

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2013
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A Recertification Survey was conducted 02/27/13 through 03/01/13. Deficiencies were cited with the highest Scope and Severity of a "F".

F 252 483.15(h)(1) SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to provide a safe, clean, comfortable and homelike environment related to sewer gas odors emanating from the bathtub in room 110.

The findings include:
During initial tour, on 02/27/13 at 11:45 AM, a strong sewer odor was detected in the bathroom of room 110. Blankets were piled in the bathtub on and around the drain area.

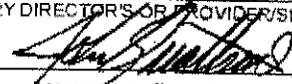
Interview with the Unit Manager (UM) of the 100 Hall on, 02/27/13 at 11:45 AM, revealed it was reported to her as a sewer odor due to the bathtub being taken out of service. Further interview revealed, she thought the blankets had been put in the tub to decrease the sewer gas odor.

F 000 "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **BridgePoint Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

F 252

- F252**
1. No resident resided in room 110 at the time of survey and this room remains out of service. The bathtub drain in room 110 has been plugged by the maintenance department and the tub taken out of service. The blankets in the tub were removed by the maintenance director on 2/27/13 during the tour with the surveyor. The center has contacted a contractor to provide service to the bathtub for repair of drain/plumbing. The room and bathtub will remain out of service until the

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/22/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 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 252	Continued From page 1 Interview with the Maintenance Director, on 02/27/13 at 12:05 PM, revealed the odor was due to the sewer gases building up in the drain that was not in use. Further interview revealed he would carry water in a bucket occasionally in attempts to keep the drain trap wet with water to control the sewer odor.	F 252	problem is resolved completely.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	2. There are no other rooms in the center with a bathtub. The Maintenance Director completed rounds with the surveyor on 2/27/13 when no other odors were noted. Additionally, the Maintenance Director completed center rounds on 2-27-13 and no other odors were noted. 3. The Maintenance Director was re-educated on 3/11/13 by the Administrator on the proper procedure when equipment or area is out of service. Center staff nursing and non-nursing staff, will be re-educated by the administrator by 4-7-13 on the procedure to notify maintenance of any equipment, repair, or service. Re-education included appropriate storage of linens. 4. The Maintenance Director will monitor the bathtub in room 110, and make center rounds twice weekly for four weeks, then weekly for four weeks, then monthly for sewer or other odors to validate that the center maintains a safe, clean, and homelike environment. The Maintenance Director will report on this surveillance at the Performance Improvement Committee meetings monthly for further review and recommendation. Completed by 4/8/13.	4/8/13

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F 278 Continued From page 2

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review it was determined the facility failed to ensure the assessment accurately reflected the resident's status for one (1) of twenty-four (24) sampled residents (Resident #14).

The Minimum Data Set (MDS) Assessment for the Annual MDS, dated 08/14/12, and the Quarterly MDS, dated 02/14/13, for Resident #14 revealed the resident was coded as extensive assistance needed for transfers, dressing, eating, hygiene, and bathing. However, interviews and record review revealed Resident #14 required total assistance in these care areas.

The findings include:

Interview, on 03/1/13 at 6:35 PM, with the Director of Nursing, revealed the facility had no specific policy related to accuracy of coding the MDS.

Review of Resident #14's medical record revealed diagnoses which included Alzheimer's Disease, Communication Deficit, Dysphagia, and Arthritis.

Review of the Annual MDS Assessment, dated 08/14/12, revealed the facility has assessed the resident as having both long and short term memory deficit and as having severe impairment in cognitive skills for decision making. Further review revealed the facility assessed the resident

F 278

F278

1. The center follows RAI Guidelines related to the completion and accuracy of the MDS assessment. Resident #14 was re-assessed by the registered nurse with an ARD date of 3/25/13 to accurately reflect the resident's status.
2. The MDS Coordinators, Director of Nursing, Assistant Director of Nursing, Unit Managers and/or Nursing Supervisors will review current residents most recent MDS, quarterly or comprehensive assessment, to determine it accurately reflects the residents by 4/7/13. Any identified discrepancies will be re-assessed and a MDS assessment will be either corrected and/or a new ARD set.
3. MDS Coordinators were re-educated to complete the MDS assessment accurately by the Administrator on 3/19/13. Center nursing staff will be re-educated by 4/7/13 by the MDS Coordinators and/or Assistant Director of Nursing regarding completing nursing

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F 278 Continued From page 3
as requiring extensive assistance of two persons for bed mobility, transfers and toileting, extensive assistance of one person for dressing, eating, personal hygiene and bathing.

Review of the Quarterly MDS Assessment, dated 02/14/13, revealed the facility assessed the resident as having both long and short term memory deficit and as having severe impairment in cognitive skills for decision making. Further review revealed the facility assessed the resident as requiring extensive assistance of two persons for bed mobility and transfers and as requiring extensive assistance of one person for dressing, eating, toilet use, and personal hygiene, and as totally dependent on one staff for bathing.

Review of the Care Area Assessment Summary, dated 08/28/12, revealed staff were to anticipate the residents needs as the resident required total care from staff in Activities of Daily Living (ADL's) and was incontinent of bowel and bladder. Further review revealed the resident was bed bound and was transferred to the gerichair per the Hoyer Lift. The CAAS stated the resident was dependent for nutrition and hydration per the PEG tube and was NPO (nothing by mouth).

Review of the Comprehensive Plan of Care, dated 02/16 13, revealed the resident was dependent for tube feeding, nutrition, and hydration and was NPO (nothing by mouth). Further review revealed the resident had a self care deficit and required extensive to total assistance with bed mobility, transfers, toileting, grooming, personal hygiene, and bathing, and was incontinent of bowel and required an indwelling Foley catheter.

F 278 documentation, including ADL documentation/coding. Center nurses will validate completed ADL documentation by the CNA daily.

4. ADL documentation will be reviewed 5 times a week by MDS Coordinators, Director of Nursing, Assistant Director of Nursing and/or Unit Managers to validate completion and accuracy. MDS Coordinators, the Director of Nursing and/or Assistant Director of Nursing will complete documentation audits of progress notes and ADL coding compared to MDS assessments 5% weekly for completion and accuracy. These reviews will be provided by the Director of Nursing Services and/or Assistant Director of Nursing Services to the Performance Improvement Committee monthly for review and further recommendation.

Completed by 4/8/13.

4/8/13

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F 278 Continued From page 4

F 278

Review of the Resident Functional Performance Record, dated 08/07/12 through 8/14/12, revealed the resident was coded for total dependence of one person for grooming, bed mobility, eating, and toilet use. Further review revealed the resident was coded as "activity did not occur" or total dependence for transfers, dressing, and bathing. However, there was omissions of documentation for bed mobility, transfers, eating, toilet use grooming, dressing, and bathing for the night shift on 08/13/12.

Review of the Resident Functional Performance Record, dated 02/07/13 through 02/14/13, revealed the resident was coded for total dependence of one person for grooming, bed mobility, eating, and toilet use, and was coded as "activity did not occur" or total dependence for transfers, dressing, and bathing. However, there was omissions of documentation for bowel and bladder function on 02/12 on the day shift.

Observation of Resident #14, on 02/27/13 at 5:00 PM and 6:00 PM, revealed the resident was reclined back in a gerichair and a urinary drainage bag was draining yellow urine. Tube feeding Jevity 1.2 was infusing per gastric tube at sixty (60) milliliters (ml's) per hour. Further observation, on 02/28/13 at 8:40 AM, 9:10 AM, and 10:00 AM, revealed the resident was lying on his/her back in the bed with the head of the bed up forty-five (45) degrees and Jevity 1.2 tube feeding was infusing at 60 ml per hour.

Interview, on 03/01/13 at 5:30 PM, with State Registered Nurse Aide (SRNA) #6 revealed she was assigned to Resident #14. She stated the

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F 278	Continued From page 5 resident was unable to do anything for himself/herself and all care was performed by staff. Interview, on 03/01/13 at 3:10 PM, with MDS Nurse #1 revealed she had completed both the MDS's for Resident #14. She agreed the resident required total assistance with all ADL's per interview with staff and observation as well as record review. However, she stated was unable to code total assistance of ADL's on the MDS if any of the Resident Functional Performance Record for the seven (7) day look back period had omissions of data or was illegible because of the validation survey for the Resource Utilization Groups (RUG,s).	F 278		
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 facility policy it was determined the facility failed to ensure services provided by the facility met professional standards of quality for three (3) of twenty-seven (27) sampled residents. The facility failed to ensure medications were administered per the Physician's orders for two (2) of the nine (9) unsampled residents in the medication pass (Unsampled Resident A and Unsampled Resident B). Unsampled Resident A	F 281	F281 1. Unsampled resident A is alert and oriented with a BIMS score of 15 and received a regular consistency HCC	

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F 281 Continued From page 6
received two (2) medications by the incorrect route. Unsampled Resident B received one (1) medication at the wrong time.

In addition, although Physician's Orders were received for Invanz (antibiotic medication) for a Urinary Tract Infection for Resident #13 on 02/22/13, there was no documented evidence the antibiotic medication was started until 02/24/13, two (2) days later.

The findings include:

Review of the facility Long Term Care Facility's Pharmacy Services and Procedures Manual, revised 05/01/10, revealed prior to administration of medication, facility staff should take all measures required by Facility Policy and Applicable Law, including: verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident.

1. Observation of the noon medication pass, on 02/27/13, revealed a twenty (20) mg tablet of Dicyclomine was given to Unsampled Resident A per mouth. Further observation revealed a ten (10) mg tablet of Metoclopramide was given to Unsampled Resident A by mouth.

Review of the Physician's orders, dated February 2013, for Unsampled Resident A revealed both the Dicyclomine and Metoclopramide were ordered to be give via the gastrostomy tube.

Interview on 02/27/13 at 12:55 PM, with Licensed Practical Nurse (LPN) #3 revealed Unsampled

F 281 PO diet. Family and physician were notified 2-27-13 that two medications were given by mouth with no adverse effects. New orders were obtained, effective 2-25-13, that medications may be administered per gastrostomy tube or by mouth as tolerated. LPN #5 was re-educated on 2/27/13 by the unit manager on medication pass procedures and following physician orders as written and completed a medication skills competency on 3-18-13 with the ADNS.

The family and physician of unsampled resident B were notified on 2-28-13 of the medication error. The physician gave no new orders and the resident had no adverse effects due to the error. LPN #6 was re-educated on 2-28-13 by the DNS on medication pass procedures and will complete a medication skills competency on 3-23-13 with the ADNS.

Resident #13 completed antibiotic treatment for a urinary tract infection on 3-2-13 and remains asymptomatic. The family and physician of resident #13 were notified on 3-1-13 of the delay in receipt and initiation of the antibiotic. LPN #2 was re-educated on 3-1-13 by the DNS on the process for ordering new medications from the pharmacy to prevent a delay in administration

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F 281	<p>Continued From page 7</p> <p>Resident A's medications were given by mouth because the resident's condition had changed, but the Physician had not written an order for the medication route to be changed.</p> <p>Interview, on 02/27/13 at 1:00 PM, with the Unit Manager of the 100 Hall (UM) revealed the medication had been ordered to be given by mouth until 11/12/12 and the order was changed to be given by gastrostomy tube due to a change in resident condition. Interview further revealed that the resident was now able to swallow the medications; however, the Physician had not written the order to give the medications by the oral route.</p> <p>Observation of the medication pass, on 02/28/13 at 8:00 AM, revealed a twenty-five (25) microgram tablet of Levothyroxine was given at 8:00 AM and ordered to be given at 6:00 AM.</p> <p>Review of the Physician's Orders, dated February 2013, for Unsampled Resident B revealed the Levothyroxine was ordered to be given at 6:00 AM.</p> <p>Interview, on 02/28/13 at 8:45 AM, with LPN #6 revealed Unsampled Resident B's medication was scheduled to be given at 6:00 AM and she had given a second dose at 8:00 AM which was a medication error. Further interview revealed she assessed the resident and notified all parties involved.</p> <p>Interview with the Director of Nursing, on 03/01/13 at 4:40 PM, revealed giving the medication by the wrong route and or at the wrong time would both be a medication error. The</p>	F 281	<p>and completed a medication skills competency on 3-18-13 with the ADNS.</p> <p>3. Licensed Nurses and Medication Aides were provided re-education on medication pass procedures, following physician orders as written, and the process for ordering new medications from the pharmacy to prevent a delay in administration, by the Director of Nursing and/or Assistant Director of Nursing as of 4/4/13.</p> <p>4. The Director of Nursing and/or Assistant Director of Nursing will complete medication administration competencies with licensed nurses and/or medication aides 4 times per week for 4 weeks, then 2 times per week for 4 weeks, then 2 times monthly for 2 months. The Director of Nursing, Assistant Director of Nursing, Unit Managers and/or Nursing Supervisors will review new physicians' orders daily Mon-Fri to ensure new orders include an appropriate route of administration for the resident and that new orders for medications were received timely from the pharmacy. The Director of Nursing/Assistant Director of Nursing will report results of</p>	
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F 281	<p>Continued From page 8</p> <p>DON further stated she would expect either of these errors to be reported to the Physician, family, and Administration. Continued interview revealed she would expect an incident reported to be initiated and medication errors tracked.</p> <p>2. Review of Resident #13's medical record revealed diagnoses which included Dementia, Cerebral Vascular Accident (CVA), and a History of Urinary Tract Infections (UTI's). Review of the the Quarterly Minimum Data Set (MDS) Assessment, dated 12/03/12, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a two (2) out of fifteen (15). Further review revealed the facility assessed the resident as always incontinent of bowel and bladder and as requiring requiring extensive assistance with hygiene and bathing.</p> <p>Review of the Comprehensive Plan of Care, revised 02/25/13, revealed the resident had a UTI and the interventions included contact isolation.</p> <p>Review of the laboratory report culture and sensitivity data for a urine specimen collected 02/19/13 indicated the organism was Escherichia coli confirmed as positive for Extended Spectrum Beta Lactamase (ESBL) (antiblotic resistant pathogen) and Morganella morganii. New Physician's Orders were obtained on 02/22/13 for Invanz (antibiotic medication) one (1) gram to be administered intramuscular for seven (7) days.</p> <p>Review of the Medication Administration Record (MAR) for February 2013 revealed the medication was started on 02/24/13 at 6:00 AM.</p>	F 281	<p>competencies and reviews of new physicians' orders to the Performance Improvement Committee meeting monthly for further review and recommendation.</p> <p>Completed by 4/8/13.</p>	4/8/13

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F 281 Continued From page 9

Review of the Interdisciplinary Note, dated 02/22/13 at 6:00 PM, by Licensed Practical Nurse (LPN) #2 revealed the culture and sensitivity results were faxed to the physician, a new order for Invanz was obtained and the resident was on contact precautions for ESBL of the urine.

Interview with Licensed Practical Nurse (LPN) #2, on 02/28/13 at 3:45 PM, revealed she had obtained the order from the physician the evening of 02/22/13 and normally antibiotics were pulled from the facility emergency box until the medication arrived from pharmacy. However, she stated Invanz was not in the emergency box. She further stated the order was faxed to pharmacy on the evening of 02/22/13 and the medication should have been at the facility by 02/23/13; however, the MAR indicated the medication was not started until 02/24/13 at 6:00 AM, two (2) days later.

Further interview with LPN #2, on 03/01/13 at 8:25 PM, revealed she did not usually fax pharmacy for stat antibiotics; however, if the medication was not in the emergency box it would need to be ordered stat. She stated at the time she obtained the order from the physician she did not think about ordering it stat because the pharmacy ran twice a day, at midnight and at 4:30 PM and she expected the antibiotic would have been delivered to the facility from pharmacy by midnight on the day it was faxed to the pharmacy (02/22/13).

Review of the Pharmacy Requisition Report for the Invanz revealed it was faxed to pharmacy on 02/22/13 at 5:08 PM. Review of the Proof of

F 281

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PRINTED: 03/14/2
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OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

F 281 Continued From page 10
Delivery from Pharmacy revealed the Invanz medication was filled on 02/22/13, shipped on 02/23/13 and received by the facility on 02/24/13 at 2:31 AM.

Interview, on 03/01/13 at 8:30 PM, with the facility consultant pharmacist revealed if Invanz had been ordered stat, it would have been delivered to the facility within four (4) hours.

Interview with the Director of Nursing (DON), on 03/01/13 at 5:00 PM, revealed the Invanz should have been ordered stat from pharmacy since the facility did not stock Invanz in the emergency box and if the medication was ordered stat it would have been at the facility in four (4) to six (6) hours. She stated all Physician's Orders were reviewed in the morning clinical meeting Monday through Friday and the Unit Manager was to check the MARS as follow up after clinical to validate the medication came from pharmacy and was administered the day it was ordered. She stated there was no Unit Manager on the 300 Hall at that time, and it must have been missed. Further interview revealed it was the expectation that antibiotics would be administered the day they were ordered.

F 281

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER

F 315

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract

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PRINTED: 03/14/2013
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OMB NO. 0938-0392

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F 315 | Continued From page 11
infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and facility policy, it was determined the facility failed to ensure residents receive appropriate treatment and services to prevent Urinary Tract Infections (UTI's) for one (1) of twenty-four (24) sampled residents (Resident #14).

Observation of Foley catheter care/incontinence care for Resident #14 who was being treated for a Urinary Tract Infection for Escherichia Coli Extended Spectrum Beta Lactamase (ESBL) (antibiotic resistant pathogen), revealed poor infection control technique.

The findings include:

Review of Resident #14's clinical record revealed diagnoses which included Alzheimer's Disease, Chronic Kidney Disease, a History of Urinary Tract Infections. Review of the Quarterly Minimum Data Set (MDS), dated 02/14/13, revealed the facility assessed the resident as having both long and short term memory deficit and as having severe impairment in cognitive skills for decision making. Further review revealed the facility assessed the resident as requiring extensive assistance for personal hygiene.

Review of the Care Area Assessment Summary (CAAS), dated 08/28/12, revealed the resident required total assistance for incontinence and

F 315

F315

1. Incontinence and catheter care was completed for resident #14 by the certified nursing assistant 2/28/13 using proper infection control technique. CNA #5 was re-educated on 2/28/13 by the Assistant Director of Nursing on peri-care/incontinence care, including care of catheter.
2. The Director of Nursing, Assistant Director of Nursing, Unit Managers and/or Nursing Supervisors will review current residents bowel and bladder status as of 4/7/13 to validate continued need of catheters for residents whom have a catheter and that incontinent residents have a plan of care that addresses their toileting/elimination needs to prevent UTIs as much as possible.

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F 315: Continued From page 12
was unable to report needing to be cleaned or changed and staff were to use incontinence products as ordered.

Review of the Comprehensive Plan of Care, dated 02/25/13, revealed the resident had a Urinary Tract Infection with a goal that the UTI would resolve without complications. The interventions included contact precautions, antibiotics as ordered and monitor for pain/burning and signs and symptoms of infections. Further review of the Plan of care, dated 02/16/13, revealed the resident had a problem of alteration in continence requiring an indwelling Foley catheter related to Urinary Retention. The goal stated the resident would have no signs and symptoms of a Urinary Tract Infection (UTI) related to catheter placement. The interventions included catheter care every shift.

Review of the laboratory report culture and sensitivity dated 02/27/13 for a urine specimen collected 02/24/13 indicated the organism was Escherichia Coli ESBL. New Physician's Orders were obtained on 02/27/13 for Macrobid 100 milligrams (mg's) every twelve (12) hours for seven (7) days to make a total of ten (10) days. (A Physician's Order was obtained on 02/25/13 for Macrobid 100 mg twice a day for three days until the urine culture and sensitivity results).

Observation, on 02/28/13 at 2:20 PM, revealed a sign on the name plate by Resident #14's door which stated, "stop and see nurse for instructions" and there was a bin of plastic drawers in the hallway by the resident's door containing gowns and gloves. Further

F 315

3. Re-education of nursing staff will be completed by 4/7/13 by the Director of Nursing Services, Assistant Director of Nursing, and/or Unit Managers. Education will include the center's Incontinence Program, including pericare, catheter care, the bowel and bladder assessment and developing plans of care to meet each resident's individual needs.

4. The Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, and/or Nursing Supervisors will complete random observations of pericare and/or foley catheter care skills with nursing staff weekly for 4 weeks, then 3 times monthly for 1 month, then monthly. A summary of findings will be presented at monthly PI meeting by the Director of Nursing and/or Assistant Director of Nursing for review and further recommendations.

5. Completed by 4/8/13.

4/8/13

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPRING DRIVE FLORENCE, KY 41042
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F 315 Continued From page 13

observation revealed State Registered Nursing Assistant (SRNA) #5 gowned and gloved prior to entering the resident's room and stated this was because the resident was on contact precautions. Observation of Foley catheter care/ incontinence care for Resident #14 revealed SRNA #5 wiped stool from the residents buttocks and anal area, and with the same soiled gloves obtained a clean wet washed cloth and cleansed the residents genital area and Foley catheter.

Interview with SRNA #5, on 2/28/13 at 3:00 PM, revealed she failed to remove the soiled gloves and wash her hands after cleansing the residents buttocks and anal area and prior to cleansing the resident's genital area and Foley catheter.

Interview, on 03/01/13 at 3:30 PM, with the Director of Nursing (DON) revealed the facility had just been purchased by a new corporation and the first thing they rolled out at the facility was inservices and check offs related to infection control. However, she was unaware if skills check offs had been done for peri care/Foley care and stated would need to check with the Assistant Director of Nursing (ADON).

Interview, on 03/01/13 at 6:50 PM, with the ADON/Infection Control Nurse revealed the facility had an inservice related to pericare and Foley catheter care recently; however, skill check offs to ensure proper procedure was not done with staff at that time.

F 315

F 332 483.25(m)(1) FREE OF MEDICATION ERROR
SS=E RATES OF 5% OR MORE

F 332

F332

The facility must ensure that it is free of medication error rates of five percent or greater.

1. Unsampled resident A is alert and oriented with a BIMS score of 15.

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F 332 Continued From page 14

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure that it is free of medication error rates of five (5) percent or greater. During medication the passes, two (2) of the nine (9) unsampled residents that were given medications were either given at the incorrect time or by the incorrect route. Two (2) medications were given by the incorrect route for Unsampled Resident A and one (1) medication was given at the wrong time for Unsampled Resident B. These medication errors resulted in a medication error rate of seven percent (7%).

The findings include:

Review of the facility Long Term Care Facility's Pharmacy Services and Procedures Manual, revised 05/01/10, revealed prior to administration of medication, facility staff should take all measures required by Facility Policy and Applicable Law, including; verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident.

Observation of the noon medication pass, on 02/27/13, revealed a twenty (20) mg tablet of Dicyclomine was given to Unsampled Resident A per mouth. Further observation revealed, a ten (10) mg tablet of Metoclopramide was given to Unsampled Resident A by mouth.

F 332

She is ordered and receives a regular consistency HCC PO diet. Family and physician were notified 2-27-13 that two medications were given by mouth with no adverse effects. New orders were obtained, effective 2-25-13, that medications may be administered per gastrostomy tube or by mouth as tolerated. LPN #5 was re-educated on 2/27/13 by the unit manager on medication pass procedures and following physician orders as written and completed a medication skills competency on 3/18/13 with the Assistant Director of Nursing.

The family and physician of unsampled resident B were notified on 2/28/13 of the medication error. The physician gave no new orders and the resident had no adverse effects due to the error. LPN #6 was re-educated on 2/28/13 by the Director of Nursing Services on medication pass procedures and will complete a medication skills competency on 3/23/13 with the Assistant Director of Nursing Services.

- The Director of Nursing, Assistant Director of Nursing, Unit Managers and/or Nursing

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F 332

Continued From page 15

Review of the Physician's orders, dated February 2013, for Unsampld Resident A revealed both the Dicyclomine and Metoclopramide were ordered to be give via the gastrostomy tube.

Interview, on 02/27/13 at 12:55 PM, with Licensed Practical Nurse (LPN) #5 revealed the medications were given by mouth because the resident's condition had changed; however, the Physician had not written an order for the medication route to be changed.

Interview, on 02/27/13 at 1:00 PM, with the Unit Manager of the 100 Hall (UM), revealed the medication had been ordered to be given by mouth until 11/12/12 and the order was changed to be given by gastrostomy tube due to a change in resident condition. Interview further revealed that the resident is now able to swallow the medications; however, the Physician had not written the order to give the medications by the oral route.

Observation of the medication pass, on 02/28/13 at 8:00 AM, revealed a twenty-five (25) microgram tablet of Levothyroxine was given at 8:00 AM and ordered to be given at 6:00 AM for Unsampld Resident B.

Review of the Physician's Orders, dated February 2013, for Unsampld Resident B revealed the Levothyroxine was scheduled to be given at 6:00 AM.

Interview, on 02/28/13 at 8:45 AM, with LPN #6 revealed the medication was scheduled to be given at 6:00 AM and she had given a second

F 332

Supervisor reviewed physician's orders of current residents to determine if orders had been transcribed to be given via the correct route; and compared physician's orders to the MAR to determine medications were on the MAR to be given at the correct time per MD order as of 4/7/13. The responsible party and physician will be notified of any issues, and any new orders obtained followed as given.

Licensed Nurses and Medication Aides were provided re-education on medication pass procedures and following physician orders as written, by the Director of Nursing and/or Assistant Director of Nursing as of 4/7/13.

The Director of Nursing and/or Assistant Director of Nursing will complete medication administration competencies with licensed nurses and/or medication aides 4 times per week for 4 weeks, then 2 times per week for 4 weeks, then 2 times monthly for 2 months. The Director of Nursing, Assistant Director of Nursing, Unit Managers and/or Nursing Supervisors will review new

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F 332	Continued From page 16 dose at 8:00 AM. Further interview revealed she assessed the resident and notified all parties involved. Interview with the Director of Nursing, on 03/01/13 at 4:40 PM, revealed giving the medication by the wrong route and/or at the wrong time would both be a medication error. The DON further stated she would expect either of these errors to be reported to the Physician, family and Administration. The DON further state she would expect an incident reported to be initiated and medication errors tracked.	F 332	physicians' orders daily Mon-Fri to ensure new orders include an appropriate route of administration for the resident. The Director of Nursing/Assistant Director of Nursing will report results of competencies and reviews of new physicians' orders to the Performance Improvement Committee meeting monthly for further review and recommendation.		
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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observations, on 02/27/13, revealed a trash can near a food preparation area had gnats present when the lid was lifted; coffee cups with dried brown substance on the inside of the cups; the lip on the serving counters were sticky; a spoodle in	F 371	Completed by 4/8/13. F371 1. The trash cans in the kitchen were cleaned by the kitchen staff on 2/28/13. The coffee cups and clear plastic cups were inspected by the Nutritional services director on 2/28/13. Cups found to be stained were either cleaned or disposed of and new mugs were placed into service. The serving counters were cleaned by the kitchen staff on 2/27/13. The utensils in the serving drawer were re-washed by the kitchen staff on 2/27/13. The drawer with the utensils in different directions was emptied, the utensils were	4/9/13	

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F 371

Continued From page 17
the utensil drawer with dried brown residue and the handles of utensils pointed in different directions; the back splash extending from the tray-line had greasy/sticky build-up; a cereal dispenser that had build-up of dust and grease coating the outside of the dispenser; door and door handle of the walk-in refrigerator with build-up of grease and dried food; fried chicken stored in the walk-in with a date of 02/18/13 (9 days earlier); meatballs with sauce stored in the walk-in dated 02/23/13 (4 days earlier); a white cream liquid stored in the walk-in not labeled and dated 02/21/13 (6 days earlier); dirty and sticky floors in the walk-in freezer and dried store room and the dishwasher rinse cycle registering 150 degrees Farenheit (required temperature should be 180 degrees Farenheit).

The findings include:

Review of the Census and Condition, dated 02/27/13, revealed fourteen (14) of the one-hundred thirty-six (136) residents were tube feeders.

1) Review of the facility policy titled "Food Preparation", dated 07/08, revealed food preparation procedures were to be used that avoid contamination by potentially harmful physical, biological and chemical contamination. In addition, all staff were to use serving utensils appropriately to prevent cross contamination.

Observation of the kitchen, on 02/27/13 at 8:30 AM, revealed twelve (12) out of fifteen (15) coffee cups stored on a tray had dried brown residue inside the cups. Further observation revealed eleven (11) out of eleven (11) clear plastic cups

F 371

rewashed, and stored appropriately on 2/27/13 by the kitchen staff. The backsplash of the tray line was cleaned by the kitchen staff on 2/27/12. The cereal dispenser and the door handle on the reach in were cleaned by the kitchen staff on 2/27/13. The chicken, meatballs, and the white liquid, were disposed of by the food service director on 2/27/13. The floors on the freezer and dried store room were mopped and cleaned by the kitchen staff on 2/27/13. The dish machine was serviced by ecolab on 2/27/13 allowing for a low rinse bleach solution to be in effect permanently to properly clean/sanitize in the event the booster heater does not hit 180 degrees on the final rinse. A Cleaning Schedule was posted in the kitchen on 3/12/13 by the Nutritional Services Director.

2. The center recognizes residents benefit from proper sanitary conditions in the kitchen. The kitchen was deep cleaned by the dietary staff on 3/12/13. The dietary staff were re-educated by the Nutritional Services Director as of 4/7/13 on the department Cleaning Schedule. The dish machine was repaired on 2/27/13.

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F 371	<p>Continued From page 18</p> <p>stored on a tray had an off-white residue build-up on the inside of the cups. Continued observation revealed when a lid of a trash can was opened that was adjacent to a food preparation area, two (2) gnats flew out of the trash can.</p> <p>Continued observation of the kitchen, on 02/27/13 at 8:45 AM, revealed the lips on the edges of the food preparation counters were sticky with grease build-up. A plastic storage bin contained a spoodle with dried brown residue and the handles of the utensils in the container were pointed in different directions. Further observation of the back splash area extending from the tray-line had greasy/sticky build-up.</p> <p>Additional observation of the kitchen, on 02/27/13 at 9:00 AM revealed a cereal dispenser that had build-up of dust and grease coating the outside of the dispenser. Further observation of the walk-in refrigerator revealed the door and door handle of the refrigerator had build-up of grease and dried food. Continued observation revealed fried chicken stored in the walk-in with a date of 02/18/13 (9 days earlier), meatballs with sauce stored in the walk-in dated 02/23/13 (4 days earlier) and a white cream liquid stored in the walk-in not labeled and dated 02/21/13 (6 days earlier). In addition the floor underneath a black mat in the walk-in freezer had food and brown sticky substance under the mat. Observation of the dried good store room revealed there was crumbs and sticky substance on the floor. Continued observation of the kitchen revealed there was not a cleaning schedule posted.</p> <p>Interview with Dietary Aide # 1, on 02/28/13 at 9:50 AM, revealed everyone in dietary was</p>	F 371	<p>3. The Nutritional Services Director was re-educated by the Administrator on 3/4/13 on kitchen cleanliness and sanitation to include food storage, utensil storage, dishwasher temperatures and/or manual washing procedures. Dietary staff were re-educated on 3/11/13 by the Nutritional Services Director on kitchen cleanliness and sanitation to include food storage, utensil storage, dishwasher temperatures and/or manual washing procedures.</p> <p>4. The Administrator, Registered Dietician, and/or Nutritional Services Director will conduct kitchen sanitation audits 2 times weekly for 4 weeks, then 2 times monthly. The Dietician and/or Nutritional Services Director will report findings to the Performance Improvement Committee monthly for review and further recommendations.</p> <p>Completed by 4/8/13</p>	4/8/13	

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F 371	<p>Continued From page 19</p> <p>responsible for cleaning the area in which they worked that day. Additional observation revealed everyone that worked in the kitchen was obligated to check dates on items in the refrigerator to ensure food is discarded after three (3) days. Further interview revealed as far as deep cleaning there used to be a schedule on the board outside the managers office, but there had not been one in awhile and staff just knew they were supposed to make sure everything is properly cleaned at the end of their shift.</p> <p>Interview with Dietary Aide/Cook #2, on 02/28/13 at 10:15 AM, revealed the floors were cleaned at the end of the day in the main kitchen area; however, wasn't sure about the floors in the refrigerator, freezer or dry good store room. She stated she thought Dietary Aide/Cook #3 came in and did deep cleaning once per week. She indicated that sometimes there was a cleaning schedule on the board outside the Dietary Managers office but there had not been one in awhile.</p> <p>Interview with Dietary Aide/Cook #3, on 02/28/13 at 1:40 PM, revealed every Tuesday he put the food delivery up as it came in and also did some cleaning. He indicated he and the Dietary Manager discussed what needed to be deep cleaned that day and due to limited time some of the "minor things got missed". He stated the cereal dispenser was taken apart and run through the dishwasher every one to two weeks and it just depended upon who could get to it. Additional interview revealed he mopped the floors in the dried good stock room, the freezer and refrigerator once a week after stock was delivered and put away.</p>	F 371	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 20 Record review and interview with the Dietary Manager (DM), on 02/28/13 at 2:00 PM, revealed a Nutrition Services Cleaning Schedule had not been posted since 01/16/13 which Included cleaning above and below work tables, cleaning of the walk-in refrigerator and freezer, and stock room. Additional record review and interview revealed cleaning the cereal dispenser was not on the cleaning schedule. The DM stated he and Dietary aide/Cook #3 would pick an area and do deep cleaning on that area once a week. The DM indicated he needed to ensure a cleaning schedule was posted so that all areas of the kitchen could be deep cleaned weekly. 2) Review of the facility policy titled 'Ware Washing', dated 07/08, revealed all dishware would be cleaned and sanitized after each use and all dish machine water temperatures was maintained in accordance with manufacturers recommendations for high temperature machines. Observation of the dish machine area, on 02/27/13 at 9:15 AM, revealed staff ran dirty dishes through the dish machine and the temperature of the high temperature rinse cycle was one-hundred fifty degrees Fahrenheit (150 F). Review of the facility's Dish Machine Temperature Log, dated February 2013, revealed the rinse temperature was documented as being between 180-185 F from 02/01/13 through breakfast 02/25/13. Further review of the log revealed the rinse temperature was 150 F on lunch and dinner 02/25/13, lunch 02/26/13 and 140 F for dinner on 02/26/13.	F 371			

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F 371	Continued From page 21 Interview with the DM. on 02/27/12 at 10:30 AM, revealed he could not locate manufacturer's guide-lines for what the temperature of the high temperature rinse cycle should be to effectively sanitize the dishes; however, per facility protocol it should be one-hundred and eighty degrees Farenheit (180 F). When asked how was he going to ensure residents were served food on dishes that were properly sanitized, he indicated he would have to run the dishes through the dish machine again and add bleach and continue that process until the facility either switched to a chemical means of sanitizing the dishes or repaired the hot water heater.	F 371			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F441 i. Incontinence and catheter care was completed for resident #14 by the certified nursing assistant on 2/28/13 using proper infection control technique. CNA #5 was		

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F 441	<p>Continued From page 22</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infections.</p> <p>Observation of Foley catheter care/incontinence care for Resident #14 and Resident #7 revealed poor infection control technique</p> <p>Observation during initial tour, on 02/27/13, revealed urinals which were unlabeled and undated, bed pans which were unlabeled and unbagged, an unlabeled emesis basin at the sink in a resident's room, a wash pan in the floor of a resident bathroom, and plungers in resident bathrooms.</p>	F 441	<p>re-educated on 2/28/13 by the Assistant Director of Nursing on peri-care/incontinence care, including care of catheter. Incontinence and catheter care was completed on resident #7 by the LPN and STNA on 2/28/13 using proper infection control technique. LPN #4 was re-educated on 2/28/13 by the Assistant Director of Nursing on peri-care/incontinence care, including care of catheter. The wash pan in the bathroom of 318 was discarded, replaced, labeled, and properly stored by certified nursing assistant on 2/27/13. The urinal in room 315-2 was discarded, replaced and labeled by certified nursing assistant on 2/27/13. The emesis basin in room 318-2 was discarded, replaced and labeled by certified nursing assistant on 2/27/13. The urinal in room 308-1 was discarded, replaced and labeled by certified nursing assistant on 2/27/13. The ice chest and scoop on the 100 hall were taken to the kitchen on 2/27/13, emptied, cleaned and returned to service by the dietary department. The concierge was re-educated on procedure of ice pass following infection control practices on 3/11/13 by the Assistant Director of Nursing. The toilet plungers</p>	

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F 441	<p>Continued From page 23</p> <p>Observation, on initial tour on 02/27/12, revealed the ice chest which was in use was left in the 100 hall with the lid open and the scoop inside the chest on the ice.</p> <p>Observation, on initial tour, on 02/27/13, revealed the 100 hall to have toilet plungers in two (2) of the facility's resident bathrooms.</p> <p>The findings include:</p> <p>Review of the facility "Peri Care/Incontinence Care Competency General Overview" Policy, dated 03/10, revealed a section entitled, "completing perineal care of the resident with an indwelling catheter, revealed the steps included: putting on clean gloves, use a clean wash cloth, wipe in a circular motion along the length of the catheter about four (4) inches.</p> <p>1. Observation of Foley catheter care/ incontinence care performed, on 02/28/13 at 2:20 PM, for Resident #14 revealed State Registered Nursing Assistant (SRNA) #6 wiped stool from the residents buttocks and anal area and with the same soiled gloves obtained a clean wet washed cloth and cleansed the residents genital area and Foley catheter.</p> <p>Interview with SRNA #5, on 2/28/13 at 3:00 PM, revealed she agreed she failed to remove the soiled gloves and wash her hands after cleansing the residents buttocks and anal area and prior to cleansing the resident's genital area and Foley catheter.</p> <p>2. Observation of Foley catheter</p>	F 441	<p>in rooms 110 & 111 were removed by the maintenance director on 2/27/13. The floors in room 110 & 111 were cleaned and disinfected by the housekeeper on 2/27/13.</p> <p>2. Center rounds were completed on 2/28/13 and 3/1/13 by the Administrator and Infection Control Coordinator to identify any other infection control issues. Any identified concerns were addressed.</p> <p>3. Re-education of nursing staff will be completed by 4/7/13 by the Director of Nursing Services, Assistant Director of Nursing, and/or Unit Managers. Education will include the facility's infection control program, guidelines to prevent the development and transmission of infections, pericare/foley catheter care, dating, labeling and proper storage of resident care supplies, hand washing, and glove usage.</p> <p>Re-education of facility staff, nursing and non-nursing, on proper storage of plungers and procedure for ice/water pass, ice chest and scoop storage, will be completed by the Administrator, Maintenance Director, Director of Nursing, Assistant Director of</p>

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042	
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F 441	Continued From page 24 care/incontinence care for Resident #7, on 2/28/13 at 10:06 AM, revealed Licensed Practical Nurse (LPN) #4 cleansed stool from the resident's buttocks and with the same soiled gloves obtained a clean wet wash cloth and cleansed the residents genital area and Foley catheter. Interview with LPN #4, on 2/28/13 at 2:45 PM, revealed she had not washed her hands and changed gloves after cleansing the resident's buttocks and prior to performing Foley catheter care. Interview, on 03/01/13 at 6:50 PM, with the Assistant Director of Nursing (ADON)/ Infection Control Nurse revealed the facility had an inservice related to pericare and Folely catheter care recently; however, skill check offs to ensure proper procedure was not done with staff at that time. 3. Observation, on 02/27/13 from 8:30 AM to 9:30 AM, revealed there was a wash pan in the floor of the bathroom of Room 318, a urinal on the bed rail of Room 315-2 with no name or date, an emesis basin at the sink with no name in Room 318-2, and a urinal with no name or date on the bedside table in Room 308-1. Interview, on 03/01/13 at 6:35 PM, with the DON, there was no written policy related to urinals or bed pans. She stated they asked CNA's to label the urinals with resident names and place in privacy bags on the side of the beds. She further stated the urinals were to be changed when obviously soiled. Further interview revealed the bed pans should be labeled with the resident's	F 441	Nursing, Dietary Manager, and Housekeeping Director as of 4/7/13. 5. Infection Control Surveillance rounds will be completed weekly by the Administrator, Director of Nursing Services, Assistant Director of Nursing Services for 4 weeks, then monthly. Surveillance will include proper storage of resident care items ie: bedpans, urinals, emesis basins, plungers being stored appropriately, and ice chest/scoop storage. The Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, and/or Nursing Supervisors will complete random observations of pericare and/or foley catheter care skills with nursing staff weekly for 4 weeks, then 3 times monthly for 1 month, then monthly. A summary of findings will be presented at monthly PI meeting by the Director of Nursing and/or Assistant Director of Nursing for review and further recommendations.	4/8/13

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042	
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F 441	<p>Continued From page 25</p> <p>name or room number and placed in a bag and put in the closet or in the bedside cabinet.</p> <p>Interview, on 03/01/13 at 6:50 PM, with the ADON/Infection Control Nurse revealed wash pans should not be left in the floor, urinals should be labeled with room and bed number, emesis basins should also be labeled with room number and bed number or name, and bed pans should be labeled with room number and placed in plastic bag and put in the resident's drawer or the bottom of the closet.</p> <p>4. Observation during initial tour, on 02/27/13 at 11:50 AM, revealed there was an ice chest on the 100 Hall, with the lid open. The scoop was inside the ice chest.</p> <p>Interview with the Concierge, on 02/27/13 at 11:50 AM, revealed she passed the ice and the normal process would be to close the lid and place the scoop in the holder on the cart.</p> <p>Interview with the Director of Nursing, on 03/01/13 at 4:40 PM, revealed the facility did not have a policy for infection control related to the ice chest; however, her expectation was that the lid would be closed and the scoop kept in the container on the outside of the chest.</p> <p>5. Observation during initial tour of the 100 Hall, on 02/27/13 at 9:10 AM, revealed the bathroom in room 111 to have a toilet plunger beside the toilet. The plunger was sitting on plastic with a liquid substance running off of the plunger and plastic onto the floor in the bathroom. Further observation revealed the toilet to have a gray frothy substance in the bowl. Additionally, the</p>	F 441	

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPONT DRIVE FLORENCE, KY 41042		
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F 441	<p>Continued From page 26</p> <p>bathroom in room 110 had a toilet plunger beside the toilet. The plunger was in a plastic bag. The maintenance director removed the plunger from the bathroom. A brown substance remained on the tiles when the plunger was removed.</p> <p>Interview with the Maintenance Director, on 02/27/13 at 9:25 AM, revealed the rooms had not been reported to maintenance as having any issues. He further stated his staff did not leave the plungers in the bathrooms.</p> <p>Interview with the Infection Control Nurse on 03/01/13 at 7:15 PM, revealed the facility did not have a policy related to the plungers in the resident's bathrooms. Further interview revealed the plungers should not have been in the resident's bathrooms. Additionally, the infection Control Nurse revealed this was an infection control issue.</p>	F 441		

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: Construction Date 6/10/69 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) Story, Type III (000) Unprotected SMOKE COMPARTMENTS: Nine (9) smoke compartments. COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (Dry SYSTEM) EMERGENCY POWER: Type II Diesel Generator. A life safety code survey was conducted on 02/27/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred fifty-one (151) beds and the census was one hundred thirty-six (136) the day of the survey.	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, BridgePoint Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." RECEIVED MAR 13 2013 BY: _____	
			<p>K027</p> <p>1. The doors located in the smoke barriers located in the corridors near rooms 101, 112, 202, 211 were adjusted by the maintenance director to ensure closure to resist the passage of smoke on 3/7/13. The work completed now allows for the doors to close leaving only the minimum clearance necessary for proper operation and it does not include undercuts, louvers, or grilles.</p> <p>2. The Maintenance Director completed rounds with the surveyor on 2/27/13 when no additional concerns related to smoke barriers were noted.</p> <p>3. The Maintenance Director was re-educated by the Administrator on</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator (X6) DATE: 3/22/13

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

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K 000 Continued From page 1
Deficiencies were cited with the highest deficiency identified at "F" level.

K 027 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors to resist the passage of smoke, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of nine (9) smoke barriers, eighty-seven (87) residents, staff and visitors.

The findings include:

Observation, on 02/27/13 between 1:30 PM to 2:00 PM, revealed the doors located in the smoke barriers located in the corridors near rooms 101, 112, 202, and 211 did not completely close to resist the passage of smoke.

Interview, on 02/27/13 at 2:00 PM, with the Maintenance Director, revealed work needed to

K 000

3/4/13 on Life Safety Code requirements for smoke passage requirements.

K 027

4. The Maintenance Director will inspect the doors monthly for 3 months to determine proper operation. The Maintenance Director will report the inspection outcomes to the Performance Improvement Committee monthly for further review and recommendation.

4/8/13

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K 027 Continued From page 2
be completed on the doors and he would start on them immediately.

K 027

Reference: NFPA 101 (2000 edition)
8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.

K 056 Centers for Medicare and Medicaid Services survey and certification letter: 7-18
SS#D NFPA 101 LIFE SAFETY CODE STANDARD

K 056

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 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

K056

1. A contractor has been contacted to install an exterior sprinkler to cover the overhang located outside of the 100 wing hall exit extending out from the building. The contractor will have the work completed by 4/7/13.

2. The Maintenance Director completed rounds with the surveyor on 2/27/13 when no additional concerns were noted related to the sprinklers installed under exterior roofs or canopies.

3. The Maintenance Director was re-educated by the Administrator on 3/4/13 on Life Safety Code requirements for sprinkler installation.

4. The Maintenance Director will completed sprinkler inspections/testing per center routine/preventative

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 findings include:

maintenance program and report results to the Performance Improvement Committee monthly for further review and recommendations.

4/8/13

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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K 056

Continued From page 3

Observation, on 02/27/13 at 1:30 PM, revealed one (1) overhang that was located outside of the 100 Wing Hall Exit extended out from the building four (4) foot or greater that was made of combustible materials and were not sprinkler protected.

Interview, on 02/27/13 at 1:30 PM, with the Maintenance Director revealed the overhang was made of combustible materials and he was not aware the overhang needed to be sprinkler protected.

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