

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

PRINTED: 02/16/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/02/2012
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NAME OF PROVIDER OR SUPPLIER  BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240
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F 000	INITIAL COMMENTS  A recertification survey and abbreviated survey (KY#17762) was conducted on 01/31/12 through 02/02/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of an "E." KY #17762 was unsubstantiated with deficiencies cited.	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	<b>F157</b> <b><u>483.10(b)(11) Notify of Changes (Injury/ Decline/Room, ETC):</u></b>  It is the routine practice of Bradford Heights Health and Rehab to notify the physician when there is a significant change in the resident's status.  <b><u>Corrective measures for resident identified in the deficiency:</u></b>  The physician of Resident #6 was notified of lab reports and changes in resident's condition on 2/02/2012. By LPN Charge Nurse.  <b><u>How other residents who may be affected by this practice were identified:</u></b>  The 24 hour reports from 2/2/2012 through 2/16/2012) have been reviewed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), or Unit Manager (UM), to identify other residents that may have experienced a change in condition or had lab findings that required physician notification. An audit of the identified resident's records was completed by the DON on 2/20/2012 to verify that the physicians for residents who have developed fever or experience other significant change in condition were promptly notified of the change. Resident's lab reports from 2/2/2012 through 2/16/2012 were reviewed by the DON to confirm that physicians were promptly notified of abnormal findings.	03/16/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Selina Beck LWA TITLE: Administrator (X6) DATE: 02-24-2012

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

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F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure immediate notification of the physician, for one resident (#6), in the selected sample of sixteen residents, when the resident experienced a change in condition. Resident #6 developed a change in medical condition which consisted of fever, nausea and diarrhea. A lab draw, dated 02/01/12, revealed a low Hemoglobin and Hematocrit. The physician was not notified regarding the resident's change in condition until 02/02/12. The resident was directly admitted to the hospital for a blood transfusion on 02/02/12.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Notification Requirements," dated 01/01/07 and revised 01/09/11, revealed "the facility should notify the resident's attending physician and representative, when there was a significant change in the resident's physical, mental or psychosocial status or need to alter the resident's treatment significantly."</p> <p>A record review revealed Resident #6 was admitted to the facility on 01/25/12 with diagnoses to include Anemia, Dysphagia, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease</p>	F 157	<p>continued from page 1</p> <p><b><u>Measures implemented or systems altered to prevent recurrence:</u></b></p> <p>Licensed nurses, including Rns and LPNs were re-educated by the Staff Development Coordinator on requirements for physician notification, for change in condition and reporting lab findings which are normal. The reeducation was initiated on 2/8/12 and will continue through 3/3/12. Any licensed nurse not re-educated by 03/03/12 will be re-educated on or before next day worked.</p> <p>Copies of the lab reports will be retained with 24 hour lab reports to verify results with physician notification.</p> <p>As part of the ongoing Abbreviated Quality Assurance process the Unit Manager will review the 24 hour report and will verify physician notification of changes in condition.</p> <p><b><u>Monitoring Measures to Maintain On-going Compliance:</u></b></p> <p>The 24 hour nursing report will be audited by the ADON, DON or designee to identify changes in resident conditions and to verify that physician notifications for these changes has occurred. The audits will be completed daily for two (2) weeks, if no concerns are identified by the daily audits, the audits will be completed weekly for four (4) weeks, then monthly for six (6) months.</p>		

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F 157	<p>Continued From page 2 and Malnutrition.</p> <p>A review of the nurses' notes, dated 02/01/12 at 7:20 AM and 4:00 PM, revealed the resident "complained of abdominal pain and appeared to be very weak."</p> <p>A review of the Hematology Report, dated 02/01/12, revealed the resident's Hemoglobin was 7.6-Low (normal range 13.5-17.5), and Hematocrit was 24.2-Low (normal range 41.0-53.0).</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 02/02/12 at 11:02 AM, revealed Resident #6 complained of nausea and had developed a fever. The attending physician was notified about the resident's change in condition associated with these symptoms. Labs were faxed to the physician with no follow-up for new orders. The LPN further stated, she called the hospital and gave a report, on 02/02/12 at 9:30 AM, as ordered by the attending physician. The resident was a direct admit to the hospital for a blood transfusion.</p> <p>An interview with LPN #2, on 02/02/12 at 3:00 PM, revealed Resident #6 developed a fever which required Tylenol and complained of diarrhea. He/she was given medication for diarrhea and abdominal cramping. The attending physician was not made aware of the resident's change in condition. The LPN faxed the resident's labwork to the physician, but did not follow-up to ensure the physician reviewed them.</p> <p>An interview with LPN #3 (Unit Manager), on 02/01/12 at 2:45 PM, revealed she expected the</p>	F 157	<p>The results of the audits will be reported to the Quality Assurance Committee. If concerns are found during any of the audits, daily audits will resume for a duration of time to be determined by the Quality Assurance Committee.</p>		

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F 157	Continued From page 3 staff to contact the resident's attending physician regarding the change in Resident #6's condition. LPN #3 further stated that she did consider the change in the resident's condition a significant change, which required physician notification.  An interview with the Director of Nursing (DON), on 02/01/12 at 4:30 PM revealed she expected the staff to notify the attending physician regarding the resident's change in condition whenever the resident became ill. No further explanation was provided.	F 157			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by improper storage of bedpans, urinals, bath basins, and graduated cylinders.  The findings include:  There was no evidence of a policy/procedure provided by the facility related to the proper storage of bedpans, urinals and bath basins.  1. Observations in Room #207, on 01/31/12 at	F 253	<b>F253</b> <b><u>483.15(H)(2) Housekeeping &amp; Maintenance Services:</u></b>  It is the normal practice of Bradford Heights Health and Rehab to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment.  <b><u>Corrective measures for resident identified in the deficiency:</u></b>  Rooms 207, 208, 209, 211, 212, 214, 215, and 217 were audited by the Unit Manager on 2/21/2012 for any wash basins, bed pans, and graduated bylnders that were not stored properly in a sanitary condition. Any found not stored properly in a sanitary condition were disposed of and new items replaced, labeled and properly stored. <b><u>How other residents who may be affected by this practice were identified:</u></b>  All other rooms in the facility were audited by the Unit Manager on 2/21/2012 for any wash basins, bed pans, and graduated cylinders that were not stored properly in a sanitary condition. Any found not stored properly in a sanitary condition were disposed of and new items replaced, labeled and properly stored.	03/31/12	

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F 253	Continued From page 4 8:27 AM and 2:25 PM, on 02/01/12 at 8:11 AM, and on 02/02/12 at 7:28 AM, revealed there was an uncovered graduated cylinder, without any identification listed on it, stored in the resident's bathroom.  2. Observations in Room #208, on 01/31/12 at 8:47 AM and 2:33 PM, on 02/01/12 at 8:12 AM, and on 02/02/12 at 7:28 AM, revealed there was an uncovered graduated cylinder, without any identification listed on it, stored in the resident's bathroom.  3. Observations in Room #209, on 01/31/12 at 8:32 AM, revealed there was an uncovered graduated cylinder and bed pan, without any identification listed on it, stored in the resident's bathroom.  4. Observations in Room #211, on 01/31/12 at 8:41 AM and 2:22 PM, on 02/01/12 at 8:10 AM, and on 02/02/12 at 7:28 AM, revealed an uncovered graduated cylinder, without any identification listed on it, stored in the resident's bathroom. Additionally, there was a urinal labeled with the resident's name on it and, "Need urine for test- 09/07-09/08." A dark brown build-up was noted on the rim of the urinal.  5. Observations in Room #212, on 01/31/12 at 9:00 AM and 2:36 PM, on 02/01/12 at 8:13 AM, and on 02/02/12 at 7:37 AM, revealed an uncovered bed pan and bath basin, without any identification listed on it, stored in the resident's bathroom.  6. Observations in Room #214, on 01/31/12 at 9:38 AM, revealed two uncovered bath basins,	F 253	continued from page 4  <u>Measures implemented or systems altered to prevent reoccurrence:</u>  All nursing staff including SRNAs, Med Techs, Restorative Aides, LPNs, and RNs will be in-serviced by the Staff Development Coordinator on properly labeling and storing wash basins, bed pans, urinals, and graduated cylinders. The re-education was initiated on 2/20/2012 and will be completed on 3/2/2012. Any employee not receiving required re-education by 3/2/2012 will receive training on or before their next day worked.  <u>Monitoring Measures to Maintain On-going compliance:</u>  A twenty five percent random sample of resident rooms will be audited by a designated member of the Quality Assurance Committee to verify that wash basins, bed pans, urinals, and graduated cylinders are labeled and stored properly. The audit will be done weekly for four (4) weeks and then monthly for three (3) months.  Results of the audit will be reported to the Quality Assurance Committee. The frequency or duration of the audits may be increased as determined necessary by the Quality Assurance Committee.  Upon completion of the monthly audits, the Quality Assurance Committee will continue to do quarterly audits to verify that wash basins, bed pans, urinals, and graduated cylinders are labeled and stored properly through utilization of scheduled Focus Reviews completed by designated members of the Quality Assurance Committee. The quarterly audits will continue for a period of time to be determined by the Quality Assurance committee.		

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F 253	<p>Continued From page 5</p> <p>without any identification listed on it, stored in the resident's bathroom. Further observations on 01/31/12 at 2:37 PM, on 02/01/12 at 8:14 AM, and on 02/02/12 at 7:38 AM, revealed an uncovered bath basin, without any identification listed on it, stored in the resident's bathroom.</p> <p>7. Observations in Room #215, on 01/31/12 at 9:05 AM, revealed a bed pan, graduated cylinder, and three bath basins, without any identification listed on it, stored in the resident's bathroom.</p> <p>8. Observations in Room #217, on 01/31/12 at 9:12 AM, revealed a urinal, without any identification listed on it, stored in the resident's bathroom.</p> <p>Interviews with three Certified Nurses Aides (CNAs #2, #3, and #4), on 02/02/12 at 2:07 PM, 2:27 PM, and 2:45 PM, respectively, revealed bed pans were supposed to be cleaned after each use, labeled, and were supposed to be stored in special bags. Bath basins were supposed to be labeled with the resident's name and stored in the resident's bedside table or out of sight. Urinals were to be labeled with the resident's name and replaced after they were soiled.</p> <p>Interviews with two Licensed Practical Nurses (LPNs #4 and #5), on 02/02/12 at 3:10 PM and 3:25 PM, revealed they expected the staff to clean, label and cover bath basins and bed pans appropriately. Additionally, they expected staff to label urinals, store them in the resident's bedside table, and replace them when they were soiled.</p> <p>An interview with the Director of Nursing (DON), on 02/02/12 at 4:05 PM, revealed she expected</p>	F 253			

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F 253	Continued From page 6 the staff to clean, cover and label the bedpans appropriately. She expected the staff to label store bath basins appropriately.	F 253			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to revise the plan of care for one resident (#11), in the selected sample of sixteen residents. Resident #11 was assessed to have a decline in eating from "set up only" to the need of limited assistance; however, a review of the comprehensive care plan revealed	F 280	<u>F280</u> <u>483.20(d)(3), 483.10(k)(2) right to Participate Planning Care-Revise CP:</u>  It is the normal practice of Bradford Heights Health and Rehab to periodically review and revise resident's care plans when indicated.  <u>Corrective measures for resident identified in the deficiency:</u>  The comprehensive care plan and nurse aide data sheets for resident #11 were revised by MDS coordinator to include an intervention for limited assistance with eating. 02/21/12  <u>How other residents who may be affected by this practice were identified:</u>  Residents who require assistance with eating will be identified by the MDS Coordinator. The Comprehensive Care Plans and Nurse Aide Data Sheets for these residents will be audited by the MDS Coordinator to verify the need for assistance is appropriately careplanned. This audit will be completed by 3/5/2012.  <u>Measures implemented or systems altered to prevent recurrence:</u>  MDS personel including the MDS coordinator and LPN/MDS personel were re-educated on 2/6/2012 by the ADON on appropriately reviewing and revising comprehensive careplans and Nurse Aide Data Sheets.  Licensed Nurses, including Rns and LPNs will be re-educated by the Staff Development Coordinator on appropriately reviewing and revising comprehensive careplans and Nurse	03/06/12	

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F 280	<p>Continued From page 7</p> <p>the facility failed to revise the care plan to include an intervention for limited assistance.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Comprehensive Care Plan," dated 01/07, revealed "the plan of care will be reviewed and revised when indicated, based on resident's response."</p> <p>A record review revealed Resident #11 was admitted to the facility on 10/12/09, and re-admitted on 02/16/11, with diagnoses to include Parkinson's Disease, Senile Dementia and Muscle Weakness.</p> <p>A review of a significant change Minimum Data Set (MDS), dated 12/22/11, revealed the facility assessed Resident #11 to be cognitively impaired and had a decline in eating, as he/she now required limited assistance of one staff for eating. A review of the Care Area Assessment (CAA) for Activities of Daily Living (ADL), revealed if the resident needed to be fed, the staff should do so.</p> <p>A review of the Nurse Aide Data Sheet, dated 09/11 through 12/11, revealed the resident was able to feed self and there was no revision to address Resident #11's need for limited assistance with eating.</p> <p>A review of the Comprehensive Care Plan for self care deficit, dated 01/03/12, revealed there were no revisions to the care plan to address the resident's need for limited assistance with eating.</p> <p>An observation during the noon meal, on</p>	F 280	<p>continued from page 7</p> <p>Alde Data Sheets. This re-education began on 2/6/2012 and will be completed by 3/2/2012. Any licensed Nurse not receiving re-education by 3/2/2012 will be re-educated before their next shift worked.</p> <p>All nursing staff (including State Registered Nursing Assistants, Med Techs, Restorative Aides, Rns, and LPNs) will be re-educated by the Staff Development Coordinator on verifying the resident has finished eating and/or offering assistance with feeding prior to removing the meal trays. This education began on 2/6/2012 and will be completed by 3/2/2012. Any persons not educated by 3/2/2012 will be trained be their next scheduled shift.</p> <p><b>Monitoring Measures to Maintina On-going compliance:</b></p> <p>The ADON will conduct scheduled audits with a 10% random sample of residents to verify that comprehensive careplans and Nurse Aide Data sheets have appropriately been reviewed and revised. These audits will be completed daily for a week. If no concerns are identified, the audits will be conducted weekly for four (4) weeks, then monthly for six (6) months to verify ongoing compliance. Results of these audits will be reported to the Administrator and the Quality Assurance Committee. If any concerns are identified, the frequency and or duration of the audit may be increased.</p> <p>The ADON will assign a member of the Quality Assurance Committee to do a random audit of at least 10% of residentsw to validate that staff members are providing necessary assistance when needed and are verifying the resident has completed their meal prior to removing the meal tray. The audits will be done randomly and will include staff feeding breakfast, lunch, and supper. The audits will be conducted weekly for eight (8) weeks, then</p>	

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F 280	Continued From page 8 01/31/12 at 11:45 AM, revealed the resident was having difficulty feeding himself/herself and only ate a few bites of his/her meal. The Certified Nurse Aide (CNA) removed Resident #11's plate without asking if he/she was finished, and did not attempt to assist the resident with eating. An observation, on 02/01/12 at 8:30 AM, revealed the resident did not touch his/her meal. The CNA removed the tray without asking the resident if he/she needed any assistance.  An interview with the MDS Coordinator, on 02/02/12 at 10:50 AM, revealed she should have updated the comprehensive care plan and the CNA Data Sheet when the MDS assessment was completed, and identified Resident #11's eating ability had declined.  An interview with the Director of Nursing (DON), on 02/02/12 at 3:28 PM, revealed the MDS Coordinator should have updated the care plan when it was identified Resident #11 had a decline in eating.	F 280	continued from page 8  Assurance Committee. If any areas of concern are identified, the frequency and or duration of the audit may be increased.	
F 281 SS=D	483.20(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, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide professional standards of quality for one resident (#2), in the selected sample of sixteen residents, related to the application of a prescription	F 281	<b>F281</b> 483.20(k)(3)(i) Services Provided meet professional standards:  It is the normal practice of Bradford Heights Health and Rehab to provide services that meet professional standards of quality.  <u>Corrective measures for resident identified in the deficiency:</u>  The Bacitracin Zinc Oxide was removed from resident #2's room. Resident #2 was evaluated by a licensed Nurse 2/1/2012 and received the correct treatment per the physician's order.	3/3/2012

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NAME OF PROVIDER OR SUPPLIER  BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 HIGHPOINT DR. HOPKINSVILLE, KY 42240		
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F 281	<p>Continued From page 9</p> <p>ointment by unlicensed personnel without a physician's order.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Medication Administration," revised 06/05, revealed, "Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with written orders of attending physicians, manufacturer's specifications, and professional standards of practice."</p> <p>A record review revealed Resident #2 was admitted to the facility on 02/28/08, with a re-admission date of 11/23/11, with diagnoses to include Alzheimer's, Episodic Mood Disorder, Dementia with Behavioral Disturbance and Diabetes Mellitus.</p> <p>An observation, on 01/31/12 at 2:20 PM, revealed Certified Nurse Aide (CNA) #4 applied Bacitracin Zinc Oxide to the resident's buttocks after incontinent care was provided. When asked about the ointment, she was unsure about the ointment's indication for use. She stated she applied the cream because it was in the resident's bedside table.</p> <p>A review of the physician's orders, dated January 2012, revealed "Secura EPC: apply topically to the bilateral buttocks after each incontinent episode and twice daily." There was no documented evidence of a physician's order for Bacitracin Zinc Oxide.</p>	F 281	<p>The physician was notified that the Bacitracin Zinc Oxide was applied to the resident.</p> <p><u>How other residents who may be affected by this practice were identified:</u></p> <p>All resident rooms were searched by the Unit Manager, ADON, and DON on 2/6/2012 for any medicated creams/ointments. There were no other prescription ointments found in any of the resident rooms.</p> <p><u>Measures implemented or systems altered to prevent reoccurrence:</u></p> <p>Nursing staff including State Registered Nursing Assistants, Med Techs, Restorative Aides, RN s, and LPNs will be re-educated by the staff Development Coordinator on providing treatments only as ordered by a physician; providing treatments only within their scope of practice; and removing any prescription ointments found in a residents room immediately. This education will also emphasize that prescription ointments need to be kept in the treatment carts between use and that treatments are to be done by licensed staff only. This re-education will be completed by 3/2/2012. Staff not re-educated by March 2, 2012 will be re-educated on or before their next shift worked. Only preventive moisture barrier or emollient skin protectents should be applied by State Registered Nurse Assistants.</p> <p><u>Monitoring Measures to Maintain On-going compliance:</u></p> <p>The ADON will assign members of the Quality Assurance Committee to audit random resident rooms for the presence of any medicated ointments/treatments. The audits will be conducted daily for one (1) week and will include all resident rooms at least once during the week. If no concerns are identified, the audits will be conducted weekly for four (4) weeks with at least</p>		

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F 281	Continued From page 10  Interviews with four CNAs (#1, #2, #3, and #4), on 02/02/12 at 2:07 PM, 2:27 PM, 2:45 PM, and 3:10 PM, respectively, revealed they referenced the CNA care plans for information related to skin treatment requirements. They stated if they found a prescription ointment, they would give the ointment to the charge nurse. They stated prescription ointments were supposed to be stored in the medication cart and were to be applied only by a licensed staff member. CNA #4 stated she was not aware the ointment was a prescribed ointment.  Interviews with two Licensed Practical Nurses (LPNs) #4 and #5, on 02/02/12 at 3:10 PM and 3:22 PM, respectively, revealed the CNA care plans indicated which type of skin treatment each resident required. They expected the CNAs to check the care plans often, and to bring prescription ointments to the licensed staff, if discovered. They stated prescription ointments required a physician's order, and only licensed nurses can apply ointments.  An interview with the the Registered Nurse Unit Manager, on 02/01/12 at 2:52 PM, revealed an ointment could only be applied if there was a valid physician's order. Ointments were to be stored in the treatment cart and only licensed nurses could apply ointments.  An interview with the Director of Nursing (DON), on 02/02/12 at 5:15 PM, revealed she expected the staff to follow written physician's orders for each resident. She stated a physician's order is required for any treatment.	F 281	continued from page 10  50% of the resident rooms included each week, then monthly for six (6) months with at least 25% of the resident rooms included each month. The results of the audits will be reported to the Administrator and the Quality Assurance Committee. If concerns are identified, daily audits will resume for a period of time determined by the Quality Assurance Committee.  On going re-education will be scheduled by the Staff Development Coordinator quarterly for nursing staff including State Registered Nursing Assistants, Med Techs, Restorative Aides, RN s, and LPNs on providing treatments only as ordered by a physician and only within their scope of practice. The duration of quarterly re-education will be determined by the Quality Assurance committee as a result of audit results.		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282	F282 483.20(k)(3)(ii) Services by Qualified Persons/Per Care Plan	3/3/2012	

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F 282 SS=D	<p>Continued From page 11</p> <p><b>PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to implement the Comprehensive Care Plan for one resident (#8), in the selected sample of sixteen residents. The facility failed to provide supervision during meals for Resident #8 according to the resident's Comprehensive Care Plan.</p> <p>The findings include:</p> <p>A review of the facility's "Comprehensive Care Plan" policy/procedure, dated 01/01/07 and revised 06/14/11, revealed "care plan approaches will be communicated to staff by the use of care plans and utilized for use in providing direction for care, and care plans are developed based on the assessed needs of the resident."</p> <p>A record review revealed Resident #8 was admitted to the facility on 10/04/10 with diagnoses to include Senile Dementia, Osteoporosis and Visual Impairment.</p> <p>A review of the quarterly MDS, dated 01/23/12, revealed the facility assessed Resident #8 to be cognitively impaired with a Brief Interview for Mental Status (BIMS) score of one (1) out of a</p>	F 282	<p>It is the normal practice of Bradford Heights Health and Rehab to ensure services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care.</p> <p><u>Corrective measures for resident identified in the deficiency:</u></p> <p>State Registered Nurse Assistance assigned to Resident #8 were re-educated on assisting the resident at meal times per the Comprehensive Care Plan by the Director of Nursing on 2/1/2012.</p> <p><u>How other residents who may be affected by this practice were identified:</u></p> <p>Residents requiring supervision during meal service were identified through Medical Record review by the Director of Nursing and the Dietician on 1/31/2012. The Comprehensive Care Plans and Nurse Aide Data Sheets for identified residents were reviewed by the Director of Nursing on 1/31/2012 to verify reflection of the need for supervision.</p> <p><u>Measures implemented or systems altered to prevent reoccurrence:</u></p> <p>Nursing staff including State Registered Nursing Assistants, Med Techs, Restorative Techs, Rns, and LPNs will be re-educated on 3/2/2012 by the Staff Development Coordinator on providing adequate supervision at meal time as indicated on the nurse aide data sheets and Comprehensive Care Plans. Any nursing employee that has not</p>	

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F 282	<p>Continued From page 12 possible score of fifteen (15), and required assistance of one (1) for eating.</p> <p>A review of the Comprehensive Care Plan, dated 01/24/12, revealed the resident was to be "fed by staff." A review of the Certified Nurse Aide (CNA) care plan, dated January 2012, revealed the resident was totally dependent for any dietary needs.</p> <p>An observation of the breakfast meal, on 01/31/12 from 8:30 AM to 9:00 AM, revealed the resident was alone and unsupervised by staff and attempted to feed himself/herself. Observations of the lunch and dinner meals, on 01/31/12 at 12:01 PM and 5:45 PM, respectively, revealed Resident #8's family was feeding him/her, without supervision provided by the staff.</p> <p>An interview with the Dietician, on 02/01/12 at 2:15 PM, revealed Resident #8 was on a pureed diet due to swallowing issues and being a choking risk. The resident was assessed to have a pureed diet and she expected the staff to supervise each meal provided for Resident #8.</p> <p>An interview with the Speech Therapist, on 02/02/12 at 10:30 AM, revealed Resident #8 was at an increased risk for choking and swallowing due to oropharyngeal dysphagia, and she expected the staff to follow the care plan, to feed and supervise all of Resident #8's meals.</p> <p>An interview with the Director of Nursing (DON), on 02/02/12 at 4:30 PM, revealed Resident #8's Comprehensive Care Plan, the CNA Care Plan and the dietary card, revealed the resident was to be fed by staff, and she expected the staff to feed</p>	F 282	<p>Continued from page 12 been re-educated by 3/2/2012 will be re-educated on or before their next shift worked.</p> <p><b><u>Monitoring Measures to Maintain On-going compliance:</u></b></p> <p>The ADON or designee will observe residents that require supervision with meals weekly for eight (8) weeks. The observation will include a random sample of 20% of residents requiring assistance and will include breakfast, lunch, and supper meals to verify the residents are receiving appropriate supervision. If there are no concerns identified in the initial audits, the audits will be done every two (2) weeks for two (2) months then monthly for six (6) months to monitor ongoing compliance. Findings will be reported to the Administrator and the Quality Assurance Committee. If concerns are found during an audit, audits will be done daily for a duration of time to be determined by the Quality Assurance Committee.</p>		

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F 282	Continued From page 13 and supervise all of the residents' meals. She stated that she expected the staff to follow the care plan for each resident. She revealed the Nurse Aide Data Sheet was kept on the back of each resident's door so staff would know what care should be provided for each resident.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS  A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to provide the appropriate treatment and services to maintain or improve the resident's abilities for one resident (#11), in the selected sample of sixteen residents. The facility failed to ambulate Resident #11 and from meals to try to maintain the resident's ability to ambulate.  The findings include:  A review of the facility's "Comprehensive Care Plan" policy/procedure, dated 01/01/07 and revised 08/14/11, revealed "care plan approaches will be communicated to staff for use in providing direction for care."  A record review revealed Resident #11 was admitted to the facility on 10/12/09, and re-admitted on 02/16/11, with diagnoses to include Parkinson's Disease, Senile Dementia	F 311	<b>F311</b> <u>483.25(a)(2) Treatment/services to improve/maintain ADLS:</u>  It is the normal practice of Bradford Heights Health and Rehab to provide appropriate treatment and services to maintain or improve the resident's abilities.  <u>Corrective measures for resident identified in the deficiency:</u>  Resident #11 is being ambulated by nursing to and from the dining room for each meal as tolerated by resident. The State Registered Nurse Aide caring for this resident were re-educated on this task on 2/6/2012 by the Director of Nursing.  <u>How other residents who may be affected by this practice were identified:</u>  All residents care planned for ambulation to the dining room were reviewed by the Director of Nursing on 2/4/2012 for compliance.  <u>Measures implemented or systems altered to prevent recurrence:</u>  Nursing staff including State Registered Nursing Assistants, Med Techs, Restorative Techs, Rns, and LPNs will be re-educated on 3/2/2012 by the Staff Development coordinator on following the comprehensive Care Plan and the Nurse Aide Date Sheets for residents to provide treatment and services in accordance with the plan. For	3/3/2012

continued

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F 311	<p>Continued From page 14 and Muscle Weakness.</p> <p>A review of the Significant Change Minimum Data Set (MDS), dated 12/22/11, revealed the facility assessed Resident #11 to be cognitively impaired and required limited assistance of one staff for ambulation.</p> <p>A review of the Comprehensive Care Plan for self care deficit, dated 01/03/12, revealed an intervention, dated 01/18/12, for nursing to ambulate the resident to and from the dining room for each meal.</p> <p>A review of a "Therapy Communication to Nursing Sheet," dated 01/25/12, revealed Resident #11 was discontinued from physical therapy to nursing for ambulation with a rolling walker from room to dining room for all meals.</p> <p>A review of the "Nurse Aide Data Sheet," dated 01/12 through 04/12, revealed staff should ambulate the resident to the dining room for meals.</p> <p>Observations, on 01/31/12 at 5:45 PM, 02/01/12 at 5:30 PM and 02/02/12 at 11:15 AM, during lunch and dinner meals, revealed staff wheeled the resident in a wheelchair to and from the dining room at meals.</p> <p>An interview with the Physical Therapist, on 02/02/12 at 10:50 AM, revealed Resident #11 wanted to continue to ambulate as long as he/she could. She stated therapy worked with the resident's ambulation and felt continuing to ambulate the resident would possibly delay the process of the Parkinson's Disease.</p>	F 311	<p>licensed nurses, this education will include supervision of implementation of the care plan.</p> <p><b>Monitoring Measures to Maintain On-going compliance:</b></p> <p>A designated member of the Quality Assurance Committee will randomly observe staff transferring residents to the dining room to validate that residents are being ambulated to and from the dining room per their care plan. The ADON will assign observations to be done randomly including breakfast, lunch, and supper meals. The observations will be daily for a week, then weekly for 2 months, and then monthly for six (6) months to monitor ongoing compliance. Results of the observations will be reported to the Administrator and the Quality Assurance Committee. If discrepancies from the careplan are noted, daily observations will continue for a duration of time to be determined by the Quality Assurance Committee.</p>	

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F 311	Continued From page 15	F 311			
F 312 SS=D	<p>Interviews with Licensed Practical Nurse (LPN) #5, Certified Nurse Aide (CNA) #1 and CNA #2, on 02/02/12 at 10:00 AM, 10:45 AM and 1:45 PM, respectively, revealed they were not aware the staff were supposed to ambulate Resident #11 to and from the dining room for meals.</p> <p>An interview with the Director of Nursing (DON), on 02/02/12 at 3:28 PM, revealed she expected the staff to follow the care plan for each resident.</p> <p><b>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</b></p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to ensure one resident (#11), in the selected sample of sixteen residents, received the necessary services to maintain good nutrition. Resident #11 was assessed to require minimal assistance with eating. Observations revealed the staff were not providing the required assistance with eating.</p> <p>The findings include: A review of the facility's "Dining" policy and procedure, dated 01/01/07 and revised 01/28/10, revealed "assistance with meals should be</p>	F 312	<p><b>F312</b> <b><u>483.25(a)(3) ADL Care Provided for Dependent Residents:</u></b></p> <p>It is the normal practice of Bradford Heights Health and Rehab to ensure residents receive the necessary services to maintain good nutrition.</p> <p><b><u>Corrective measures for resident identified in the deficiency:</u></b></p> <p>Resident #11 care plan and nurse aid data sheet were revised by the Director of Nursing on 2/21/2012 to include an intervention for limited assistance with eating as needed. Resident #11 is being assisted with meals as needed.</p> <p><b><u>How other residents who may be affected by this practice were identified:</u></b></p> <p>Residents who require assistance with eating will be identified by the MDS Coordinator. The Comprehensive Care Plans and Nurse Aide Data Sheets for these residents will be audited by the MDS Coordinator to verify the need for assistance is appropriately care planned. This audit will be completed by 3/5/2012.</p>	3/6/2012	

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NAME OF PROVIDER OR SUPPLIER  BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240		
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F 312	<p>Continued From page 16 provided for those residents identified as assessed."</p> <p>A record review revealed Resident #11 was admitted to the facility on 10/12/09, and re-admitted on 02/16/11, with diagnoses to include Parkinson's Disease, Senile Dementia and Muscle Weakness.</p> <p>A review of a significant change Minimum Data Set (MDS), dated 12/22/11, revealed the facility assessed Resident #11 to be cognitively impaired and had a decline in eating as he/she now required limited assistance of one staff. A review of the Care Area Assessment (CAA) for Activities of Daily Living (ADL), revealed if the resident needed to be fed, staff should do so.</p> <p>A review of the Comprehensive Care Plan for self care deficit, dated 01/03/12, revealed there was no intervention related to assisting Resident #11 with eating, and a review of the Nurse Aide Data Sheet, dated 09/11 through 12/11, revealed the resident was able to feed himself/herself.</p> <p>An observation during the noon meal, on 01/31/12 at 11:45 AM, revealed Resident #11 was at the dining room table attempting to feed himself/herself. The resident was having difficulty placing his/her fork in the food, and bringing the food to his/her mouth. The food dropped off the fork before the resident was able to get it to his/her mouth. A resident, who was sitting beside Resident #11, assisted by feeding Resident #11 a couple of bites of food. A Certified Nurse Aide (CNA) approached the table when most of the residents were finished eating. The CNA proceeded to remove Resident #11's plate</p>	F 312	<p>continued from page 16</p> <p><u>Measures implemented or systems altered to prevent recurrence:</u></p> <p>MDS personnel including the MDS Coordinator were re-educated on 2/6/2012 by the ADON on appropriately reviewing and revising comprehensive care plans and Nurse aide Data Sheets.</p> <p>Licensed nurses, including RN s and LPNs will be re-educated by the Staff Development coordinator on appropriately reviewing and revising comprehensive care plans and Nurse Aide Data Sheets. This re-education began on 2/6/2012 and will be completed by 3/2/2012. Any Licensed nurse not receiving re-education by 3/2/2012 will be re-educated before their next shift worked.</p> <p>All nursing staff including State Registered Nursing Assistants, Med Techs, Restorative Aides, RN s, and LPNs will be re-educated by the Staff Development Coordinator on verifying the resident has finished eating and/or offering assistance with feeding prior to removing meal trays. Re-education will be completed by 3/2/2012. Those not re-educated by 3/2/2012 will be re-educated by their next scheduled shift worked.</p> <p>Nursing staff including State Registered Nursing Assistants, Med Techs, Restorative Aides, RN s, and LPNs will be re-educated by the Staff Development Coordinator on identifying residents that are not feeding themselves sufficiently, offering these residents assistance, and then notifying the charge nurse of the observation. Re-education will be completed by 3/2/2012. Those not re-educated by 3/2/2012 will be re-educated by their next scheduled shift worked.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  02/02/2012
NAME OF PROVIDER OR SUPPLIER  BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240		
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F 312	<p>Continued From page 17</p> <p>without asking if he/she was finished, and did not attempt to provide assistance for the resident. The resident had only eaten a few bites of his/her meal.</p> <p>An observation of the breakfast meal, on 02/02/12 at 8:30 AM, revealed the resident's breakfast tray was in front of him/her on the over the bed table. The resident was resting quietly with his/her eyes closed. Approximately, 10 minutes later, a CNA entered the room and removed the tray and did not attempt to provide assistance for the resident to eat. An observation of the resident's tray revealed the resident had not eaten any of his/her meal. A few minutes later, a Licensed Practical Nurse (LPN) entered the room to administer medication and the resident kept saying "I want some oats."</p> <p>An interview with the MDS Coordinator, on 02/02/12 at 10:50 AM, revealed she should have added the interventions to the comprehensive care plan related to assistance with eating, and to the CNA Data Sheet when the MDS assessment was completed, after they identified Resident #11's eating ability declined. She stated "it must have been overlooked."</p> <p>Interviews with Licensed Practical Nurse (LPN) #4, LPN #5, CNA #1, and CNA #2, on 02/02/12 at 10:00 AM, 10:45 AM, 11:20 AM and 1:55 PM, respectively, revealed Resident #11 was able to feed himself/herself. They were not aware Resident #11 required assistance with eating.</p> <p>An interview with the Director of Nursing (DON), on 02/02/12 at 3:28 PM, revealed the staff should have identified the resident was not feeding</p>	F 312	<p>continued from page 17</p> <p><b><u>Monitoring Measures to Maintain On-going compliance:</u></b></p> <p>The ADON will conduct scheduled audits with a 10% random sample of residents to verify that comprehensive careplans and Nurse Aide Data Sheets have appropriately been reviewed and revised. These audits will be completed daily for a week. If no concerns are identified, the audits will be conducted weekly for four (4) weeks, then monthly for six (6) months to verify ongoing compliance. Results of these audits will be reported to the Administrator and the Quality Assurance Committee. If any concerns are identified, the frequency and or duration of the audit may be increased.</p> <p>The ADON will assign a member of the Quality Assurance Committee to do a random<sup>2</sup> monitoring of at least 10% of residents to validate that staff members are providing necessary assistance when needed at meal times. The Comprehensive Care plans and Nurse Aide Data Sheets for the selected residents will be audited to verify the amount of assistance needed is accurately reflected. The audits will be done randomly and will include breakfast, lunch, and supper meals. The audits will be conducted weekly for eight weeks, then monthly for six (6) months to verify ongoing compliance. Results of the audits will be reported to the Administrator and the Quality Assurance Committee. If any areas of concern are identified, the frequency and or duration of the audit may be increased.</p>		

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NAME OF PROVIDER OR SUPPLIER  BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 960 HIGHPOINT DR. HOPKINSVILLE, KY 42240		
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F 312	Continued From page 18	F 312			
F 323 SS=D	<p>himself/herself sufficiently, offered the resident assistance with eating his/her meal, and notified the nurse the resident was not eating properly.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policies/procedures, and review of the Material Safety Data Sheet (MSDS), it was determined the facility failed to provide adequate supervision to prevent accidents for two residents (#8 and #12), in the selected sample of sixteen residents, and for one resident (#19), not in the selected sample. The facility failed to supervise Residents #8 and #12, who were assessed to be at risk for choking, and in Resident #19's room, a bottle of nail polish remover was left unsupervised on a rolling bedside table.</p> <p>The findings include: A review of the facility's policy/procedure, "Contraband," dated 03/07, revealed "For the safety and welfare of others, it is the policy of this facility that visitors may not enter with, and</p>	F 323	<p>F323 483.25(h) Free of Accident Hazards/Supervision/Devices:</p> <p>It is the normal practice of Bradford Heights Health and Rehab to provide adequate supervision to prevent accidents.</p> <p><u>Corrective measures for resident identified in the deficiency:</u> Nursing staff who serve meals were re-educated to provide assistance to residents #8 and #12 are being provided assistance at meals by the Staff Development Coordinator on 2/6/2012. Resident #12 was immediately assessed by a licensed nurse. The seating arrangement in the dining room was evaluated by the Dietician to determine a more appropriate seating for resident # 12 to minimize his/her exposure to residents with a regular diet due to his/her history of non-compliance with his/her ordered diet. The resident was relocated to a more suitable table. The nail polish remover was removed from resident #19 room on 1/31/2012. Resident #19 was re-educated on following the facilities contraband policy on 1/31/2012 by the Social Services Director.</p> <p><u>How other residents who may be affected by this practice were identified:</u> All residents requiring supervision during meal service were identified through medical record review by the Director of Nursing on 1/31/2012 to verify reflection of the need for supervision during meals.</p>	3/6/2012	

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NAME OF PROVIDER OR SUPPLIER  BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240	
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F 323	<p>Continued From page 19</p> <p>residents may not retain, any material considered to be contraband. The facility reserves the right to confiscate and dispose of contraband according to state and federal regulations. Contraband is defined as any illegal substance, volatile/explosive material."</p> <p>A review of the facility's policy/procedure, "Incident/Accident," revised 06/11, revealed "It is the policy of this facility to provide a safe and hazard free environment as is possible."</p> <p>A review of the facility's "Dietary" policy/procedure, dated 01/01/07 and revised 01/28/10, revealed "assistance with meals would be provided for those residents who had been identified and assessed as requiring supervision for meals."</p> <p>1. A record review revealed Resident #8 was admitted to the facility on 10/04/10 with diagnoses to include Senile Dementia, Osteoporosis and Visual Impairment.</p> <p>A review of a "Dysphagia Therapy Initial Evaluation," dated 10/05/10, revealed Resident #8 had moderate oropharyngeal dysphagia and required a diet of pureed foods with thin liquids to prevent choking.</p> <p>A review of a "Speech Therapy Functional Needs Identification Assessment," dated 01/08/11, revealed Resident #8 had an abnormal oral/pharyngeal phase, with overt signs and symptoms of dysphagia and required a pureed diet.</p> <p>A review of the physician's orders, dated 12/16/11</p>	F 323	<p>Continued from page 19</p> <p>Residents with a history of non-compliance with their diet were identified by the Dietician on 1/31/2012. The seating arrangement for these residents was reviewed by the Dietician, the dietary Manager, and the DON on 1/31/2012 to determine the most appropriate seating arrangements to minimize their exposure to residents with varying diets.</p> <p>Designated members of the Quality Assurance Committee checked all resident rooms on 2/6/2012 to verify there were no items considered as contraband present – any identified items were removed.</p> <p><u>Measures implemented or systems altered to prevent reoccurrence:</u></p> <p>All nursing staff including State Registered Nursing Assistants, Med Techs, Restorative Techs, Rns, and LPNs will be re-educated on 3/2/2012 by the Staff Development Coordinator on providing adequate supervision at meal time as indicated on the nurse aide data sheets and Comprehensive Care Plans. For Licensed Nurses this education will include supervision of implementation of the care plans. Any nursing employee that has not been re-educated by 3/2/2012 will be re-educated on or before their next shift worked.</p> <p>All nursing staff including State Registered Nursing Assistants, Med Techs, Restorative Techs, Rns, and LPNs will be re-educated on 3/2/2012 by the Staff Development Coordinator</p>	

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NAME OF PROVIDER OR SUPPLIER  BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240	
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F 323	<p>Continued From page 20 through 01/12/12, revealed Resident #8 required a diet of pureed foods with thin liquids.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 01/23/12, revealed the facility assessed Resident #8 to be cognitively impaired with a Brief Interview for Mental Status (BIMS) score of one (1) out of a possible score of fifteen (15), and required assistance of one for eating.</p> <p>An observation of the breakfast meal, on 01/31/12 from 8:30 AM to 9:00 AM, revealed the resident was alone and unsupervised by staff and attempted to feed himself/herself. Observations of the lunch and dinner meals, on 01/31/12 at 12:01 PM and 5:45 PM, respectively, revealed Resident #8's family was feeding him/her, without supervision provided by the staff.</p> <p>An interview with the Dietician, on 02/01/12 at 2:15 PM, revealed Resident #8 was on a pureed diet due to swallowing issues and being a choking risk. The resident was assessed to have a pureed diet and she expected the staff to supervise each meal provided for Resident #8.</p> <p>An interview with the Speech Therapist, on 02/02/12 at 10:30 AM, revealed Resident #8 was at an increased risk for choking and swallowing due to oropharyngeal dysphagia, and she expected the staff to follow the care plan, to feed and supervise all of Resident #8's meals.</p> <p>An interview with the Director of Nursing (DON), on 02/02/12 at 4:30 PM, revealed the resident was to be fed by staff, and she expected the staff to feed and supervise all of the residents' meals.</p>	F 323	<p>continued from page 20</p> <p>on supervising residents in the dining room for compliance with their ordered diets and on reporting any non-compliance to the supervisor on duty immediately. Staff will be educated that residents with a history of non-compliance with their diet will be seated with residents with the same diet orders to minimize their exposure to residents with varying diets.</p> <p>Staff including State Registered Nursing Assistants, Med Techs, Restorative Techs, Rns, LPNs, Housekeepers, Department Managers, Activity Staff, Laundry Aides, Therapy, and Maintenance Staff will be re-educated on 3/2/2012 by the Staff Development Coordinator on the contraband policy and procedure.</p> <p>Residents will be re-educated by the Social Service director or the Administrator on the Contraband policy and procedure at the next Resident's Council Meeting on March 5, 2012.</p> <p>Information related to the facility's contraband policy will be given to new Admissions by the Admissions Coordinator.</p> <p><u>Monitoring Measures to Maintain On-going compliance:</u></p> <p>The ADON or designee will audit residents that require supervision with meals weekly for eight (8) weeks. The audits will include a random sample of 20% of residents requiring assistance and will include breakfast, lunch, and supper meals. If there are no concerns identified in the initial audits, the audits will be done every two (2) weeks for two (2) months then monthly for six (6) months to monitor ongoing compliance. Findings will be reported to the Administrator and the Quality Assurance Committee. If concerns are found during an audit, audits will be done daily for a duration of time to be determined by the Quality Assurance Committee.</p>	

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F 323	<p>Continued From page 21</p> <p>2. A record review revealed Resident #12 was admitted to the facility on 10/15/10, with a re-admission date of 05/04/11, with diagnoses to include Dementia, Cerebral Vascular Accident, Diabetes Mellitus, Hemiplegia and Dysphagia Oropharyngeal phase.</p> <p>A review of the "Dysphagia Therapy Initial Evaluation," dated 05/05/11, conducted by Speech Therapist #1 after a choking incident in the dining room while on a pureed diet, revealed, "During meal, resident frequently being cued from staff to decrease rate." The speech therapist identified a precaution of "Impulsive."</p> <p>A review of the comprehensive care plan, dated 12/14/11, revealed "Resident has a history of refusing pureed diet with nectar thick liquids as family brings food from home" with interventions to include, "Monitor for signs/symptoms of aspiration and notify MD as needed. Obtain X-ray as needed." Further review of the comprehensive care plan, dated 01/18/12, revealed "Therapeutic diet of puree consistency, related to the resident has been admitted to the facility following a stroke," with approaches to include, "Provide LCS puree diet with nectar thickened liquids as ordered."</p> <p>A review of Resident #12's quarterly Minimum Data Set (MDS), dated 01/26/12, revealed the facility assessed Resident #12 to be severely cognitively impaired, requiring limited assistance of one staff member for eating, and requiring a mechanically altered diet (a change in texture of food or liquids).</p> <p>A review of the physician's orders, dated January</p>	F 323	<p>Continued from page 21</p> <p>The Dietary Manager and the ADON will conduct random audits on meal service to monitor diet compliance and seating arrangements. The audits will alternate between breakfast, lunch, and supper meals and will be done daily for a week, then weekly for four (4) weeks, then monthly for six (6) months to validate ongoing compliance. Findings will be reported to the Administrator and the Quality Assurance Committee. If concerns are found during an audit, daily audits will resume for a duration of time to be determined by the Quality Assurance Committee.</p> <p>A 10% sample of resident rooms on each unit will be audited for contraband by assigned members of the Quality Assurance Committee. The ADON will make the assignments daily for one (1) week, weekly for four (4) weeks, then monthly for six (6) months to validate no contraband items are present in the resident rooms. Findings will be reported to the Administrator and the Quality Assurance Committee. If concerns are found during an audit, daily audits will resume for a duration of time to be determined by the Quality Assurance Committee.</p>		

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F 323	<p>Continued From page 22</p> <p>2012, revealed Resident #12 received a low concentrated sweets (LCS) diet, pureed with nectar thickened liquids.</p> <p>An observation, on 01/31/12 at 5:39 PM, during the dinner meal, revealed Resident #12 was sitting at a table with another resident who received a mechanical soft diet. The resident, who was on the mechanical soft diet passed a chocolate chip cookie to Resident #12, and Resident #12 proceeded to eat the cookie in a fast manner. The staff did not discover Resident #12 consumed the cookie until the surveyor intervened, and at that time, Resident #12 consumed the majority of the cookie. When Certified Nurse Aide (CNA) #5 approached Resident #12, and told the resident it would choke him/her. Observation revealed the resident put his/her hand up and ate the remainder of the cookie.</p> <p>An interview with CNA #5, on 01/31/12 at 5:48 PM, revealed she monitored what each resident consumed and tried to watch them all. She stated she "slipped up," and the resident with the mechanical soft diet must have passed the cookie without her seeing it. She stated Resident #12 was not supposed to have the cookie.</p> <p>Interviews with Certified Nurse Aides (CNAs #1, #2, #3, and #4 ) and Licensed Practical Nurses (LPNs #4 and #5), on 02/02/12 at 2:07 PM, 2:27 PM, 2:45 PM, 3:10 PM, 3:12 PM, and 3:22 PM, respectively, revealed residents with different diets should not be allowed to be seated at the same table. Additionally, CNA #2 stated if residents with two different diets were seated at the same table, there was an increased risk a</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>resident with a regular diet could give food to someone that received a pureed diet.</p> <p>An interview with Speech Therapist (#1), on 02/02/12 at 10:34 AM, revealed she evaluated Resident #12 after a choking episode in the dining room. She stated he/she had impulsiveness, or eating fast. She stated Resident #12 should have nothing but pureed due to the inability to slow down during eating.</p> <p>An interview with the Director of Nursing (DON), on 02/02/12 at 4:05 PM, revealed she did not have a problem with residents who received different diets being seated at the same table.</p> <p>3. A review of the facility's "MSDS for Regular Nail Polish Remover," dated 03/08, revealed, "If the material is swallowed, get medical attention or advice."</p> <p>A record review revealed Resident #19 was admitted to the facility on 05/13/04 with diagnoses to include Congestive Heart Failure, Muscle Weakness, Diabetes Uncontrolled and Chronic Airway Obstructive Disease.</p> <p>A review of the annual Minimum Data Set (MDS), dated 12/12/11, revealed the facility assessed the resident to be cognitively independent.</p> <p>Observations, on 01/31/12 at 8:32 AM and at 5:53 PM, revealed there was a full bottle of nail polish remover on a rolling bedside table in Resident #19's room.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, on 01/31/12 at 5:55 PM, revealed she</p>	F 323			

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F 323	Continued From page 24 confirmed Resident #19 had nail polish remover in his/her room. She stated staff conduct checks every two hours. After discovery of the bottle of nail polish remover on 01/31/12, the LPN removed the nail polish remover from Resident #19's room. She stated residents were not supposed to store nail polish remover in their rooms.  Interviews with four Certified Nurse Aides (CNAs #1, #2, #3, and #4), on 02/02/12 at 2:07 PM, 2:27 PM, 2:45 PM, and 3:00 PM, respectively, revealed they monitored residents' rooms during room checks and on residents' shower days. They stated residents were not supposed to store nail polish remover in their rooms. If they were to discover nail polish remover, they would notify the nurse.  An interview with the Director of Nursing (DON), on 02/01/12 at 10:25 AM, revealed CNAs were to monitor rooms, and recognize things residents were not supposed to have. She stated if staff discovered contraband, they should confiscate it. Nail polish remover was to be locked up until use.	F 323		
F 371 SS=E	483.35(i) 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	F 371	<u>F371</u> <u>483.35(i) Food Procure, Store/Prepare/Serve - Sanitary:</u>  It is the normal practice of Bradford Heights Health and Rehab to prepare, distribute, and serve food under sanitary conditions.	03/16/12

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NAME OF PROVIDER OR SUPPLIER  BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240		
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F 371	Continued From page 25  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Dietary Sanitation policy/procedure, it was determined the facility failed to prepare food under sanitary conditions related to the can opener blade having a build-up of a black substance and the meat slicer not being covered when not in use.  A review of the facility's census and condition, dated 01/31/12, revealed there were 78 residents in the building and five residents received tube feedings.  The findings include:  A review of the facility's "Dietary Sanitation" policy/procedure, dated 01/01/07 and revised 06/08/11, revealed "food service staff shall follow procedures that reduce potential for food born pathogens, in preparing food."  Observations during an initial tour of the kitchen, on 01/31/12 at 8:30 AM, revealed the meat slicer was not covered when not in use, and the can opener had a build-up of a black substance on the blade.  An interview with the Dietary Manager, on 01/31/12 at 8:30 AM, revealed they did not keep the meat slicer covered when it was not in use. She stated the can opener was run through the dishwasher every night.  An interview with the Dietician, on 02/02/12 at 2:00 PM, revealed the meat slicer should be	F 371	Continued from page 25  <u>Corrective measures for resident identified in the deficiency:</u>  The meat slicer was immediately covered and the can opener blade was cleaned by the Dietary Manager on 2/06/2012. There were no residents identified in this deficiency.  <u>How other residents who may be affected by this practice were identified:</u>  Residents receiving PO diets have the potential to be affected by this practice.  <u>Measures implemented or systems altered to prevent reoccurrence:</u>  The Dietary Staff including the aides and cooks were re-educated 2/06/2012 by the Dietary Manager on proper cleaning, sanitizing, and covering of the meat slicer as well as the cleaning schedule and proper technique for cleaning the can opener after each use.  The Daily cleaning Schedule was updated by the Dietary Manager on 2/21/2012 to include cleaning the can opener after each use.  The Daily Cleaning Assignments were updated by the Dietary Manager on 2/21/2012 to include cleaning the can opener after each use.  <u>Monitoring Measures to Maintain On-going compliance:</u>  The Dietary Manager will be validating that the assigned cleaning tasks are completed and that the equipment appears clean and in sanitary condition on a routine basis. The Dietary Manager will audit the meat slicer and the can opener daily for seven (7) days to validate the meat slicer is clean and covered when not in use and that the can opener is cleaned after use. The Dietary Manager will then audit the meat slicer.		

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F 371	Continued From page 26 covered when not in use and the can opener should be cleaned after every use.	F 371	Continued from page 26 and the can opener three (3) days a week for two (2) weeks, then monthly for six (6) months to validate the meat slicer is clean and covered when not in use and that the can opener is cleaned after use.		
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and ... services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are accurately documented for two residents (#6 and #14), in the selected sample of sixteen residents. The facility's failure to document the intake amounts of fluid and nutrition for residents with gastric tube feedings on the "Enteral Feeding Record," resulted in the facility's inability to determine if these residents were provided the accurate amount of nutrition and hydration, as ordered by the physician.  The findings include:	F 514	Results of the audits will be given to the Administrator and The Quality Assurance Committee to ensure ongoing compliance. If concerns are found during any of the audits, a daily audit will resume for a duration of time to be determined by the Quality Assurance Committee.  The facility Quality Assurance team will continue a monthly Dietary Sanitation focus and will add a specific focus on Dietary equipment sanitation and cleanliness.  <b>F514</b> <b><u>483.75(I)(1) Res Records- Complete/Accurate/Accessible:</u></b>  It is the routine practice of Bradford Heights Health and Rehab to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  <b><u>Corrective measures for resident identified in the deficiency:</u></b> Use of the enteral feeding record was initiated for residents #6 and #14 by the ADON on 2/02/2012. Re-education of all licensed staff, including Rns and LPNs, on proper documentation of intake amounts of fluid and nutrition on the on the enteral feeding record was initiated on 2/02/2012 by the ADON and Staff Development Coordinator and will be completed on 2/17/2012. Licensed staff not receiving re-education by 2/17/2012 will receive the re-education on or before their next shift worked.	03/16/12	

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F 514	<p>Continued From page 27</p> <p>A review of the facility's policy/procedure "Documentation Standards," dated 01/01/07 and revised 02/01/12, revealed "it was the policy of the facility that documentation would reflect medical presence, team approach, and clinical decision making to promote quality of care. Documentation standards would follow established professional ethics and practices. Skilled nursing level residents would require daily charting to include observation, assessments, interventions, follow up and response to treatment/therapy."</p> <p>1. A record review revealed Resident #8 was admitted to the facility on 01/25/12 with diagnoses to include Anemia, Dysphagia, Congestive Heart Failure and Malnutrition.</p> <p>A review of the "Enteral Feeding Record," dated 01/12, revealed no documentation of Resident #6's daily enteral feeding for seven days in January (day 25 - 31), and on the 02/12 "Enteral Feeding Record," day one and two (2 days) revealed documentation for day shift only, and with no total daily fluid intake listed on either 01/12 or 02/12 record.</p> <p>2. A record review revealed Resident #14 was admitted to the facility on 08/09/11, and re-admitted on 12/12/11, with diagnosis to include Dysphagia.</p> <p>Further review revealed there was no documentation of the amount of feeding administered to the resident during 01/12.</p> <p>An interview with the Dietician, on 01/01/12 et</p>	P:514	<p><u>How other residents who may be affected by this practice were identified:</u></p> <p>Medical records of residents receiving enteral feedings were reviewed by the ADON on 2/2/2012 to validate the appropriate utilization of an Enteral Feeding Record.</p> <p><u>Measures implemented or systems altered to prevent recurrence:</u></p> <p>Licensed staff including RNs and LPNs were re-educated by the ADON or Staff Development Coordinator on required documentation of intake amounts of fluid and nutrition for residents with gastric tube feedings on the Enteral Feeding Record. This re-education was initiated on 2/2/12 and will be completed on 2/17/2012. Licensed staff not receiving re-education by 2/17/2012 will receive the re-education on or before their next shift worked.</p> <p><u>Monitoring Measures to Maintain On-going compliance:</u></p> <p>An audit will be completed on the Medical Records of residents receiving enteral feedings to validate the utilization of the Enteral Feeding Record. The audit will be completed by the ADON, the DON, or the Unit Manager and will be completed on 100% of residents with enteral feedings daily for two (2) weeks, then weekly for four (4) weeks, then monthly for six (6) months to monitor ongoing compliance.</p> <p>Results of the audit will be reported to the Administrator and to the Quality Assurance Committee. If concerns are found during any of the audits, daily audits will resume for a period of time to be determined by the Quality Assurance Committee.</p>		

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F 514	Continued From page 28 1:45 PM, revealed the facility was not documenting on the "Enteral Feeding Record" as required.  An interview with the Director of Nursing (DON), on 02/02/12 at 4:00 PM, revealed the facility should document on the "Enteral Feeding Record" for tube feeding residents. She further stated staff should document the residents' intake, so it could be determined that the residents received the accurate amount of nutrition and hydration. Residents #6 and #14 medical record did not identify if the residents received the correct amount of nutrition or hydration per the residents' feeding pump.	F 514			



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K 000	Continued From page 1	K 000	Submission of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	03/16/12	
K 025 SS=D	<p>Deficiencies were cited with the highest deficiency identified at " F " level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of seventy eight (78) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/01/12 at 1:05 PM, with the Environmental Director revealed the smoke partitions extending above the ceiling at the</p>	K 025	<p><b>K 025 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>It is the normal practice of Bradford Heights Health &amp; Rehab Center to maintain all smoke barriers.</p> <p><u>Corrective Measures for Residents Identified in the Deficiency:</u></p> <p>No residents were identified in this deficiency.</p> <p><u>How Other Residents were Identified who may have been affected by this practice were identified:</u></p> <p>Residents in 3 of the 6 smoke compartments had the potential to be affected.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The Environmental Director was re-educated on NFPA 101 Life Safety Code relating to smoke barriers on 02-23-2012 by the Administrator.</p> <p>The cement block turned sideways in the dietary smoke barrier wall will be assessed and repaired by Pennyrite Fire and Safety by March 16, 2012.</p> <p>The smoke barrier adjacent to room 213 will be filled with fire rated material by the Environmental/Plant Director by March 16, 2012. There were no other openings in the rest of the smoke barriers.</p> <p>When smoke barriers are accessed by any contracted individuals, the Environmental/Plant Director will check to verify any openings created are sealed with</p>		

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K 025	<p>Continued From page 2</p> <p>Dietary Smoke Barrier has a cement block turned sideways in the smoke barrier. The block is directly above the ductwork passing through the smoke barrier. Also, the smoke barrier adjacent to room 213 has conduit pipe with wires penetrating the smoke barrier. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview, on 02/01/12 at 1:15 PM, with the Environmental Director revealed he was aware of the penetration but not sure if it was sealed.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 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 as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p>	K 025	<p>fire rated materials.</p> <p>The Environmental/Plant Service Director will audit the smoke barriers monthly to assure smoke barriers are intact without breaches or penetrations for the next six months and report findings to the Quality Assurance and Assessment Committee to validate ongoing compliance.</p>		

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K 025	Continued From page 3	K 025			
K 029 SS=0	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of (78) on the day of the survey.</p> <p>The findings include:  Observation, on 02/01/12 at 2:15 PM, with the Environmental Director revealed the doors to the kitchen dry storage, the storage directly across</p>	K 029	<p><b>K 029</b></p> <p>It is the normal practice of Bradford Heights Health &amp; Rehab Center to meet the requirements of Protection of Hazards in accordance with NFPA standards, and have self closing devices on required doors. <u>Corrective Measures for Residents Identified in the Deficiency:</u>  No residents were identified in this deficiency.  <u>How Other Residents were Identified that may have been affected by the practice:</u>  Residents in one (1) of six (6) compartments had the potential to be affected by the practice.  <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u>  A self closing device will be installed by the Environmental Director on the doors of the kitchen dry storage, the storage directly across from the kitchen storage, and in the dietary managers office by March 01, 2012. The Environmental Director was re-educated on 2/23/2012 by the Administrator on proper self closure devices on doors to all hazardous areas.  <u>Monitoring Measures to Maintain On-going Compliance:</u>  Hazardous areas in the facility will be audited by the Environmental Director monthly to validate the presence of self closing devices on the doors. The results of the audits will be given to the Administrator and the Quality Assurance Committee to validate ongoing compliance.</p>	03/16/12	

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K 029	<p>Continued From page 4</p> <p>the hall from the kitchen storage, and storage in the dietary manager ' s office did not have a self closing device.</p> <p>Interview, on 02/01/12 at 2:15 PM, with the Environmental Director revealed they were not aware the doors needed a self closing device.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms</p> <p>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</p> <p>(3) Paint shops</p> <p>(4) Repair shops</p> <p>(5) Soiled linen rooms</p> <p>(6) Trash collection rooms</p> <p>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</p>	K 029			

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K 029	Continued From page 5 (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	K045 It is the normal practice of Bradford Heights Health & Rehab Center to ensure exits are equipped with lighting according to NFPA standards.	03/16/12
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of seventy eight (78) on the day of the survey.  The findings include:  Observation, on 02/01/12 between 1:40 PM and 3:00 PM, revealed the exterior exit at the back of 200 and 100 hall were equipped with a single bulb for illuminating the public way from the exit. Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete	K 045  <u>Corrective Measures for Residents Identified in the Deficiency:</u>  No residents were identified.  <u>How Other Residents were Identified that may have been affected by the practice:</u>  Potential to affect six residents in six (6) smoke compartments.  <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u>  An electrician will install proper lighting at the exterior exits at the back of 100 and 200 halls by 3/16/2012. Other exits in the facility were audited by the Environmental Director on 2/23/2012 to verify presence of appropriate lighting. The Environmental Director was re-educated by the Administrator on 2/23/2012 on NFPA standards for lighting at exterior exits.  <u>Monitoring Measures to Maintain On-going Compliance:</u>  The exterior exits will be monitored by the Environmental/Plant Director monthly To verify ongoing compliance with lighting according to NFPA standards. The results of the audits will be reported to the Quality Assurance Committee. If concerns are identified, the frequency or duration of the audits may change.		

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NAME OF PROVIDER OR SUPPLIER  BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240		
(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 045	Continued From page 6 darkness. The observation was confirmed with the Environmental Director.  Interview, on 02/01/12 at 3:00 PM, revealed the Environmental Director was unaware the lighting fixtures serving the exterior exits must include more than one bulb.  Reference: NFPA 101 (2000 edition) Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 8 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted in accordance with NFPA standards. The deficiency had the potential to	K 050	K 050  It is the normal practice of Bradford Heights Health and Rehab Center to conduct fire drills at unexpected times under varying conditions.  <u>Corrective Measures for Residents Identified in the Deficiency:</u>  No residents were identified.  <u>How Other Residents were Identified that may have been affected by the practice:</u>  Residents in 6 of 6 smoke compartments have the potential to be affected by the practice.  <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u>  The Administrator re-educated the Environmental/Plant Service Director on conducting fire drills on all shifts at unexpected times under varied conditions on 02-20-2012.	03-16-12	

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K 050	Continued From page 7 affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of seventy eight (78) on the day of the survey.  The findings include:  Fire Drill review, on 02/01/12 at 12:22 PM, with the Environmental Director revealed the fire drills were not being conducted quarterly. The facility failed to perform a fire drill in the 1st quarter of 2011 on 3rd shift.  Interview, on 02/01/12 at 12:22 PM, with the Environmental Director revealed they were not aware the fire drill had been missed in the 1st quarter on 3rd shift.  Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	The schedule for quarterly fire drills was reviewed by the Administrator on 02-20-2012 to validate that fire drills are scheduled on a quarterly basis for all shifts and at unexpected times under varied conditions during the shifts.  <u>Monitoring Measures to Maintain On-going Compliance:</u>  The Environmental/Plant Service Director will bring fire drill logs to the monthly Quality Assurance Meeting for review by the Quality Assurance committee.  The Environmental/Plant Service Director will provide a quarterly schedule in advance for review by the Administrator to validate ongoing compliance with conducting fire drills at unexpected times under varied conditions. The Administrator will affirm that the schedule is followed or that changes are appropriate.		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of	K 051	K 051  It is the normal practice of Bradford Heights Health and Rehab Center to have devices installed according to the NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building.  <u>Corrective Measures for Residents Identified in the Deficiency:</u>  No residents were identified.	03-16-12	

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K 051	<p>Continued From page 8</p> <p>power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficient practice has the potential to affect six (6) of six (6) smoke compartments, staff, and the residents. The facility is licensed for one hundred (100) beds with a census of seventy eight (78) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/01/12 at 3:43 PM with the Environmental Director revealed the Fire Alarm Control Panel (FACP) Annunciator was located in a locked medicine room at the 100 hall Nurses' Station. The nurses at the nursing station could not visually see any annunciation panels.</p> <p>Interview, on 02/01/12 at 3:45 PM with the</p>	K 051	<p><u>How Other Residents were Identified that may have been affected by the practice:</u></p> <p>The deficient practice has the potential to affect six of six smoke compartments, staff, and the residents.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u></p> <p>Environmental/Plant Director will schedule for Pennyrite Fire and Safety to relocate the annunciator panel to an area with visible access to staff.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>Annunciator panel will be monitored with monthly fire drills for visible access. Findings will be reported to Administrator and Quality Assurance Committee for review.</p>	

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K 051	<p>Continued From page 9</p> <p>Environmental Director revealed the nurses' station had a key to unlock the room if they heard the announcement of a signal.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>1-5.4.4 Distinctive Signals. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively announced.</p> <p>1-5.4.6 Trouble Signals. Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard.</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by</p>	K 051			

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K 051	Continued From page 10 telephone.  5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.  3-8.1* Fire Alarm Control Units. Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as standalone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance.	K 051			
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056	K 056 It is the normal practice of Bradford Heights Health & Rehab Center to meet the Standard for the Installation of Sprinkler Systems.  <u>Corrective Measures for Residents Identified in the Deficiency:</u>  No residents were identified in this deficiency.	3/16/2012	

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K 056	<p>Continued From page 11</p> <p>supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of seventy eight (78) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/01/12 between 1:40 PM and 3:30 PM, with the Environmental Director revealed that the 2 porches on the north side of the 100 end 200 corridor exits do not have sprinkler coverage. Any roof that exceeds 4' must have sprinkler coverage.</p> <p>Interview, on 02/01/12 at 5:30 PM, with the Environmental Director revealed he was not aware the porches needed to be sprinkler protected.</p> <p>Observation, on 02/01/12 at 1:47 PM, with the Environmental Director revealed that the porch on</p>	K 056	<p><u>How Other Residents were Identified who may have been affected by this practice were identified:</u></p> <p>Residents in four (4) of the six (6) smoke compartments had the potential to be affected.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Pennyryle Fire &amp; Safety will be installing sprinklers on the 2 porches on the north side of the 100 and 200 corridor exits, and in the closet in the administrator's office will have sprinkler installed by March 16, 2012. The sprinkler on the north side of the central hall exit by the kitchen will be relocated by Pennyryle Fire and Safety to allow 18" of clearance around the sprinkler head by March 16, 2012. The Environmental Director was re-educated by the Administrator on 2/23/2012 on NFPA Life Safety relating to the standard for installation of sprinkler systems.</p> <p><u>Monitoring Measures to Maintain Ongoing Compliance:</u></p> <p>The Environmental/Plant Service Director will schedule Pennyryle Fire &amp; Safety to inspect sprinklers quarterly. The Environmental/Plant Director will report findings to the Quality Assurance and Assessment Committee to validate ongoing compliance.</p>		

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K 056	Continued From page 12 the north side of the central hall exit by the kitchen does not have 18 " of clearance around the sprinkler head due to the air curtain.  Interview, on 02/01/12 at 5:30 PM, with the Environmental Director revealed he was not aware the sprinkler head did not have the proper clearance.  Observation, on 02/01/12 at 3:06 PM, with the Environmental Director revealed that the closet in the administrator ' s office does not have sprinkler coverage.  Interview, on 02/01/12 at 3:07 PM, with the Environmental Director revealed he was not aware there was no sprinkler head in the closet.  Reference: NFPA 13 (1999 Edition) 5-13 8.1  Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.8, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by:	K 062	K 062  It is the normal practice of Bradford Heights Health and Rehab Center to ensure sprinkler heads are maintained as required.  <u>Corrective Measures for Residents Identified in the Deficiency:</u>  No residents were identified in this deficiency.	03-16-12	

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K 062	<p>Continued From page 13</p> <p>Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained as required. The facility is licensed for one hundred (100) beds and the census the day of the survey was seventy eight (78).</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey tour, on 02/01/12 at 12:33 PM, with the Environmental Director revealed the sprinkler heads above the drop ceiling were not being properly cleaned. Not maintaining sprinkler heads can decrease their ability to react as intended.</p> <p>Interview with the Maintenance Director, on 02/01/12 at 12:40 PM, revealed he was not aware that the sprinklers were not being cleaned.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>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.</p> <p>Observation, on 02/01/12 between 12:30 PM and 1:30 PM, with the Environmental Director revealed wires hanging over sprinkler piping in the attic throughout the facility. The sprinkler pipe also had wire tied to the pipe to try and</p>	K 062	<p><u>How Other Residents were Identified that may have been affected by the practice:</u></p> <p>Residents in six of the six smoke compartments had the potential to be affected.</p> <p>The sprinkler heads above the drop ceiling were contracted with Pennyrite Fire and Safety on 02-14-2012 to be properly cleaned by 03-16-2012.</p> <p>The wires hanging over the sprinkler piping in the attic were relocated was contracted with Pennyrite Fire and Safety 02-14-12 to be relocated by 03-16-12.</p> <p>The wires tied to the pipes were removed by the Environmental/Plant Service Director on 02-23-12.</p> <p>The Environmental Director was reeducated by the Administrator on 02-23-12 on required maintenance for sprinkler heads.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrences:</u></p> <p>The Environmental/Plant Service Director has scheduled Pennyrite Fire and Safety to move sprknlers in the phone room in 100 hall and the administrators office., more than 4 inches from the wall.</p> <p>All sprinkler heads on the facility were audited by the Quality Assurance Committee to validate appropriate location.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The Environmental/Plant Service Director has scheduled Pennyrite Fire &amp; Safety to complete quarterly maintenance and testing of sprinklers in the facility.</p> <p>The Environmental Director will audit the sprinkler heads above the drop ceiling monthly to validate they have been properly cleaned.</p>	

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K 062	<p>Continued From page 14</p> <p>strengthen the drops in the 100 hall. This was confirmed by the Environmental Director. The deficiency had the potential to affect six (6) of six (6) smoke compartments seventy eight (78) residents, staff and visitors.</p> <p>Reference: NFPA 25 (1998 edition)</p> <p>2-2.2" Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe.</p> <p>Exception No. 1: Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection.</p> <p>Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p> <p>Observation, on 2/01/12 at 4:00 PM, revealed a sprinkler head located in the administrators office and the phone room in 100 hall were located too close to the wall, less than four (4) inches. The observations were confirmed with the Environmental Director.</p> <p>Interview, on 2/01/12 at 4:05 PM, with the Environmental Director, revealed he was</p>	K 062	<p>The Environmental Director will audit the sprinkler piping in the attic monthly to validate they are free of materials resting on them.</p> <p>The Results of the audits will be reported to the Administrator and Quality Assurance Committee to validate ongoing compliance if concerns are identified, the frequency or duration of the audits may be increased.</p>		

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K 062	Continued From page 15 unaware of these requirements.	K 062		
K 064 SS=D	<p>Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen had signage in place for the proper use of the Class-K portable fire extinguisher. This deficient practice affected one of six smoke compartments, staff, and no residents. The facility has the capacity for one hundred (100) beds with a census of seventy eight (78) on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 02/01/12, at 2:08 PM, with the Environmental Director, two Class-K portable fire extinguishers were noted not to have signage near the extinguisher for the proper use of this type of extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.</p> <p>Interview on 02/01/12, at 2:08 PM, with the</p>	K 064	<p><b>K 064</b></p> <p>It is the normal practice of Bradford Heights Health &amp; Rehab Center to ensure signage is in place for the proper use of class-k portable fire extinguishers.</p> <p><u>Corrective Measures for Residents Identified in the Deficiency:</u></p> <p>Signage will be obtained from Pennyrile Fire &amp; Safety for the two Class-K portable fire extinguishers and installed by the Environmental/Plant Director by 3/16/2012.</p> <p><u>How Other Residents were Identified that may have been affected by the practice:</u></p> <p>Residents in one (1) of six (6) smoke compartments had the potential to be affected.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u></p> <p>The Environmental Director was re-educated by the Administrator on 2/23/2012 on NFPA 101 Life Safety Code Standards for required signage near fire extinguishers.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The Environmental Director will audit fire extinguishers monthly in conjunction with fire drills to verify appropriate signage is visible near fire extinguishers. Results of these audits will be reported to the Administrator and the Quality Assurance Committee to monitor ongoing compliance.</p>	03/16/12

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NAME OF PROVIDER OR SUPPLIER  BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240		
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K 064	Continued From page 16 Environmental Director revealed he was unaware of the signage requirement.  Reference: NFPA 10 (1998 Edition).	K 064	<b>K 072</b> It is the normal practice of Bradford Heights Health & Rehab Center to maintain means of egress free of all obstructions or impediments to full instant use in case of fire or other emergency.  <u>Corrective Measures for Residents Identified in the Deficiency:</u>  No residents were identified in the deficiency.	03/16/12	
K 072 SS=E	2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.  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 maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect five (5) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of seventy eight (78) on the day of the survey.  The findings include:  Observation, on 02/01/12 between 1:00 PM and 4:00 PM, with the Environmental Director revealed medicine carts were being stored in the 100 and 200 corridors around the nurse stations.	K 072	<u>How Other Residents were Identified that may have been affected by the practice:</u>  Residents in five (5) of six (6) smoke compartments had the potential to be affected.  <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u>  The medication carts will be relocated to a new storage area out of the corridors on 3/16/2012 by the Environmental Director.  All nursing staff including all State Registered Nurse Aides, Med Techs, Restorative techs, Rns, and LPNs will be educated on the new location of the medication carts by the Staff Development Coordinator by 3/16/2012. Any staff that have not been educated by 3/16/2012 will be educated before their next shift worked.  <u>Monitoring Measures to Maintain On-going Compliance:</u>  The DON, ADON, and Unit Manager will verify appropriate storage of medication carts during daily rounds to monitor for ongoing compliance. The results of these observations will be reported to the Administrator in the Abbreviated QA meeting five times per week. Any non-compliance will be addressed by the Quality Assurance Committee.		

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K 072	Continued From page 17 Interview, on 02/01/12 at 4:00 PM, with the Environmental Director revealed the facility routinely stored the medicine carts in the corridor.	K 072		
K 076 SS=E	Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 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. NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect four (4) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a	K 076	K 076 It is the normal practice of Bradford Heights Health and Rehab Center to ensure oxygen cylinders are stored in accordance with NFPA standards. <u>Corrective Measures for Residents Identified in the Deficiency:</u> 03/16/12 No residents were identified. <u>How other Residents were Identified that may have been affected by the practice:</u> The practice has the potential to affect residents four of six smoke compartments. <u>Measures Implemented or Systems Altered to Prevent RE-Occurrence:</u> Environmental /Plant Service Director obtained signage indicating full or empty oxygen tanks for all oxygen storage rooms on February 23, 2012. The Environmental/Plant Service Director and Licensed Nursing including RN's and LPN's were reeducated by the Director of Nursing on 02-25-2012 on the required storage for oxygen storage rooms. <u>Monitoring Measures to Maintain On-going Compliance:</u> Oxygen storage rooms will be audited for signage indicating full or empty oxygen tanks by the Quality Assurance Nurse weekly x 4 weeks, then monthly	

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K 076	<p>Continued From page 18</p> <p>census of seventy eight (78) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/01/12 at 2:10 PM, with the Environmental Director revealed there was no signage indicating full or empty oxygen tanks in any of the oxygen storage rooms. .</p> <p>Interview, on 02/01/12 at 2:10 PM, with the Environmental Director revealed he was not aware the oxygen tanks needed to be labeled.</p> <p>Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m<sup>3</sup> (300 ft<sup>3</sup>) but less than 85 m<sup>3</sup> (3000 ft<sup>3</sup>) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprnkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible</p>	K 076	x 6 months. Results of the audits will be reported to the Quality Assurance Committee to monitor on-going compliance.	

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K 076	Continued From page 19 construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076		
K 147 SS=F	8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: <b>CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</b> NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  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 six (6) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of 78 (78) on the day of the survey.  The findings include:  Observation, on 02/01/12 between 12:30 PM and 4:30 PM, with the Environmental Director revealed:	K 147	K 147 It is the normal practice of Bradford Heights Health & Rehab Center to maintain electrical wiring and equipment is in accordance with NFPA 70 standards.  <u>Corrective Measures for Residents Identified in the Deficiency:</u>  No residents were identified in the deficiency.  <u>How Other Residents were Identified who may have been affected by this practice were identified:</u>  Residents in six (6) of six (6) smoke compartments had the potential to be affected by the practice.  <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>  The electrical junction box located in the attic in the 100 hall next to room #110 will have an adapter box and cover plate installed by the Pennyrlle Fire and Safety by March 16, 2012.	03/16/12

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K 147	<p>Continued From page 20</p> <ol style="list-style-type: none"> <li>1) Open electrical junction box was found in the attic in the 100 hall next to room #110.</li> <li>2) A bed and a mini nebulizer were plugged into a power strip located in room #220.</li> <li>3) An oxygen concentrator was plugged into a power strip located in room #104.</li> <li>4) A wheelchair was plugged into a power strip in room #206 .</li> <li>5) A bed was plugged into a power strip located in room #203 .</li> <li>6) A bed, wheelchair battery charger, and a refrigerator were plugged into a power strip located in room #102.</li> <li>7) A suction pump was plugged into a power strip located in room #108.</li> </ol> <p>Interview, on 02/01/12 between 12:30 PM and 4:45 PM, with the Environmental Director revealed they were not aware of the misuse of power strips and the open junction box in the attic.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the 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.</p> <p>Reference: NFPA 70 (1999 edition)</p>	K 147	<p>The bed and mini nebulizer in room #220 were removed from the power strip and plugged into wall receptacles by the Environmental Director on 2/1/2012.</p> <p>The oxygen concentrator in room #104 was removed from the power strip and plugged into a wall receptacle by the Environmental Director on 2/1/2012.</p> <p>The wheelchair in room #206 was removed from the power strip and plugged into wall receptacle by the Environmental Director on 2/1/2012.</p> <p>The bed in room #203 was removed from the power strip and plugged into a wall receptacle by the Environmental Director on 2/1/2012.</p> <p>The bed, wheelchair battery charger, and refrigerators in room #102 were removed from power strips and plugged into wall receptacles by the Environmental Director on 2/1/2012.</p> <p>The suction pump in room #108 was removed from the power strip and plugged into the wall receptacle by the Environmental Director on 2/1/2012.</p> <p>All resident rooms were audited by the Quality Assurance Committee members on 2/6/2012 to verify all medical equipment is plugged directly into wall receptacles.</p> <p>The Environmental Director was re-educated by the Administrator on 2/23/2012 on electrical wiring and equipment in accordance with the NFPA codes.</p> <p>Staff including all State Registered Nurse Assistants, Med Techs, Restorative techs, RN s, LPNS, house keeping, laundry, therapy department, dietary, and maintenance department by the Staff Development Coordinator on 3/16/2012 on properly placing medical equipment into wall receptacles rather than power strips.</p>	

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K 147	Continued From page 21  370.28(c) Covers.  All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147	<u>Monitoring Measures to Maintain Ongoing Compliance:</u>  The Environmental Director will audit five (5) rooms weekly for eight (8) weeks, then monthly for six (6) months to verify ongoing compliance with properly plugging medical equipment into wall receptacles. This is approximately 10% of resident rooms.  The Environmental Director will audit different junction boxes on each unit weekly for eight (8) weeks then monthly for six (6) months to verify ongoing compliance with junction boxes being closed. Results of these audits will be given to the Administrator and Quality Assurance Committee to monitor ongoing compliance.  If areas of concern are identified, the frequency and duration of the audit may be increased.		