2</p>	F 281		

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

PRINTED: 12/08/2011
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 11/18/2011
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 281	<p>Continued From page 8</p> <p>revealed she had documented "0" Insulin administered on 11/08/11 and 11/07/11 at 11:30 AM and the resident should have received "1" Unit of SS Insulin at those times according to the FSBS. She stated she could have administered the "1" Unit of SS Insulin and documented none as given, although she could not remember.</p> <p>3. Record review revealed the facility admitted Resident #12 on 11/09/11 with diagnoses which included Type II Diabetes. The resident had a Physician's Order, with an Order Date of 05/12/11 and a Start Date of 11/09/11, for diabetes medicine Novolin R (Insulin Regular (Human)) 100 Unit/Millimeter Solution was to be given by Subcutaneous Injection. The medication was to be given by sliding scale based on the resident's blood sugar before meals and at bedtime. Part of the order read: If the blood sugar level was between two-hundred and fifty-one (251) and three-hundred (300) give four (4) units of the medication and if their blood sugar level was between three-hundred and one (301) and three-hundred and fifty (350) give six (6) units.</p> <p>Further record review of the November 2011 Medication Administration Record (MAR) revealed, on 11/11/11, Resident #12's blood sugar at 8:00 PM was three-hundred and fourteen (314). The amount of Novolin R (Insulin Regular (Human)) 100 Unit/Millimeter Solution given by Subcutaneous Injection was four (4) units.</p> <p>Interview, on 11/17/11 at 3:10 PM, with Licensed Practical Nurse #6 (Unit Manager), who reviewed the MAR, revealed based on the blood sugar level of three-hundred and fourteen (314) and the amount of medication ordered when the level is between three-hundred and one (301) and</p>	F 281		

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

PRINTED: 12/06/2011
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 11/18/2011
--	--	--	---

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 281	Continued From page 9 three-hundred and fifty (350) the nurse should have given six (6) units of Novolin R (Insulin Regular (Human)) 100 Unit/Millimeter Solution. The nurse only gave four (4) units.	F 281	F282	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure services were provided in accordance with the resident's written Comprehensive Plan of Care for two (2) of twenty (20) sampled residents, (Resident #5, and #10). Resident #5's Care Plan was not followed related to ensuring the bedside table was locked at all times. In addition, Resident #10 did not receive weekly one on one activities as per the Plan of Care. The findings include: Review of the facility's policy: Care Plan - Interdisciplinary, dated January 2008, revealed it is the policy of the center to develop an individualized plan of care for each resident utilizing the information gathered during each assessment. The policy also stated, under the Actions Steps #3, The Interdisciplinary Team	F 282	1. The Care Plan for resident #5 was reviewed and updated to discontinue the intervention for the locking bedside table with no new intervention needed on 11/17/11 by the Director of Nursing. Resident #10 received 1:1 Activities by the Activity staff as per plan on 11/21/11 and then at least weekly ongoing. 2. The plan of care for current residents have been reviewed as of 12/14/11 by the Interdisciplinary team to determine that interventions were provided as indicated in the resident Plan of Care. Issues noted were corrected as indicated. 3. Nursing staff have been re-educated as of 12/12/11 by the Assistant Director of Nursing regarding following the residents Plan of Care. The Administrator re-educated the Activity Director and Activity assistant on the Activity Policies and Procedure and following the residents plan of care on 12/13/11.	

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

PRINTED: 12/08/2011
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 11/18/2011
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 282	<p>Continued From page 10</p> <p>educates the resident/responsible party to the care plan and implements the care plan.</p> <p>1. Record review revealed Resident #5 was admitted by the facility, on 04/08/08, with diagnoses which included Mental Retardation, Difficulty Walking, and Debility.</p> <p>Record review of the resident's Plan of Care revealed Resident #5 to be at risk for falls related to impaired balance, non-compliance with mobility aide use, and decreased safety awareness. The care plan also revealed the resident had a recent fall in his/her room on 11/07/11. The interventions listed on the Comprehensive Plan of Care included "lock wheels of bedside table".</p> <p>Observation, on 11/15/11 at 2:05 PM, revealed the bedside (overbed) table was not equipped with any locking mechanism for the wheels. Observation, on 11/15/11 at 6:00 PM and on 11/16/11 at 12:15 PM, revealed Resident #5 eating his/her meal in the room. The resident's meal tray was located on the bedside (overbed) table that was not equipped with a locking mechanism for the wheels.</p> <p>Interview with the Certified Nursing Assistant (CNA) #7, who was assigned to provide care for Resident #5, on 11/18/11 at 2:30 PM, revealed she was not aware the Comprehensive Plan of Care stated the bedside table needed to be locked.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, the Charge Nurse assigned to provide care for Resident #5, revealed the overbed table currently in his/her room did not come equipped with wheels that could be locked.</p>	F 282	<p>4. The Director of Nursing Services, Assistant Director of Nursing Services and or the Unit Managers will audit 5 resident's Plan of Care and the resident to determine that interventions are provided as indicated weekly for 2 months, then monthly for 1 month. A summary of these findings will be submitted monthly x3 months to the Performance Improvement Committee for further review and recommendation.</p> <p>5. Completion date:</p>	12/22/11	

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

PRINTED: 12/08/2011
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2011
--	--	--	---

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 282	<p>Continued From page 11</p> <p>Interview with CNA #10, on 11/18/11 at 2:40 PM, revealed the resident previously had a bedside (overbed) table that could be locked although she could not state when or why that table would have been changed out to a non-locking table.</p> <p>Interview with the Unit Coordinator, Registered Nurse (RN) #3, on 11/18/11 at 3:30 PM, revealed the facility failed to have the proper equipment such as the locking bedside (overbed) table available in Resident #5's room per the intervention listed as part of the resident's Plan of Care. Further interview revealed she also was unaware the proper equipment was not in the resident's room.</p> <p>2: Record review revealed Resident #10 was admitted by the facility, on 09/16/10, with diagnoses which included Depression and Alzheimer's Disease. Record review of the resident's activity care plan, revision on 09/20/11, revealed the resident was unable to self initiate activities and needed reminders and transportation to and from activities. In addition, it noted the resident was hard of hearing and enjoyed music and conversation with staff. The goals included receiving one (1) on one (1) activities twice (2) a week and to keep the resident active in facility life. Interventions included: introducing the resident to other residents with the same interest; alert the resident about activities he/she has interest; receive one (1) on one (1) activities on a weekly basis; activity calendar in room; remind and invite to activities of choice; to provide transportation to activities of choice; and in room visits for conversation as</p>	F 282		

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

PRINTED: 12/06/2011
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 11/18/2011
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 282	<p>Continued From page 12 tolerated.</p> <p>Further record review of Resident #10's Program Participation Record for October 2011 revealed: only one (1) visit (October 14 th) was documented under the section showing one (1) on one (1) activities, and the resident participated in only one facility program activity (Helping Hands) on October 4 th. There was no documentation the resident declined to participate in the other facility activities. The Program Participation Record for November 2011 revealed only one (1) visit was documented under the section showing one (1) on one (1) activities. There was no documentation showing the resident participated in any other facility activities listed and the resident declined to participate.</p> <p>Observations of Resident #10 on 11/16/11 at 9:10 AM, 10:20 AM, 11:35 AM, 12:35 PM, and 2:00 PM revealed the resident was awake in his/her room. No one on one activities were observed and the resident was not taken to any group activities scheduled for that day. Further observation, on 11/17/11 at 2:35 PM, revealed the resident was in his/her room while the facility had a music activity in progress.</p> <p>Interview, on 11/17/11 at 2:40 PM, with Certified Nursing Assistant (CNA) #11, regarding the resident participating in the music activity, revealed she did not ask the resident if she wanted to attend the activity. When asked about Resident #10 attending activities, CNA # 11 thought the resident only attended about one activity a month. When asked how the resident spent his/her days, CNA #11 stated the resident looked out the window, talked to his/her doll and</p>	F 282			

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

PRINTED: 12/08/2011
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 11/18/2011
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 282	Continued From page 13 with CNA's when in the room for care. Interview, on 11/18/11 at 2:10 PM, with CNA #12, who cared for Resident #10, regarding activities, revealed the CNA was not aware the resident attended any religious services or listened to music. In addition, the resident did not attend alot of group activities. Interview, on 11/18/11 at 2:20 PM, with the Activities Assistant (AA), revealed it had been awhile since Resident #10 attended group activities and now most activities for him/her were individualized in his/her room. After review of Resident #10's activity log for October 2011 and November 2011, the AA revealed the facility was not meeting the activity needs of the resident or following the care plan to provide one to one activities weekly.	F 282			
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 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Material Safety Data Sheet (MSDS), it was determined the facility failed to ensure that the environment remains as free of accident hazards	F 323	F323 1. Chemical found in unlocked cabinet on Hall 1 was removed on 11/15/2011 by Director of Nursing Services. 2. Rounds of the facility were completed on 11-15-11 by the Director of Nursing Services to determine if all chemicals were stored appropriately. No other concerns were identified.		

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

PRINTED: 12/06/2011
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 11/18/2011
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 323	Continued From page 14 as is possible. The general bathroom on the 100 Unit had an unlocked cabinet which contained a chemical accessible to residents. The findings include: Observation on initial tour, on 11/15/11 at 10:00 AM, revealed an unlocked cabinet in the general bathroom on the 100 Hall containing a bottle of "Enzymatic #502 Foul Odor Digester" which stated "Keep out of the reach of Children". Interview with Licensed Practical Nurse (LPN) #2 at that time revealed there should not have been any chemicals in the unlocked cabinet. Interview, on 11/16/11 at 4:10 PM and 11/18/11 at 8:30 AM, with the Director of Nursing (DON), revealed the Unit Managers were to audit daily for proper storage of chemicals and materials which should not be accessible to residents. Further interview revealed there were wandering residents on the hall. Review of the Material Safety Data Sheet (MSDS), revealed Enzymatic Foul Odor Digester #502 was a health hazard if the eye or skin were exposed. Further review, revealed emergency and first aide procedures: eyes- flush immediately with water for at least fifteen (15) minutes and call a Physician, skin- wash thoroughly with soap and water and remove contaminated clothing, ingestion- drink large quantities of water or milk and call a Physician, Inhalation- remove exposed person to air and treat immediately.	F 323	3. Nursing staff have been re-educated regarding the prevention of accidents/incidents including chemical storage as of 12/12/11 by the Assistant Director of Nursing Services. 4. An audit of the facility to determine that measures to prevent accidents/incidents including the appropriate storage of chemicals will be completed 3 times per week x2 months and then weekly x1 month by either the Director of Nursing, Assistant Director of Nursing or Unit Managers. A summary of findings will be submitted to the Performance Improvement Committee by the Director of Nursing Services for further review and recommendations. 5. Date of completion:	12/22/11	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328			

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

PRINTED: 12/06/2011
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 11/18/2011
--	--	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 328	<p>Continued From page 15 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews it was determined that the facility failed to ensure proper respiratory care for one (1) of thirteen (13) sample residents, (Resident 13).</p> <p>The findings include:</p> <p>Record Review revealed that Resident #13 was admitted to the facility on 7/16/07 with diagnoses of Chronic Airway and Intestinal Obstruction. Review of the Physician Orders, dated 11/11, revealed an order for oxygen at 2 liters via nasal cannula PRN (as needed).</p> <p>Observation, on 11/18/11 at 9:30 AM, revealed Resident #13 with oxygen per nasal cannula on his/her forehead. Also, the oxygen concentrator was set at six (6) liters.</p> <p>Interviews with State Registered Nurse Assistant (SRNA) #7 stated she was not aware that the oxygen cannula was not in Resident #13 nose.</p>	F 328	<p>F328</p> <ol style="list-style-type: none"> 1. The oxygen tubing for resident #13 was applied to her nares and oxygen placed at 2 liters, a re-assessment was completed and no change of condition was identified on 11/18/11 and physician notified by a licensed nurse. 2. Residents with current oxygen orders were reviewed on 11/18/11 by Director of Nursing Services for proper application and appropriate setting of concentrators. No other concerns were identified. 3. Nursing staff have been re-educated to providing proper treatment and care of residents with special services and included applying oxygen to the nares as well as providing the correct liters of oxygen as ordered as of 12/12/11 by the Assistant Director of Nursing Services. 	
-------	--	-------	---	--

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

PRINTED: 12/08/2011
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 11/18/2011
NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1040 UB 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 328	Continued From page 16 Interview with License Practical Nurse (LPN) #4 revealed the oxygen concentrator should be set at 2 liters. LPN #4 stated the oxygen was checked between 8:30 AM and 9:00 AM and it was at 2 liters, and she did not know how it got to 6 liters.	F 328	4. Current residents with respiratory care needs will be reviewed by Director of Nursing Services, the Assistant Director of Nursing Services and or the Unit Manager for proper application and oxygen setting five times/week for 1 month, then weekly for 1 month, then monthly times one month. A summary of findings will be reported to the Performance Improvement Committee monthly x3 months for further review and recommendation. 5. Date of completion	12/22/11
F 371 86=E	483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations on 11/15/11 during supper preparation and service revealed, the cook put a cheese sandwich on the grill without gloves and put food in the grinder, adjusted glasses, removed food from grinder and returned to serving trays. Observation on 11/16/11, revealed the delivery driver was not wearing a hair restraint while walking through the kitchen to deliver food to the storage areas in kitchen. The findings include:	F 371		

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

PRINTED: 12/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2011
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 371	<p>Continued From page 17</p> <p>Review of the facility's policy revealed: no separate Kitchen Infection control policy; uses facility general infection control policy titled "Infection Control Program", dated 01/08.</p> <p>Interview, on 11/17/11 at 10:30 AM, with the Director of Nursing (DON), revealed the facility did not have a separate Dietary Department Infection Control policy. She further stated the Dietary Department used the facility Infection Control policy, of which she oversaw the overall Infection Control Program.</p> <p>Observations, on 11/15/11 at 4:35 PM, revealed Cook #3 used her bare hands to place a cheese sandwich on the grill. Further observation at 5:15 PM, revealed Cook #3 placed food in the grinder, adjusted glasses, removed food from the grinder and continued to serve the supper meal.</p> <p>Interview with Cook #3, on 11/15/11 at 4:30 PM, revealed she knew she should have worn gloves for infection control. Further interview with Cook #3 at 5:20 PM, revealed she was unaware she had touched her glasses.</p> <p>Observations, on 11/16/11 at 11:20 AM, revealed food delivery person (pulled back shoulder length hair) to deliver food to kitchen areas without wearing a hair covering. The storage areas (dry goods and refrigerator and freezer) were behind the cooking/serving area of the kitchen.</p> <p>Interview, on 11/16/11 at 11:25 AM, with Cook #2, revealed delivery drivers never wore hair covering when making deliveries.</p> <p>Interview with the Dietary Manager (DM), on</p>	F 371	<p>F371</p> <ol style="list-style-type: none"> 1. On 11/16/11, the driver was educated by the Dietary Manager and immediately put a hair net on to complete the delivery process. Dietary Manager 11/17/11 on proper glove use and hand washing. Signage was placed at the kitchen door entrance by the Dietary Manager on 11/17/11 to alert delivery drivers to wear hair nets. 2. The facility recognizes all residents benefit from proper sanitary conditions to include hand washing, wearing gloves and the use of hairnets in the dietary department. 3. The Dietician and Dietary Manager re-educated dietary staff on our use of Kentucky current food code and facility policy and procedures relating to proper glove use, hand washing, infection control, and properly restraining hair in all areas of the kitchen as of 12/13/11. 	

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

PRINTED: 12/06/2011
FORM APPROVED
OMB NO. 0998-0391

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 11/18/2011
--	--	--	---

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 371	Continued From page 18 11/16/11 at 11:30 AM, revealed the delivery drivers always wore a hair covering when making deliveries.	F 371	4. Dietician/Dietary Manager and/or Administrator will conduct audits of the kitchen for sanitary practices three times/week for four weeks then monthly times two months. Findings will be submitted to the Performance Improvement Committee monthly	
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 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	times three months for review and recommendations. 5. Date of compliance:	

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

PRINTED: 12/08/2011
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 11/18/2011
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 431	<p>Continued From page 19</p> <p>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 the facility's policy it was determined the facility failed to ensure the safe and secure storage of drugs and biologicals in the medication rooms. Observation of Hall 300 Medication Room revealed food stored with medication, cleaning supplies stored in medication room, suction equipment/supplies stored on the floor and expired culture/specimen collection tubes in the cabinets. Also observation of the Hall 200 Medication Room revealed medication logs which indicated medication failed to be stored at temperatures to preserve their integrity.</p> <p>The findings include:</p> <p>Review of the facility policy, "5.3 Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles", effective date 12/01/07, stated the facility should ensure that drugs and biologicals are stored in an orderly manner in cabinets. The policy also stated that food is not to be stored in the general storage areas where drugs and biologicals are stored. In addition the policy states the facility should ensure that drugs and biologicals are stored at their appropriate temperatures - Refrigeration: thirty-six (36) to forty-six (46) degrees Fahrenheit. Facility personnel should inspect nursing station storage</p>	F 431	<p>F431</p> <ol style="list-style-type: none"> 1. Medication Rooms were cleared of all food, objects on floor and items on top shelf removed, cleaning supplies removed, expired lab supplies removed, cardio case was removed, 11/15/11 by Unit Manager/Assistant Director of Nursing, and Director of Nursing. Medications were removed and discarded from the refrigerator on 12/16/11 by the Director of Nursing Services. 2. An audit of the facility was completed on 11-15-11 by Unit Managers, Assistant Director of Nursing, and Director of Nursing to determine that drugs and biologicals are stored appropriately. Additional items were identified on 11/15/11 by the Director of Nursing and removed. Revised Medication Refrigerator Temperature Logs were instituted on 12/01/11 to include recommended temperature ranges for medication storage by the Director of Nursing Services. 	

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

PRINTED: 12/06/2011
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 11/18/2011
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)	(X6) COMPLETION DATE	
F 431	Continued From page 20 areas for proper storage compliance on a regularly scheduled basis. Observation of the Hall 300 Medication Room, on 11/15/11 at 4:15 PM, revealed a bag of individually packaged Krispy Kreme cookie wafers stored in the cabinet and packets of coffee creamer stored in a box with alcohol pads. Disposable wound measuring guides were stored on the top shelf which did not provide eighteen (18) inch clearance. Cleaning supplies were stored on various shelves in the medication supply room - "Smart Simple Kitchen and Bath Cleaner", a commercial brand product and a 3-M Quart Disinfectant cleaner labeled "Laundry" was positioned horizontally on a shelf and dripping fluid from the spout/nozzle. A milk crate type container was located on the floor of the medication room. Inside the milk crate container were unused "sharps containers" and unused razors. A facility cleaning product, "Foul Odor Digester", was located on top on the razors. A cardboard box labeled "Vacuum Via System 7-Day Kit" was located directly on the floor of the medication room. A cardboard box labeled "Bordered Gauze" was on the shelf and noted to contain three (3) syringes and three artificial roses. Further observation revealed expired culture and specimen collection tubes/containers including three (3) Papa Pak collection containers with expiration dates of 09/2010, four (4) Protocol Culture and Sensitivity Medium collection containers with expiration dates of 02/2011, and Vacu-tainer tubes with expiration dates of 04/2010, 05/2010 and 03/2011. A gray storage box approximately twelve (12) by ten (10) by three (3) labeled "Cardio Case" was located on the shelf and identified as belonging to a resident	F 431	3. Education was provided to Licensed Nursing Staff regarding Medication Room storage, maintaining 18inch clearance, disposing of expired supplies, recording refrigerator temps as of 12/15/11 by the Assistant Director of Nursing Services. 4. The Medication rooms and temperature logs will be audited to determine safe and secure storage of drugs and biologicals by Unit Manager, Director of Nursing Services, and or the Assistant Director of Nursing Services 3x/week x 2 months, then weekly x 2 months. Results will be submitted to the Performance Improvement Committee monthly for review and further recommendation 5. Date of completion:	12/22/11	

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

PRINTED: 12/06/2011
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 11/18/2011
--	--	--	---

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)	(X6) COMPLETION DATE
F 431	<p>Continued From page 21 that no longer lived at the facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 11/17/11 at 2:40 PM, revealed nursing was responsible for cleaning the Medication Room and checking for outdated supplies and medications. Continued interview with the Unit Coordinator on 11/17/11 at 5:15 PM, revealed the facility failed to ensure the supplies and Medication Room were in order. She further stated food and non-medical supplies should never be stored in the Medication Room.</p> <p>Interview with the Housekeeping Supervisor, on 11/18/11 at 10:40 AM, revealed the cleaning supplies were not to be stored in the Medication Room. He further revealed no Material Safety Data Sheets (MSDS) were kept on file for the non-industrial cleaners such as the "Smart Simple Kitchen and Bath Cleaner".</p> <p>Record review of the Hall 200 Medication Room Temperature Logs revealed the temperature on the October 2011 to be below the facility policy temperature of thirty-six (36) degrees Fahrenheit on five separate dates. The temperature on 10/04/11 and 10/05/11 was recorded as two (2), on 10/19/11 the recorded temperature was twenty-eight (28) degrees and recorded as thirty-two (32) degrees and both 10/25/11 and 10/28/11.</p> <p>Record review of the facility's Refrigeration Checklist (log sheet) revealed only the upper limit of the temperature range - "Temp must be maintained at or below 41 degrees".</p> <p>Interview with Licensed Practical Nurse (LPN) #6,</p>	F 431		

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

PRINTED: 12/08/2011
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 11/18/2011
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)	(X6) COMPLETION DATE	
F 431	Continued From page 22 on 11/18/11 at 10:30 AM, revealed it was the responsibility of the midnight shift to check refrigerator temperatures. Interview with LPN #7, on 11/18/11 at 1:40 PM, revealed on occasion she had checked the temperature of the medication refrigerator. However, further interview revealed she could not state the acceptable temperature range and acknowledged she had recorded a temperature of below thirty-six (36) degrees Farenheit. Interview with the Unit Manager, on 11/18/11 at 2:40 PM, revealed the temperature should be between thirty-six (36) and forty-six (46) degrees for the medication refrigerator. However, further interview revealed she could not recall when the staff was inserviced regarding the acceptable temperature range stated in the facility policy. In addition, she could not provide evidence that the log sheets were monitored for exceptions to the required temperatures or evidence measures were taken to ensure the integrity of the medications were preserved when unacceptable temperatures were recorded.	F 431			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441			

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

PRINTED: 12/06/2011
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 11/18/2011
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 441	<p>Continued From page 23 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of disease and infection for one (1) of twenty (20) sampled residents, (Resident #2) and one (1) unsampled</p>	F 441	<p>F441</p> <p>1. Soiled linen carts were removed from being in front of the washing machine and from the clean side of the laundry room on 11/18/11 by laundry staff. The bed linens were changed for resident #2 by the licensed nurse on 11/18/11.. Nursing staff education was initiated on 12/1/11 and completed 12/12/11 by the Assistant Director of Nursing regarding Infection Control Practices, including proper disposal of soiled linens during resident care procedures, and hand washing during meal service.</p>	

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

PRINTED: 12/06/2011
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 6 C 11/18/2011
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 441	<p>Continued From page 24 resident (Unsampled Resident B).</p> <p>During meal service, staff was observed to pick up tissues off the floor, wipe the floor with the tissues, and without washing or sanitizing hands, proceed to set up Unsampled Resident B's meal tray.</p> <p>Observation of perineal-care/wound care, revealed staff placed soiled linens on Resident #2 bed.</p> <p>Additionally, observation of the laundry room revealed dirty linen tubs were parked in front of the washing machine. Also, there was a dirty laundry bin parked on the clean side of the laundry room with clean garments hanging above the bin.</p> <p>The findings include:</p> <p>1. Observation during meal service on the 100 Hall, on 11/15/11 at 6:15 PM, revealed Certified Nursing Assistant (CNA) #12 picked up a wad of tissues off the floor, then proceeded to wipe the floor with the tissues. She then took a tissue out of the box on the bedside table and wiped her hands with the tissue. The CNA then proceeded to set up Unsampled B's meal tray. There was no evidence the CNA washed or sanitized her hands after picking up the dirty tissues and wiping the floor.</p> <p>Interview, on 11/15/11 at 6:20 PM, with the CNA revealed she had wiped her hands with a clean tissue; however, should have washed or sanitized her hands prior to setting up the resident's meal tray.</p>	F 441	<p>2. KR Associates Contractor assessed the laundry area for structural changes to accommodate separate soiled/clean laundry areas in the laundry room on 12-15-11. A bid was accepted by the center on 12-16-11 and construction to be complete by 2-15-12. Rounds were completed by the Director of Nursing Services and Assistant Director of Nursing on 12/15/11 to identify other Infection Control Practice concerns with no other issues identified. Soiled linens carts are being stored by nursing, housekeeping and laundry staff in the soiled utility room effective 12/15/11</p> <p>3. Nursing assistants, have been re-educated to Standard Precautions, Infection Control practices including hand washing and disposal of soiled linens by the Assistant Director of Nursing Services as of 12/12/11. Laundry and housekeeping staff were re-educated on infection control practices to include storage of soiled linen carts on 12/16/11 by the</p>		

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

PRINTED: 12/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2011
--	--	--	---

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 441	<p>Continued From page 25</p> <p>2. Observation, on 11/18/11 at 11:00 AM, of the laundry room revealed the soiled laundry bins were brought through the hall doors and the soiled clothes were emptied into the soiled gray laundry tubs which were parked in front of the washers. Further observation revealed a soiled laundry bin was parked on the clean side of the laundry room under a rack of clean garments.</p> <p>Interview, on 11/19/11 at 12:30 PM, with the Environmental Services Director, revealed there was concerns with a lack of space in the laundry room. He stated there was no place to store the soiled laundry bins or soiled gray laundry tubs and the soiled gray laundry tubs were always parked in front of the washing machine. Further interview revealed the soiled laundry bins should not be stored on the clean side of the laundry room; however, there was no other space in which to store them. He stated this could be an infection control issue which could affect all the residents.</p> <p>3. Observation, on 11/16/11 at 9:25 AM, during perineal care/wound care revealed CNA #1 place soiled linens on Resident #2 bed with Resident #2 lying in bed.</p> <p>Interview, on 11/16/11 at 9:30 AM, with CNA #1 revealed she should have placed linens directly into plastic bag.</p> <p>Interview, on 11/16/11 at 9:35 AM, with Registered Nurse (RN) #3, who was performing wound care, revealed CNA #1 should have placed soiled linens directly into plastic bag.</p>	F 441	<p>Assistant Director of Nursing Services.</p> <p>4. Meal Service audits and Infection Control practice audits to be completed to determine infection control practices are followed by the Director of Nursing Services, the Assistant Director of Nursing Service 3x/wk x 2months, then weekly x 1 months. The housekeeping supervisor will complete audits of the laundry room to determine soiled linen carts are stored appropriately 3x/week x 2 months, then weekly x1 month. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation.</p> <p>5. Date of completion:</p>	12/22/11

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

PRINTED: 12/06/2011
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 11/18/2011
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 441	Continued From page 26 Interview, on 11/17/11 at 10:05 AM, with Licensed Practical Nurse (LPN) #1 revealed while performing perineal care, soiled linens and briefs should be placed directly into separate plastic bags. Interview, on 11/17/11 at 10:15 AM, with CNA #2 revealed the process to perform perineal care would be to wash hands, put on gloves, begin cleaning from front to back, place soiled linens and briefs into plastic bags. Interview, on 11/17/11 at 10:24 AM, with CNA #3 revealed staff should place dirty linens in a plastic bag. Interview, on 11/17/11 at 11:35 AM, with CNA #4 revealed all linens were to placed into bags.	F 441			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Observation revealed loose hand rails in resident bathrooms, stains on the ceilings in the corridors and resident rooms and bathrooms, peeling paint	F 465	F465 1. The Maintenance Director repaired the following items by 11/25/11: stains on the ceiling in the hall 100 corridor was repainted. The blinds were replaced in the women's bathroom. Rm 211 electrical outlet was repaired. Rm 209 dresser was repainted, wall by sink repaired		

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

PRINTED: 12/06/2011
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 11/18/2011
--	--	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 465	<p>Continued From page 27 from wall heaters and chest of drawers in resident rooms, missing tiles from resident bathrooms, and wash pans left in bathroom floors.</p> <p>The findings include:</p> <p>Observation during environmental tour, on 11/15/11 at 10:00 AM and 5:00 PM, revealed:</p> <p>100 Hall- brown stains on the ceilings in the corridor and bent blinds in the women's general bathroom.</p> <p>200 Hall- RM 211-electrical outlet with no cover; RM 209-dresser with peeling paint, general bathroom with a chipped corridor door and missing paint and missing plaster on the wall by the sink.</p> <p>300 Hall- RM 312-brown substance between the tiles around the toilet and hand rail loose by the toilet; RM 301-wall heater with peeling paint, toilet hand rail loose, a wash pan on the floor, and dusty floor vents in resident bathroom; Room 310-brown stain on the ceiling, peeling paint from the wall heater, peeling paint from the dresser, rusty bathroom toilet hand rail, chipped paint on the ceiling around the vent in the bathroom; RM 303- chest of drawers with missing paint, and wall tile loose in the bathroom; RM 309- paint chipped off the chest of drawers; RM 304- missing paint around the ceiling vent; RM 305- tile chipped around the door entrance, peeling paint from the wall heaters in the room and bathroom; RM 307- missing paint from the wall by the headboard and around the bathroom door; RM 308- chipped paint on the wall by the door.</p>	F 465	<p>and painted. Rm 312 tiles around the toilet were cleaned and hand rail tightened. Rm 301 wall heater scraped and painted, hand rail tightened, wash pan discarded and floor vents in bathroom cleaned. Rm 310 ceiling, wall heater and dresser painted. The toilet hand rail was replaced and the ceiling around the bathroom vent was painted. Rm 303 chest of drawers painted and loose tile repaired. Rm 309 chest of drawers painted. Rm 304 chest of drawers painted, the ceiling around the bathroom vent was painted. Rm 305 tile around door entrance repaired, wall heater repainted. Rm 307 wall by headboard around the bathroom door repainted. Rm 308 wall by door repainted. Rm 412 chest of drawers was painted. Rm 401 wash pan discarded. Rm 404 wall by bathroom and wall heater repainted. Rm 406 bathroom ceiling repainted and tile around bathroom door repaired.</p> <p>2. Audit of the facility will be conducted by the Maintenance Director by 12/21/11. Issues noted will be documented on work orders and completed as of 12/30/11.</p>	
-------	--	-------	--	--

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

PRINTED: 12/06/2011
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 11/18/2011
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 465	Continued From page 28 400 Hall- RM 412- paint missing from the wall around the chest of drawers; RM 401- wash pan in the bathroom floor; RM 404- paint missing from the wall by the bathroom and peeling paint from the wall heater; RM 406- stain on the bathroom ceiling and floor tile chipping around the bathroom door. Interview, on 11/18/11 at 1:05 PM, with the Maintenance Director revealed he had been working at the facility for a month and had no set schedule at that time for painting and replacing bathroom tiles. He acknowledged the wall heaters and chest of drawers in resident rooms needed to be painted and some tiles needed to be replaced in the bathrooms. He further stated he had been repairing resident rooms as he received work orders and was constantly fixing doors and walls where the wheelchairs had hit them. He further stated he had tightened some hand rails in resident bathrooms and was still making rounds. Interview, on 11/18/11 at 9:30 AM, with the Director of Nursing revealed the wash pans should be stored in resident drawers or closets and not left on the floor.	F 485	3. Maintenance Director will be re-educated on 12/16/11 on providing a safe, functional, sanitary and comfortable environment. 4. Maintenance Director and/or Administrator will conduct weekly audits to determine a safe, functional, sanitary, and comfortable environment is maintained times 4 weeks, then monthly x 2 months. A summary of findings will be submitted to the Performance Improvement Committee for further review and recommendation. 5. Date of compliance: _____	12/22/11	
F 515 SS=D	483.75(l)(2) RETENTION OF RESIDENT CLINICAL RECORDS Clinical records must be retained for the period of time required by state law; or five years from the date of discharge when there is no requirement in State law; or, for a minor, three years after a resident reaches legal age under State law.	F 515			

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

PRINTED: 12/08/2011
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 11/18/2011
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 515	<p>Continued From page 29</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy it was determined the facility failed to ensure the clinical record was accurately documented for two (2) of twenty (20) sampled residents (Resident #3 and Resident #5). Resident #3's Physician Orders and Medication Administration Record (MAR) did not reference the correct route for administration of medication. Medications were ordered to be given by "enteral tube" (feeding tube) and the resident did not have a feeding tube in place. Also Resident #5 sustained a fall on 11/06/11 and there was no documented evidence of follow-up charting in the Interdisciplinary (IDT) Notes for three of nine shifts per the facility policy.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility admitted Resident #3 on 08/09/11 with diagnoses which included Protein-Calorie Malnutrition, Oral Phase Dysphagia, Sepsis and Anemia. Record review of the Minimum data Set (MDS) Assessment, dated 08/16/11, revealed the resident had a feeding tube in place on admission to the facility. However, further review of the record revealed the feeding tube was removed on 10/31/11. <p>Record review of the November 2011 Physician's Orders and the November 2011 Medication Administration Record (MAR) revealed oral medications with an order date prior to 11/10/11 reflected the route of administration to be via "enteral tube".</p> <p>Interview with Licensed Practical Nurse (LPN) #3,</p>	F 515	<p>F515</p> <ol style="list-style-type: none"> Physician orders for resident #3 were corrected on 11/18/11 to include the correct route of delivery of medications by Unit Manager. Physicians orders reviewed on current residents to determine documentation of accurate route of medication delivery on 11/30/11 by Director of Nursing Services. A review of residents with falls since Nov 1, 2011 was completed as of 12/15/11 by Director of Nursing to determine proper documentation recorded. Staff education initiated to address any concerns identified. Licensed Nursing Staff have been re-educated regarding retention of the clinical record and including accuracy of the route of medication deliver and post fall documentation requirements by the Assistant Director of Nursing Services as of 12/12/11. 	

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

PRINTED: 12/08/2011
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 11/18/2011
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)	(X6) COMPLETION DATE
F 515	<p>Continued From page 30</p> <p>on 11/17/11 at 5:10 PM, revealed the resident no longer had a feeding tube and had not realized the MAR still reflected the previous route "enteral tube" for the administration of Resident #3's medications. She further acknowledged she should have contacted the resident's Physician to change the route to reflect "oral" dose for the medications.</p> <p>Interview with the Nurse Practitioner involved in the primary responsibility of Resident #3's medical care, on 11/18/11 at 10:15 AM, revealed she was aware medications were being given orally but had failed to make the written change in Resident #3's orders to reflect the change of medication administration route from "enteral tube" to "oral".</p> <p>2. Review of the facility's policy, "Fall Management Program", revised 11/10, stated the Post-Fall Documentation is completed for seventy-two (72) hours following a fall. The policy further stated the licensed nurse continues to follow the resident every shift for the next seventy-two (72) hours, documents findings and resident condition in the Interdisciplinary Progress Notes.</p> <p>Record review revealed the facility admitted Resident #5 on 04/18/09 with diagnoses which included Difficulty Walking, Debility and Mental Retardation. Review of the Comprehensive Care Plan identified the resident to be at risk for falls related to: impaired balance, non-compliance of mobility aide use, visual deficit, and decreased safety awareness.</p> <p>Record review of the Interdisciplinary Progress</p>	F 515	<p>4. New Physicians orders of current residents will be reviewed for accurate documentation of route of medication by the Director of Nursing Services, the Assistant Director of Nursing Services and or the Unit Managers weekly x2 months, then monthly x1 months. The nursing notes for residents with falls will be reviewed weekly x8 weeks and then monthly x1 month to determine that follow up documentation is completed by the Director of Nursing Services, Assistant director of Nursing or the Unit Managers. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for review and further recommendation.</p> <p>5. Date of completion:</p>	12/22/11

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

PRINTED: 12/06/2011
FORM APPROVED
OMB NO. 0938-0301

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 11/18/2011
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 516	Continued From page 31 Notes, dated 11/06/11 at 6:30 PM, revealed Resident #5 sustained a fall witnessed by the resident's roommate. Record review of the Interdisciplinary Progress Notes revealed no documented evidence of fall up to the fall on 11/06/11 midnight shift or from 3:00 PM on 11/07/11 until 10:00 PM on 11/08/11. Interview with the Unit Coordinator, on 11/17/11 at 10:30 AM, revealed falls were to be documented in the Interdisciplinary Progress Notes each shift for seventy-two (72) hours. Further interview revealed no documented evidence in Resident #5's medical record to support the fall documentation policy was followed.	F 516		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520	F520 1. Administrator was released from Administrative duties as of December 1, 2011. 2. Interim Administrator assumed duties on 12/1/11.	

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

PRINTED: 12/06/2011
FORM APPROVED
OMB NO. 0938-0301

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 11/18/2011
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 520	<p>Continued From page 32 requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to ensure there was an effective infection control program, failure to ensure the Comprehensive Plan of Care was implemented, failure to ensure the resident environment remains as free of accident hazards as possible, failure to ensure proper storage of drugs and biologicals, and failure to ensure accurate maintenance of clinical records.</p> <p>The findings include:</p> <p>1. Based on observation, interview, and record review, it was determined the facility failed to maintain an effective infection control program in order to prevent the development and transmission of disease and infection within the facility. This was a repeat deficiency for the facility which was cited 09/09/10 for deficiencies related to staff failing to perform hand washing between residents during medication administration.</p>	F 520	<p>3. Department Managers will be educated by the interim administrator on Performance Improvement policies and procedures to include development and implementation of appropriate plans of action to correct quality deficiencies by 12/21/11.</p> <p>4. Performance Improvement meetings will be held monthly times 3 months and then quarterly. Plans of corrections will be reviewed and evaluated by the Performance Improvement Committee for further recommendations.</p> <p>5. Date of completion:</p>	12/22/11	

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

PRINTED: 12/06/2011
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 11/18/2011
--	--	--	---

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 520	<p>Continued From page 33</p> <p>Review of the facility's Plan of Correction, with a compliance date of 10/22/10, revealed nursing management would conduct inservices for all nursing staff on the infection control policy and procedures including general hand washing. The facility alleged infection control rounds would be completed by nursing management weekly for four (4) weeks, then monthly for two (2) months.</p> <p>Observations during this survey revealed staff was observed to pick up tissues off the floor, wipe the floor with the tissues, and without washing or sanitizing hands, proceed to set up a resident's meal tray.</p> <p>Additionally, observation of the laundry room revealed dirty linen tubs were parked in front of the washing machine and there was a dirty laundry bin parked on the clean side of the laundry room with clean garments hanging above the bin.</p> <p>Interview on 11/18/11 at 9:30 AM with the Director of Nursing (DON) and the Assistant DON/ Quality Assurance Nurse revealed they had inserviced staff on handwashing this month. Interview on 11/18/11 at 2:15 PM with the Infection Control Nurse revealed it was an infection control concern to have the dirty laundry bins and dirty laundry tubs on the clean side of the laundry room.</p> <p>2. Based on observation, interview, and record review, it was determined the facility failed to ensure the Comprehensive Plan of Care was followed. This was a repeat deficiency for the facility which was cited 04/14/11 for deficiencies related to staff failing to remove a residents lift</p>	F 520		
-------	---	-------	--	--

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

PRINTED: 12/08/2011
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 11/18/2011
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)	(X6) COMPLETION DATE	
F 520	<p>Continued From page 34 pad after transfer as per the Care Plan.</p> <p>Review of the facility's Plan of Correction, with a 05/07/11 compliance date, revealed staff were educated on following the Care Plan. Further review revealed Administrative staff would review five (5) residents per week for four (4) weeks then monthly for two (2) months to determine if the Care Plan reflected the residents current status and if the Care Plan was being followed.</p> <p>Observations during this survey revealed the Care Plan was not followed related to ensuring a resident's bedside table was locked and ensuring residents received one (1) on one (1) activities as per the Plan of Care.</p> <p>Interview on 11/18/11 at 9:30 AM with the DON and ADON/QA Nurse revealed the Certified Nursing Assistants were to carry "Care Cards" in their pocket for a reference in caring for the residents and staff may need to be educated to use them. Continued interview revealed nurses were to monitor to ensure the Plan of Care was being followed; however, there was no actual audit related to the Care Plan.</p> <p>3. Based on observation, interview, and record review, it was determined the facility failed to ensure supervision to prevent accidents and failed to ensure the resident's environment remains as free of accident hazards as is possible. This was a repeat deficiency for the facility which was cited 09/09/10 related to an unsecured biohazard room in which infectious waste and full sharps containers were stored. This is also a repeat deficiency for the facility which was cited 04/14/11 related to a resident</p>	F 520			

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

PRINTED: 12/06/2011
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 11/18/2011
--	---	--	---

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 520	<p>Continued From page 35</p> <p>sustaining a fall when staff failed to remove the lift pad from the wheelchair after transfer as per the Plan of Care.</p> <p>Review of the facility's Plan of Correction, with a compliance date of 10/22/10, revealed staff would be educated on safety awareness as it related to securing the access to hazardous areas. Further review revealed the Maintenance Director or Housekeeping Supervisor would conduct rounds three (3) times a week for four (4) weeks and monthly times two (2) months to ensure all potential hazardous areas were secured.</p> <p>Review of the facility's Plan of Correction, with a compliance date of 06/07/11, revealed the nursing staff was re-educated on the Falls Management Program by nursing management. Further review revealed the Administrative staff would review five (5) residents per week for four (4) weeks then monthly for two (2) months to determine if the Care Plan reflected the current resident status and that interventions were being followed related to falls.</p> <p>Observations during this survey revealed the general bathroom on the 100 Unit had an unlocked cabinet which contained "Enzymatic #502 Foul Odor Digester" accessible to residents.</p> <p>Interview, on 11/18/11 at 9:30 AM, with the DON and ADON/QA Nurse revealed the Unit Managers were to monitor daily to ensure cabinets in the bathrooms were locked and there was proper storage of chemicals and materials hazardous to residents.</p> <p>4. Based on observation, and interview, it was</p>	F 520		

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

PRINTED: 12/08/2011
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 11/18/2011
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)	(X6) COMPLETION DATE
F 520	<p>Continued From page 36</p> <p>determined the facility failed to ensure proper storage of drugs and biologicals. This was a repeat deficiency for the facility which was cited 09/09/10 related to unacceptable medication refrigerator temperatures on the 300 and 400 Halls.</p> <p>Review of the facility's Plan of Correction, with a 10/22/10 compliance date, revealed the DON and Administrator would re-educate staff on the proper storage of drugs and biologicals and the Unit Managers and weekend supervisors would assess the appropriate storage of medications daily. Further review revealed the ADON would complete weekly reviews for four (4) weeks and monthly reviews for two (2) months related to appropriate medication storage and ensuring temperatures were within appropriate parameters.</p> <p>Observation during this survey revealed food stored with medication, cleaning supplies stored in the medication, cleaning supplies stored in the medication room, auction equipment/supplies stored on the floor and expired culture and specimen collection tubes in the cabinets. Also the Hall 200 Medication Room revealed temperatures recorded lower than the facility policy requirement of thirty-six (36) degrees on five (5) separate dates in October 2011.</p> <p>Interview with the Unit Manager, on 11/18/11 at 2:40 PM, revealed the temperature should be between thirty-six (36) and forty-six (46) degrees for the medication refrigerator. However, further interview revealed she could not recall when the staff was inserviced regarding the acceptable temperature range stated in the facility policy. In</p>	F 520		

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

PRINTED: 12/06/2011
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 11/18/2011
--	--	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 520	<p>Continued From page 37</p> <p>addition, she could not provide evidence that the log sheets were monitored for exceptions to the required temperatures or evidence measures were taken to ensure the integrity of the medications were preserved when unacceptable temperatures were recorded.</p> <p>5. Based on observation, interview, and record review, it was determined the facility failed to ensure accurate maintenance of clinical records. This was a repeat deficiency for the facility which was cited 09/09/10 for deficiencies related to the facility failing to ensure Quarterly Restrictive Device Evaluations were completed quarterly as per policy.</p> <p>Review of the facility's Plan of Correction, with a 10/22/10 compliance date, revealed nursing staff would receive education related to timely completion of assessments to include Comprehensive Assessments, and Admission Assessments. Further review revealed the DON would conduct a weekly review of at least three (3) residents, reviewing assessments for four (4) weeks, and monthly for two (2) months of three (3) residents, to ensure clinical assessments were accurate, accessible, organized, and timely.</p> <p>During this survey record review revealed Resident #3's Physician's Orders and Medication Administration Record (MARS) did not reflect the correct route for medication administration. In addition, Resident #5 sustained a fall on 11/06/11; however, there was no documented evidence of post fall documentation in the interdisciplinary notes after the fall as per policy.</p> <p>Interview with Licensed Practical Nurse (LPN) #3.</p>	F 520		
-------	--	-------	--	--

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

PRINTED: 12/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2011
--	--	--	---

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

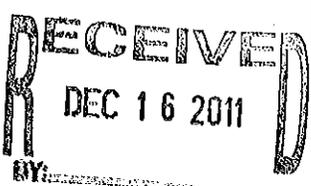
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	<p>Continued From page 38</p> <p>on 11/17/11 at 5:10 PM revealed the resident no longer had a feeding tube and had not realized the MAR still reflected the previous route "enteral tube" for the administration of Resident #3's medications. She further acknowledged she should have contacted the resident's practitioner to change the route to reflect "oral" dose for the medications.</p> <p>Interview with the Nurse Practitioner involved in the primary responsibility of Resident #3's medical care, on 11/18/11 at 10:15 AM, revealed she was aware medications were being given orally but had failed to make the written change in Resident #3's orders to the reflect the change of medication administration route from "enteral tube" to "oral".</p> <p>Interview with the Unit Coordinator, on 11/17/11 at 10:30 AM, revealed falls are to be documented in the Interdisciplinary Progress Notes each shift for seventy-two (72) hours. Further interview revealed no documented evidence in Resident #5's medical record to support the fall documentation policy was followed. She further revealed she monitored the falls documentation and noted a late entry with a strike out which she indicated she must have identified the deficient documentation but was interrupted during documentation and never completed the audit.</p>	F 520		

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

PRINTED: 12/06/2011
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2011
--	--	--	--

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)	(X6) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 007/14/76</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Wet SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel Generator.</p> <p>A life safety code survey was initiated and concluded on 11/15/11. 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-eight (98) the day of the survey.</p> <p>Deficiencies were cited with the highest</p>	K 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 style="text-align: center;">  </p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Plouffe TITLE: Administrator (X6) DATE: 12/16/11

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: 12/06/2011
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2011
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
K 000 K 062 SB=D	Continued From page 1 deficiency identified at "F" level. NFFPA 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, NFFPA 13, NFFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained, according to NFFPA standards. The findings include: Observation, on 11/15/11 at 1:34 PM, revealed a sprinkler head located in the Medical Records room on Wing 100 was located too close to the wall, less than four (4) inches. Also the sprinkler head in the bio-hazard room on Wing 100 was paint loaded. The observations were confirmed with the Maintenance Director. Interview, on 11/15/11 at 1:34 PM, with the Maintenance Director, revealed he was unaware of these requirements. Reference: NFFPA 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 000 K 062	K062 1. Sprinkler head in the Medical Records office was removed and the sprinkler head was replaced in the bio-hazard room on Wing 100 by Landmark Sprinkler, Inc on 11/30/11. 2. Sprinkler heads were visually inspected throughout the facility by the Maintenance Supervisor on 12/12/11 to determine proper maintenance in accordance with NFFPA Standards. Landmark Sprinklers completed an inspection of the facility sprinklers on 12-15-11. 3. Landmark Sprinklers submitted recommendations to relocate 7 sprinkler heads to meet code and to replace one sprinkler head due to paint to the Administrator on 12-16-11. The Administrator has signed and accepted the bid to complete the repairs as recommended as of 12-16-11. Landmark Sprinklers to notify the Administrator of when the work will begin.	

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

PRINTED: 12/06/2011
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2011
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
K 082	Continued From page 2 NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 082	4. Maintenance Supervisor will conduct audits monthly times three months to determine proper maintenance in accordance with NFPA Standards. A summary of findings will be submitted to the Performance improvement Committee monthly for three months for further review and recommendations. 5. Completion date _____	12/22/11
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions according to NFPA standards. The	K 072	1. Medication Carts were moved and stored in alcove next to nursing station 1, and alcove across from nursing station 2. Soiled linen carts were moved from wings 100,200,300 and 400 and stored in shower room when not in use. Clean linen carts stored in clean supply room on hall 2 on 11/15/11 by the Unit Managers/Director of Nursing/Assistant Director of Nursing. An area was created in the kitchen for the storage of food storage carts and food carts are being stored in appropriate area as of 12/15/11.	

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

PRINTED: 12/06/2011
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2011
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
K 072	<p>Continued From page 9</p> <p>deficiency has the potential to affect five (5) of five (5) smoke compartments, all residents, staff, and visitors. The facility is licensed for one hundred (100) beds; the census on the day of the survey was ninety-eight (98).</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey tour, on 11/15/11 between 11:00 AM and 4:30 PM, with the Maintenance Director revealed medication carts were stored and not in use near nurses stations at Wing 200 and at the nurses station in front of the activities room. Also soiled linen carts and clean linen carts were observed stored and not in use in Wings 100, 200, 300, and 400. Food storage carts and food serving carts were observed blocking exit egress in the corridor running parallel to the kitchen. The items observed in the corridors were stored and not in use for a period of more than 30 minutes. Means of egress must be kept clear at all times in case of fire or other emergency.</p> <p>Interview with the Maintenance Director, on 11/15/11 at 4:30 PM, confirmed the items were stored in the corridors and indicated that they did not have enough room.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072	<p>2. Director of Nursing completed an audit of the facility on 12/15/11 to determine that each corridor was free of all obstruction.</p> <p>3. Nursing/Dietary/Housekeeping staff re-education initiated on 12/1/11 and will be completed as of 12/21/11 by the Assistant Director of Nursing Services and Dietary Manager regarding the storage of linen carts, food carts and med carts in the corridors and the need to maintain the means of an egress continuously.</p> <p>4. Nursing Administration will complete an audit weekly for four weeks then monthly for two months to determine that corridors are free from all obstruction. A summary of findings will be submitted to the Performance Improvement Committee monthly times three months for review and further recommendations.</p> <p>5. Date of compliance:</p>	12/22/11
K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance</p>	K 147		

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

PRINTED: 12/08/2011
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2011
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
K 147	<p>Continued From page 4 with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, twenty-two (22) residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of ninety-eight (98) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/15/11 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed, an oxygen concentrator plugged into a power strip in room #111. Also observation revealed an oxygen concentrator and bed plugged into a multi plug adapter in room # 414.</p> <p>Interview, on 11/15/11 at 4:00 PM, with the Maintenance Director revealed they were not aware of the extension cords and power strips being misused.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the</p>	K 147	<p>K147</p> <ol style="list-style-type: none"> 1. Power strips identified in room 111 and 414 were removed by the Maintenance Director on 11/15/11. 2. Maintenance Director completed an audit of the facility on 11/15/11 and inspected every room for power strips/extension cords. Any issues identified was corrected by the Maintenance Director. 3. Housekeeping, Nursing, Dietary, Laundry, and Activity staff will be re-educated as of 12/21/11 by the Assistant Director of Nursing regarding the use of power strips and extension cords. 4. Maintenance Director will complete an audit to determine the use of power strips and extension cords in the center once a week for four weeks then monthly times two months. A summary of findings will be presented to the Performance Improvement Committee monthly times three months for review and further recommendations 5. Completion date: _____ 	12/22/11

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

PRINTED: 12/06/2011
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2011
--	---	---	---

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
K 147	Continued From page 5 intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

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

PRINTED: 01/27/2012
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2012
---	---	---	---

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

(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 000}	<p>INITIAL COMMENTS</p> <p>A LSC re-visit was initiated and concluded on 01/26/12. During the re-visit survey, the LSC Surveyor, was able to verify that:</p> <p>Tag K-25 was corrected, all smoke barriers identified as deficient were sealed according to NFPA requirements on 01/10/12 by the Maintenance Director. This was verified by observation and interview with the Maintenance Director and Administrator upon exit interview.</p> <p>Tag K-29 was corrected, a new door to the laundry room was installed with door closure and latch on 01/16/12 this was verified by observation and interview with the Maintenance Director and Administrator upon exit interview.</p> <p>Tag K-66 was corrected, self closing metal containers for emptying ashtrays and smoking materials was placed in service on 01/17/12, this was confirmed by observation, invoice review and interview with Maintenance Director and Administrator upon exit interview.</p> <p>Tag K-0211 was corrected, the ABHR dispenser was relocated on 12/30/11 this was verified by observation and interview with Maintenance Director and Administrator upon exit interview.</p> <p>Upon completion of the re-visit survey the facility was found to be in compliance with the requirements for participation for Medicare and Medicaid 42 CFR 483.70(a).</p>	{K 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.

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

JAN 23 2012

PRINTED: 01/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188170	(K2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(K3) DATE SURVEY COMPLETED 12/29/2011
NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601	
(K4) 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)	(K5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1876 K7 SURVEY UNDER: 2000 Existing K8 SNF/NF Type of Structure: A one story, Type III (200), 1876, unprotected ordinary construction with a total of five smoke compartments and a complete automatic (dry) sprinkler system. A Comparative Federal Monitoring Survey was conducted on 12/29/11, following a State Agency Annual Survey on 11/16/11 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Bradford Square Care and Rehabilitation Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	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."	
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	K 025	K025 1. The Maintenance Director sealed the identified penetrations with smoke resistive caulk in the smoke barrier walls on the 300 Hall and 100 Hall on January 10, 2012.	

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

Stacie Shive

TITLE

Administrator

(K6) DATE

1/11/12

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: 01/08/2012
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/29/2011
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
K 025	Continued From page 1 penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.6, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke resistive properties of two of four smoke barrier walls. The deficient practice affected three of five smoke compartments, staff and 50 residents. The facility has the capacity for 100 beds with a census of 95 the day of survey. Findings include: 1. Observation on 12/29/11 at 2:45 p.m. revealed that there was a three inch unsealed penetration for wires that passed through the 300 hall attic portion of the smoke barrier wall over the 300 wing smoke barrier doors. Interview on 12/29/11 at 2:45 p.m. with the facility Maintenance Supervisor revealed that the facility was not aware of the unsealed penetrations in the smoke barrier wall. 2. Observation on 12/29/11 at 2:55 p.m. revealed that there were two three inch unsealed penetrations for wires that passed through the 100 hall attic portion of the smoke barrier wall over the 100 wing smoke barrier doors. Interview on 12/29/11 at 2:55 p.m. with the facility Maintenance Supervisor revealed that the facility was not aware of the unsealed penetrations in the smoke barrier wall.	K 025	2. Other smoke barrier walls were visually inspected throughout the facility by the Maintenance Supervisor and Life Safety Inspector on December 29, 2011 to determine proper requirements are met regarding smoke barrier walls in accordance with NFPA Standards. In addition, Maintenance Director re-checked smoke barrier walls on January 10, 2012. 3. Maintenance Director was re-educated on Life Safety Code Standards regarding smoke barriers walls on January 10, 2012 by the Director of Construction and Engineering. 4. Maintenance Director will audit smoke barrier walls monthly for 3 months to ensure smoke barrier walls have not been penetrated. Maintenance Director will also monitor any contractor doing work in attic to determine smoke barrier walls have not been penetrated. A summary of findings will be submitted to the Performance Improvement Committee monthly x 3 months for further review and recommendation.	
			5. Date of Completion	1/18/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/29/2011
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
K 026	Continued From page 2 The census of 06 was verified by the Administrator on 12/29/11. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 12/29/11. Actual NFPA Standard: NFPA 101, 19.3.7.3. Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Actual NFPA Standard: NFPA 101, 8.3.6.1 (1) a. and b. Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected by filling the space between the penetrating item and the smoke barrier with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. NFPA 101 LIFE SAFETY CODE STANDARD	K 026		
K 029 SS-E	One hour fire rated construction (with 3/4 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	K 029	K029 1. The laundry room door will be replaced by January 16, 2012 by the Maintenance Director and a licensed contractor. Self closing devices were installed on 100 Hall medical records door and 100 Hall storage/mechanical room door on January 13, 2012 by the Maintenance Director. 2. Other doors were visually inspected throughout the facility by the Maintenance Supervisor on January 10, 2012 to determine proper requirements are met regarding separation of a hazardous area from other areas of the facility in accordance with NFPA Standards.	

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

PRINTED: 01/04/2012
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/29/2011
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
K 029	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide separation of a hazardous area from all other areas in the facility. The deficient practice affected one of five smoke compartments, staff and 22 residents. The facility has the capacity for 100 beds with a census of 86 the day of survey.</p> <p>Findings include:</p> <p>1. Observation on 12/29/11 at 1:15 p.m. revealed that the 100 hall corridor door to the Laundry struck the frame and would not close completely which left a gap of one inches across the top of the door. Interview on 12/29/11 at 1:15 p.m. with the Maintenance Supervisor revealed the facility was aware of the requirement for doors to hazardous areas to resist the passage of smoke in sprinkled buildings.</p> <p>2. Observation on 12/29/11 at 1:20 p.m. revealed that the corridor door to the 100 hall medical records storage room with a gas-fired water heater was not equipped with a self closing device. Interview on 12/29/11 at 1:20 p.m. with the Maintenance Supervisor revealed that the facility was not aware of the requirement for the corridor doors to rooms with gas-fired waters to be equipped with a self closing device.</p> <p>3. Observation on 12/29/11 at 1:30 p.m. revealed that the corridor door to the 100 hall storage/mechanical room was not equipped with a self closing device. The room was in excess of 50 square feet and was being used for storage of combustible supplies in combustible cardboard boxes on open shelving. Interview on 12/29/11 at</p>	K 029	<p>3. Maintenance Director was re-educated on Life Safety Code Standards regarding proper separation of a hazardous area from other areas of the facility on January 10, 2012 by the Director of Construction and Engineering.</p> <p>4. Maintenance Director will audit doors of the facility monthly for 3 months to determine proper separation of a hazardous area from all other areas of the facility. A summary of findings will be submitted to the Performance Improvement Committee monthly x 3 months for further review and recommendation.</p> <p>5. Date of Completion</p>	1/18/12

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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/29/2011
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	
K 029	Continued From page 4 1:30 p.m. with the Maintenance Supervisor revealed that the facility was not aware of the requirement for the corridor doors to combustible storage rooms in excess of 60 square feet to be equipped with a self closing device. The census of 95 was verified by the Administrator on 12/29/11. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 12/29/11. Actual NFPA Standard: NFPA 101, 19.3.2.1. Hazardous areas shall be safeguarded by a fire barrier of one-hour fire resistance rating or provided with an automatic sprinkler system. The doors shall be self-closing or automatic-closing. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. NFPA 101 LIFE SAFETY CODE STANDARD	K 029			
K 066 SS=D	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no-smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is	K 066	K066 1. Self-closing metal containers for emptying ashtrays and other smoking materials will be placed in center designated areas on January 17, 2012. 2. Designated smoking areas were reviewed by the Maintenance Director on January 12, 2012 to determine the need for self-closing metal containers. 3. Maintenance Director was re-educated on Life Safety Code Standards regarding self-closing metal container for emptying ashtrays and other smoking materials on January 10, 2012 by the Director of Construction and Engineering.		

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

PRINTED: 01/04/2012
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 01 - MAIN BUILDING 01 B. WING _____ *	(X3) DATE SURVEY COMPLETED 12/29/2011
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
K 066	<p>Continued From page 5 permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide metal containers with self-closing cover devices for the designated outdoor smoking area. The deficient practice affected one of five smoke compartments, staff and four residents. The facility has the capacity for 100 beds with a census of 95 the day of survey.</p> <p>Findings include:</p> <p>Observation on 12/29/11 at 2:30 p.m. revealed that the designated outdoor smoking area was not equipped with a self-closing metal container for emptying ashtrays and other smoking materials. Interview on 12/29/11 at 2:30 p.m. with the Maintenance Supervisor revealed that the facility was not aware of the requirement for a self closing metal container in smoking areas.</p> <p>The census of 95 was verified by the Administrator on 12/29/11. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 12/29/11.</p> <p>Actual NFPA Standard: NFPA 101 19.7.4 (3),</p>	K 066	<p>Housekeeping staff were re-educated on January 11 - January 14, 2012 by the Administrator regarding the requirement to empty ashtrays and other smoking materials in the self closing metal containers.</p> <p>4. Maintenance Director will audit to determine that self-closing metal container are readily available to empty ashtrays and other smoking materials 5 times weekly times one month, weekly times 2 months then monthly times 2 months. A summary of findings will be submitted to the Performance Improvement Committee monthly x 3 months for further review and recommendation.</p> <p>5. Date of Completion</p>	1/18/12

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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/29/2011
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
K 066	Continued From page 6	K 066		
K 211 SS=E	<p>(4). Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 480.72, 482.41, 483.70, 483.623, 485.623 <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that Alcohol Based Hand Rub (ABHR) dispensers were installed and protected from ignition sources. The deficient practice affected one of five smoke compartments, staff, and 20 residents. The facility has the capacity for</p>	K 211	<p>K211</p> <ol style="list-style-type: none"> 1. The ABHR dispenser in the dining room was re-located on December 30, 2011 by the Maintenance Supervisor. 2. All other ABHR dispenser were visually inspected throughout the facility by the Maintenance Supervisor on December 30, 2011 to determine proper requirements are met to ensure ABHR dispensers are installed properly in facility in accordance with NFPA Standards. 3. Maintenance Director was re-educated on Life Safety Code Standards regarding proper installation of ABHR dispensers in facility on January 10, 2012 by the Director of Construction and Engineering. 4. Maintenance Director will audit proper installation of ABHR dispensers in facility 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. 5. Date of Completion 	1/18/12

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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/29/2011
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
K 211	Continued From page 7 100 with a census of 95 the day of survey. Findings include: Observation on 12/29/11 at 1:45 p.m. revealed that the ABHR dispenser at the Dining Room was mounted directly above an electrical duplex outlet. Interview on 12/29/11 at 1:45 p.m. with the Maintenance Supervisor revealed that the facility was aware that ABHR dispensers must not be installed above or adjacent to ignition sources. The census of 95 was verified by the Administrator on 12/29/11. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 12/29/11. Federal Document Register requires that ABHR dispensers are not installed over or adjacent to an ignition source per CFR 403.744, 418.100, 480.72, 482.41, 483.70, 483.623, 486.623.0.	K 211		