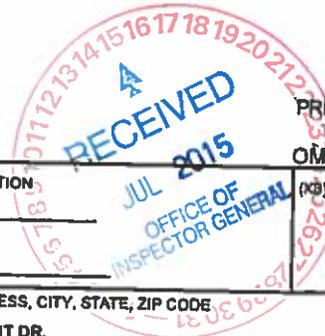


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2015
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 06/12/2015
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NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 980 HIGHPOINT DR. HOPKINSVILLE, KY 42240
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F 000	INITIAL COMMENTS A Recertification Survey was conducted on 06/09/15 through 06/11/15 with deficiencies cited at the highest Scope and Severity of an "E".	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 164 SS=D	483.10(e), 483.75(I)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced	F 164	F164 483.10(e), 483.75(I)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS <u>Corrective Measures for Resident(s) Identified In The Deficiency</u> No residents were identified in this deficiency <u>How Other Residents Who May Have Been Affected By This Practice Were Identified.</u> [I] A Privacy/Hippa audit was conducted on 06/15/15 by the Assistant Director of Nursing to make sure the Medication Administration Record books and the Treatment Administration Record books were closed and not left open by nursing staff.	07/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Spencer Hinson</i>	TITLE <i>Don</i>	(X6) DATE <i>7/10/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 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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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 164	<p>Continued From page 1</p> <p>by:</p> <p>Based on observation, interview, and review of the facility policy and procedure, it was determined the facility failed to ensure privacy and confidentiality. Observations of two (2) medication carts on two (2) separate units, Unit II and Unit III, revealed the Medication Administration Record (MAR) and Narcotic Records were left open on top of the medication carts in the hallway, visible to the public revealing resident's personal information.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Rights of Nursing Home Residents", not dated, revealed nursing home residents have the right to confidentiality of personal and clinical records. Review of another policy, titled "Privacy, Dignity, and Confidentiality", not dated, revealed resident's personal information should not be left unattended and uncovered in areas that are visible to the public.</p> <p>Observation of the Hall III Nursing Unit, on 06/09/15 at 6:25 AM, revealed the MAR and Narcotic Record were open on top of the medication cart visible to the public revealing resident's personal information and unattended.</p> <p>Interview with Licensed Practical Nurse (LPN) #12, working Hall III, on 06/09/15 at 6:30 AM, revealed she knew the MAR and Narcotic record should be closed or covered and not be left open on top of the medication cart related to the Health Information Privacy/Protection Act (HIPPA) laws.</p> <p>Observation of Hall II Nursing Unit, on 06/11/15 at 8:05 AM, revealed the MAR was open on top of</p>	F 164	<p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u></p> <p>[1] All nursing staff were educated by the Staff Development Coordinator beginning on 6/16/15 regarding keeping residents' protected health information from being visible to the public.</p> <p>[2] A Privacy/Hippa is Audit being conducted by the Assistant Director of Nursing, Unit Manager, MDS Coordinator, MDS nurse, Resident Care Coordinator, or Director of Nursing to ensure residents' protected health information is not visible to the public. Audit conducted daily times five days; three times a week times three weeks; one time a week times three weeks; every other week times three weeks; monthly times three months.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u></p> <p>The Director of Nursing will be responsible for bringing the results of the Privacy/Hippa audit to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director]</p>	07/24/15
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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 164	Continued From page 2 the medication cart visible to the public revealing resident's personal information. Interview with LPN #8, on 06/11/15 at 8:05 AM, revealed she was aware she was not supposed to leave the MAR open on top of the medication cart due to confidentiality and HIPPA regulations. Interviews on 06/11/15 with LPN #9 at 10:52 AM, LPN #6 at 11:00 AM, LPN #10 at 11:06 AM, Registered Nurse (RN) #3 at 12:20 PM, RN #4 at 12:27 PM, LPN #11 at 12:30 PM, LPN #3 on 06/09/15 at 2:40 PM, and LPN #2, on 06/10/15 at 8:30 AM, revealed MARS and Narcotic Records should not be left on top of the medication carts related to privacy and confidentiality. Interview with the Administrator, on 06/11/15 at 12:46 PM, revealed she expected the MARS and Narcotic records not to be left on top of the medication carts due to privacy and confidentiality.	F 164	monthly times six months.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to maintain/enhance residents' dignity related to Indwelling Urinary Catheter drainage bags being visible from the hallway and	F 241	F241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY <u>Corrective Measures for Resident[s] Identified In The Deficiency</u> [1] Residents # 1, #2, #3, #9, #A, Foley Catheter drainage bags were placed in a dignity bag on 06/11/15 by	07/24/15

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F 241	Continued From page 3 not placed in dignity bags for four (4) of fifteen (15) sampled residents (Resident #1, #2, #3, and #9) and one (1) unsampled resident (Resident #A). The findings include: Review of the facility's policy "Urinary Indwelling Catheter", last revised 09/29/14, revealed it did not address keeping the drainage bag in a dignity bag. Review of facility's policy "Privacy, Dignity and Confidentiality", not dated, revealed it's the policy of the facility to respect and enhance the resident's quality of life by protecting the resident's right for privacy, dignity and confidentiality. 1. Record review revealed Resident #2 was admitted on 05/11/12 with diagnoses which included Non Insulin Dependent Diabetes Mellitus, Schizophrenia, Alzheimer's, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, Senile Dementia, and Disorder of Bone/Cartilage. Review of Resident #2's Minimum Data Set (MDS) assessment, dated 05/13/15, revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of one (1), which indicated the resident was non-interviewable. Observation of Resident #2, on 06/09/15 at 12:05 PM, revealed the resident was laying in bed on his/her right side with eyes closed. There was an indwelling Urinary Catheter drainage bag which was uncovered with no dignity bag and observable from the hallway.	F 241	the Resident Care Coordinator. <u>How Other Resident's Who May Been Affected By This Practice Were Identified</u> [1] 100% of residents with Foley Catheters were audited on 06/11/15 by the Resident Care Coordinator to determine if the Foley Catheter drainage bags were inside a dignity bags. <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] 100% of residents with Foley Catheters will be by audited by the Director of Nursing, Resident Care Coordinator, or Unit Manager daily times five days; three times a week times three weeks; one time a week times three weeks; every other week times three weeks; monthly times three months. [2] All nursing staff were educated by the Staff Development Coordinator beginning on 6/16/15 regarding keeping the Foley Catheter drainage bags in the dignity bags. <u>Monitoring Measures To Maintain On-Going Compliance</u> The Director of Nursing will be responsible for bringing the results of the Foley Catheter drainage bag audit to the Quality Assurance Committee [consisting of the Administrator,	07/24/15	

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F 241	Continued From page 4 2. Record review revealed the facility admitted Resident #3 on 03/25/15 with diagnoses which included Muscular Dystrophy, Recurrent Urinary Tract Infections (UTI's) and Urinary Retention. Review of Resident #3's MDS assessment, dated 05/30/15, revealed the facility assessed Resident #3's cognition as cognitively intact with a BIMS score of (fifteen) 15, which indicated the resident was interviewable. Observation of Resident #3, on 06/09/15 at 6:52 AM and 12:10 PM, revealed the resident was laying in bed on his/her back with an Indwelling Urinary Catheter in place attached to a bed-side drainage bag which was uncovered with no dignity bag and observable from the hallway. Interview with Resident #3, on 06/12/15 at 08:55 AM, revealed he/she would have been embarrassed if visitors would have seen the drainage bag with urine in it and would not want them to have to see it. 3. Record review revealed the facility admitted Resident #9 on 05/28/15 with diagnose which included General Weakness, Urinary Tract Infection, and Urinary Retention. Review of Resident #9's MDS assessment, dated 06/04/15, revealed the facility assessed Resident #9's cognition as cognitively intact with a BIMS score of fourteen (14), which indicated the resident was interviewable. Observation of Resident #9 on 06/09/15 at 06:30 AM, revealed the resident was laying in bed on his/her right side with eyes open with an Indwelling Urinary Catheter in place attached to a bed-side drainage bag which was uncovered with	F 241	Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director] monthly times six months.	07/24/15	

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F 241	Continued From page 5 no dignity bag and observable from the hallway. 4. Record review revealed the facility admitted Resident #1 on 11/22/13 with diagnosis which included Cerebrovascular Accident (CVA), and Pressure Ulcer stage four (4) to sacrum. Review of the quarterly MDS assessment, dated 05/29/15, revealed the facility assessed Resident #1's cognition as severely impaired with a BIMS score of zero (0). Observation of Resident #1, on 06/09/15 at 6:20 AM, revealed the resident was laying in bed on his/her right side with an indwelling urinary catheter connected to a bedside drainage bag containing golden yellow urine, which was uncovered with no dignity bag and visible from hallway. 5. Record review revealed the facility readmitted Unsamped Resident A on 06/08/15 with diagnoses which included Dementia without behavioral disturbance, Palliative Care, Dysphagia, Adult Failure to Thrive, and Encephalopathy. Review of the quarterly MDS, dated 04/22/15, revealed the facility assessed Unsamped Resident A's cognition as severely impaired with a BIMS score of four (4). Observation of Unsamped Resident A, on 06/09/15 at 6:25 AM, revealed the resident was laying in bed asleep on his/her right side with an indwelling urinary catheter connected to bedside drainage bag attached to bed frame which was uncovered with no dignity bag and visible from hallway. Interviews on 06/11/15 with State Registered Nursing Assistant (SRNA) #3 at 07:42 AM, and	F 241		07/24/15	

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F 241	<p>Continued From page 6</p> <p>SRNA #5 at 7:58 AM, on 06/09/15 with SRNA #1 at 1:50 PM, and on 06/11/15 with SRNA #2 at 2:10 PM revealed indwelling urinary catheter drainage bags were to be in dignity bags and by the drainage bags not being in dignity bags or covered it could have caused the residents to be embarrassed.</p> <p>Interview with Unit Manager, Licensed Practical Nurse (LPN) #4, on 06/11/15 at 09:05 AM, revealed she expected all indwelling urinary catheter drainage bags to be placed in dignity bags to protect the residents' dignity as this could cause embarrassment for the residents if others were to see their drainage bags.</p> <p>Interview with Staff Development Coordinator (SDC), on 06/11/15 at 2:35 PM, revealed she expected the urine drainage bags to be in a dignity bag.</p> <p>Interview with Assistant Director of Nursing (ADON), Registered Nurse (RN) #2, on 06/11/15 at 09:15 AM, revealed she expected all urinary drainage bags to be placed in dignity bags for all residents who have drainage bags to protect their privacy and dignity.</p>	F 241		
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the</p>	F 278	<p>F278 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p><u>Corrective Measures for Resident(s) Identified In The Deficiency</u></p> <p>[1] Residents #3, #8, and #12, had their Minimal Data Sets modified as needed for accuracy.</p> <p><u>How Other Residents Who May</u></p>	07/24/15

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F 278	<p>Continued From page 7 assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) 3.0 User Manual, it was determined the facility failed to ensure each resident was accurately assessed to reflect their status related to eating requirements, constipation, locomotion on the unit and/or physical restraints for three (3) of fifteen (15) sampled residents (Residents #3, #8 and #12).</p> <p>The findings include: Review of the RAI 3.0 Manual, dated May 2011, revealed when conducting an MDS Assessment staff were to speak with direct care staff from</p>	F 278	<p><u>Have Been Affected By This Practice Were Identified.</u></p> <p>[1] An audit on current residents' most recent Minimal Data Sets regarding the coding of the residents' eating ability, restraint use, and constipation unit will be completed and modifications made as needed for accuracy by the Regional Resource Nurse.</p> <p>[2] An audit on current residents' with restorative ambulation programs and its impact on locomotion on unit/walk in corridor on most recent Minimal Data Sets will be completed and modifications made as needed for accuracy by the Regional Resource Nurse.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence.</u></p> <p>[1] 50% of the Minimal Data Sets will be audited monthly times three months for accuracy of eating, restraints, and constipation by the Regional Resource Nurse.</p> <p>[2] 50% of the Minimal Data Sets will be audited monthly times three for accuracy of locomotion on unit/walk in corridor on unit for residents that also have a restorative ambulation program by the Regional Resource Nurse.</p> <p>[3] The MDS coordinator and the MDS nurse will be educated by a certified RAC-CT nurse regarding MDS accuracy regarding locomotion on unit, eating, restraints, and constipation on</p>	07/24/15	

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F 278	<p>Continued From page 8</p> <p>each shift who had cared for the resident to determine his/her needs. When reviewing records, interviewing staff and observing the resident staff conducting the MDS Assessment must be specific when evaluating each component as listed in the Activities of Daily Living (ADL) activity definition. Further review of the manual revealed for Section G, the Functional Status section revealed under eating for the ADL portion, if a resident did not participate in the eating process and required assistance of one (1) staff person to feed him/her the resident was to be coded as total dependence with one (1) person physical assist. For Section P, the Physical Restraint section revealed steps for assessment included review of the resident's medical record (e.g., physicians orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the seven (7) day look-back period. Further review under Section H0600 "Bowel Patterns", revealed the definition of constipation as if the resident has two (2) or fewer bowel movements during the seven (7) day look back period or if for most bowel movements their stool is hard and difficult for them to pass no matter what the frequency of bowel movements. Under Section G0100 E, Locomotion on Unit was defined as how resident moves between locations in his/her room and adjacent corridor on same floor and if in wheelchair, self sufficiency once in chair.</p> <p>1. Record review revealed the facility admitted Resident #8 on 05/24/15 with diagnosis to include Senile Dementia, Esophageal Reflux, OT Symbolic Dysfunction, Generalized Pain, and Hyperlipidemia.</p> <p>Review of Resident #8's admission Minimum</p>	F 278	<p>the date of 6/30/15.</p> <p>Monitoring Measures To Maintain On-Going Compliance. The Administrator will be responsible for bringing the results of the MDS audit to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director] monthly times three months.</p>	07/24/15	

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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 278	<p>Continued From page 9</p> <p>Data Set (MDS) assessment, dated 05/31/15, revealed the MDS was coded under Section G, part H, related to eating as requiring the assistance of two (2) staff for eating. Further review revealed the MDS was coded under Section P, as not having a restraints. However, observations of Resident #8, on 06/10/15 at 7:55 AM and 06/11/15 at 8:04 AM during the breakfast meals, revealed Resident #8 was sitting up in his/her wheelchair in the dining room for the breakfast meal eating without staff assistance. In addition, further observation on 06/09/15 at 8:28 AM and 11:10 AM, revealed Resident #8 was sitting up in his/her wheelchair with a quick release seat belt alarm secured around the waist.</p> <p>Interview with the MDS Coordinator, on 06/10/15 at 2:19 PM, revealed the MDS was coded inaccurately, in regard to the needs of Resident #8 related to eating as the resident was able to feed him/herself for all meals. The MDS Coordinator stated she must have forgotten to code the resident for the quick release seat belt alarm.</p> <p>2. Record review revealed Resident #3 was admitted on 03/25/15 with diagnoses of Constipation, Muscular Dystrophy, Recurrent Urinary Tract Infections (UTI's) and Urinary Retention.</p> <p>Review of Resident #3's admission MDS assessment, dated 04/01/15, revealed he/she did not have constipation coded under Section H0600 of this MDS; however, review of Resident #3's elimination records, revealed Resident #3 had no documented bowel movements from the date of admission to facility on 03/25/15 through 04/01/15 (date of the Admission MDS assessment).</p>	F 278		07/24/15	

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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 06/12/2015
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 278	Continued From page 10 Interview with MDS Coordinator/Registered Nurse (RN) #5, on 06/11/15 at 9:40 AM, revealed constipation should have been coded and the MDS assessment would need to be modified/corrected to reflect the constipation. 3. Record review, revealed Resident #12 was admitted on 12/17/13 with diagnoses of Hemiplegia, Hypertension and Diabetes Mellitus type two (2). Review of Resident #12's quarterly MDS, dated 04/14/15, revealed he/she was coded under Section G0110 D (Walk in Corridor) as having walked in the corridor with limited assistance of two (2) persons physical assistance and under Section G0110 E (Locomotion on Unit) was coded as independent with no setup or physical help from staff; however, interview with MDS Coordinator Registered Nurse (RN) #5, on 06/11/15 at 09:40 AM, revealed locomotion on the unit for Resident #12 was coded wrong as Resident #12's locomotion on unit was not independent due to he/she ambulated with assistance from restorative nursing. Interview with Assistant Director of Nursing, RN #3, on 06/11/15 at 9:15 AM, revealed she expected the MDS assessments to be coded as accurately as possible to reflect the residents true status.	F 278			
F 281 SS=D	483.20(k)(3)(l) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	F281 483.20(k)(3)(l) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	07/24/15	

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F 281	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement #14 and review of the facility's "Clinical Nursing Skills (Seventh Edition)", it was determined the facility failed to ensure services were provided by the facility to meet professional standards of quality related to the facility not following physician's orders for one (1) of fifteen (15) sampled residents (Resident #3) and one (1) unsampled resident (Resident D). Licensed staff failed to administer as needed constipation medication to Resident #3 when the resident went twelve (12) days without having a bowel movement and failed to check for placement of Unsampled Resident D's feeding tube prior to administering four (4) medications. The findings include: Review of KBN AOS #14 Patient Care Orders, last revised 10/14/15, revealed licensed staff should administer medication prescribed by the physician/Advanced Practice Registered Nurse and prepare and give the medication in the prescribed dosage, route, and frequency. Record review revealed the facility admitted Resident #3 on 03/25/15 with diagnoses which included Constipation, Muscular Dystrophy, Recurrent Urinary Tract Infections (UTI's) and Urinary Retention. Review of the admission Minimum Data Set (MDS) assessment, dated 05/30/15, revealed the facility assessed Resident #3's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of (fifteen) 15, which indicated the resident was	F 281	<u>Corrective Measures for Resident[s] Identified In The Deficiency</u> [1] The "No BM IN 9 Shifts" report was audited by the Resident Care Coordinator on 06/12/15 to determine if Resident #3 had a bowel movement during the previous nine shifts and to determine if any bowel enhancing medications needed to be administered [2] Resident #D had her feeding tube checked for placement on 6/13/15 by the licensed nurse. [3] LPN #3 received one to one education by the Staff Development Coordinator on 6/10/15 regarding checking placement of the feeding tube prior to administering medications. <u>How Other Resident's Who May Been Affected By This Practice Were Identified.</u> [1] 100% audit of all residents conducted on 06/12/15 by the Resident Care Coordinator to determine any residents who had not had a bowel movement in the previous nine shifts. [2] 100% audit of all resident with feeding tubes was conducted 06/12/15-06/13/15 to check placement of each resident's feeding tube. <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] The Resident Care Coordinator will	07/24/15

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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 281	<p>Continued From page 12 interviewable.</p> <p>Review of Resident #3's Admission Physician Orders, dated 03/25/15, revealed an order for Mag Citrate one (1) bottle as needed (PRN) for no bowel movement after three (3) days, Dulcolax 10 milligrams (mg) suppository PRN daily for constipation, and a Fleets Enema every day PRN for constipation.</p> <p>Review of Resident #3's Elimination Records, revealed Resident #3 had no documented bowel movements for twelve (12) days (from the date of admission to facility on 03/25/15 through 04/06/15) when he/she was admitted to the hospital due to a Gastrointestinal Bleed.</p> <p>Review of Resident #3's March and April 2015 Medication Administration Records (MAR's) revealed none of the PRN medications for constipation were administered from 03/25/15 through 04/06/15 as ordered by the physician for signs and symptoms of constipation and or lack of bowel movement.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 06/11/15 at 07:49 AM, revealed she expected for bowel movements to be monitored routinely for all residents and licensed staff to assess any resident who had went three (3) or more days without a BM. LPN #5 stated nurses were expected to administer PRN medications as ordered by the physician for residents meeting the criteria as listed in the physician's orders.</p> <p>Interview with Unit Manager/LPN #4, on 06/11/15 at 09:05 AM, revealed she expected licensed staff to monitor and review residents daily for lack of a bowel movement and to follow physician's</p>	F 281	<p>audit the report, "No BM In 9 Shifts"</p> <p>Monday thru Friday to determine any residents not documented as having a bowel movement during the previous nine shifts. These residents will be added to the Bowel Monitoring Report for follow up. Alert and oriented residents will be asked if they have had a bowel movement and if they have, documentation will be made in the nurses notes or as a late entry into the kiosk by the MDS Coordinator. Residents who have not had a bowel movement in the previous nine shifts will have interventions instituted according to the physician orders and/or the resident's care plan. Any resident that does not orders for a bowel enhancing intervention, will have their physician notified by the licensed nurse for orders for a bowel enhancing intervention.</p> <p>[2] A copy of the Bowel Monitoring Record will be given to the Licensed nurses by the Resident Care Coordinator or the Unit Manager Monday thru Friday for the administration of bowel enhancing interventions or physician notification.</p> <p>[3] The Resident Care Coordinator or the Unit Manager will follow up on the Bowel Monitoring Record the next day to determine if the bowel enhancing interventions were successful. The residents will remain on the Bowel Monitoring Record until the bowel</p>	07/24/15	

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F 281	<p>Continued From page 13</p> <p>orders by administering PRN medications as ordered for signs and symptoms of constipation and or lack of having a bowel movement.</p> <p>Interview with Assistant Director of Nursing (ADON)/Registered Nurse #3, on 06/11/15 at 09:15 AM, revealed she expected licensed staff to follow physician's orders as part of the resident's overall plan of care and treatment.</p> <p>2. Review of the facility's Standards of Practice, titled "Clinical Nursing Skills (Seventh Edition)", not dated, revealed the procedure for checking peg tube placement included to insert a fifty (50) millimeter (ML) syringe into the Nasogastric (NG) tube and aspirate to check residual volume. Return residual and flush NG tube. The rationale for this procedure was to validate gastric capacity for receiving medication and flush solution.</p> <p>Observation of a Medication Pass, on 06/09/15 at 2:30 PM, revealed LPN #3 administered medications via a peg tube for Unsampled Resident D and did not check peg tube placement for four (4) medications prior to administration. The medications included Norco (narcotic pain medication) 7.5 mg, Coreg (blood pressure medication) 25 mgs, Keppra (selzure medication) 750 mgs, and Hydralazine (anti-hypertensive medication) 75 mgs.</p> <p>Interview with LPN #3, on 06/09/15 at 2:35 PM, revealed she knew she was supposed to check peg tube placement prior to medication administration and was nervous because she was being watched and forgot to do it. She revealed the consequences could include the medication going somewhere it shouldn't causing aspiration of the medications if the tube was not in the</p>	F 281	<p>enhancing interventions are successful.</p> <p>[4] All Licensed Nurses were educated by the Staff Development Coordinator beginning on 6/19/15 on the Bowel Monitoring Record, use of bowel enhancing interventions, and physician notification.</p> <p>[5] All nursing assistants were educated by the Staff Development Coordinator beginning on 6/19/15 regarding documentation of residents' bowel movements.</p> <p>[6] All nurses were educated by the Staff Development Coordinator beginning on 6/19/15 regarding checking the placement of a feeding tube prior to administering medications.</p> <p>[7] 100% of Licensed Nurses will be observed by the Resident Care Coordinator administering medication via feeding tube monthly times three months.</p> <p>[8] On Saturdays and Sundays, the Licensed Nurse will be responsible for auditing the residents to determine any residents who have not had a bowel movement in the past 72 hours. The residents will have their names added to the Bowel Movement Monitoring Record for follow up.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u></p>	07/24/15	

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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	Continued From page 14 correct location. Interviews on 06/11/15 with LPN #9 at 10:52 AM, LPN #8 at 11:00 AM, LPN #10 at 11:06 AM, RN #3 at 12:20 PM, RN #4 at 12:27 PM, LPN #11 at 12:30 PM, LPN #3 on 06/09/15 at 2:40 PM, and LPN #2 on 06/10/15 at 8:30 AM, revealed peg tube placement should be checked prior to medication, fluid, or any administration of anything via the tube to prevent possible aspiration. Interview with the Administrator, on 06/11/15 at 12:46 PM, revealed she expected nursing staff to follow protocol regarding checking peg tube placement.	F 281	The Resident Care Coordinator will be responsible for bringing the the results of the Bowel Monitoring Record to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director] monthly times six months and the results of the Medication Administration Observations to the Quality Assurance Committee monthly times three months for discussion and action planning as needed.	07/24/15	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility policy and review of the facility's fall investigation it was determined the facility failed to follow the care plan for two (2) of fifteen (15) sampled residents (Resident #5 and Resident #3). Resident #5 was care planned for a bed alarm when in bed and the resident sustained a fall on 05/03/15 due to the bed alarm not being activated. In addition, Resident #3 was care planned for staff to review bowel and bladder records to ensure the resident was having routine	F 282			

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F 282	<p>Continued From page 15</p> <p>bowel movements; however, Resident #3 went twelve (12) days without a bowel movement with no treatment and there was no evidence the facility monitored Resident #3's bowel and bladder records to ensure the resident was having routine bowel movements.</p> <p>The findings include:</p> <p>Review of facility's policy, Comprehensive Care Plans, revised 04/03/13, revealed the facility's care plan approaches will be communicated to staff for use in providing direction of care.</p> <p>1. Review of the Fall Prevention and Management Program policy and procedures, last revised 12/19/13, revealed it was the policy of the facility to promote a safe environment to assist in the prevention of falls for the resident and manage those that occur.</p> <p>Record review revealed the facility admitted Resident #5 on 04/02/14 with diagnoses which included Hypertension, Non-Alzheimer's Dementia, Depression, and Psychotic Disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/17/15, revealed the facility assessed Resident #5's cognition as severely impaired with a Brief Inventory of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable.</p> <p>Review of Resident #5's Comprehensive Care Plan, dated 01/05/15, and review of the Nurse Aide Data Plan revealed the resident was assessed at risk for falls with an intervention to use an alarm while in bed.</p>	F 282	<p>F282 483.20(k)(3(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p><u>Corrective Measures for Resident(s) Identified In The Deficiency</u></p> <p>[1] The "No BM IN 9 Shifts" report was audited by the Resident Care Coordinator on 06/12/15 to determine if Resident #3 had a bowel movement during the previous nine shifts to determine if care plan interventions needed to be followed.</p> <p>[2] Resident #5's falls care plan was reviewed on 7/1/15 by the Director of Nursing to ensure all fall care plan interventions were up to date and being followed.</p> <p>[3] Resident #5's bed alarm checked for proper functioning and placement on 6/30/15 by Unit Manager.</p> <p><u>How Other Resident's Who May Been Affected By This Practice Were Identified.</u></p> <p>[1] 100% audit of all residents conducted on 06/12/15 by the Resident Care Coordinator to determine any residents who had not had a bowel movement in the previous nine shifts.</p> <p>[2] 100% of resident bed alarms and chair alarms were audited on 6/30/15 by Staff Development Coordinator to check for proper placement and functioning.</p>
			07/24/15

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F 282	<p>Continued From page 16</p> <p>Review of the facility's fall investigation, dated 05/03/15 at 1:00 PM, revealed Resident #5 fell out of bed and was found sitting upright on a mat beside his/her bed. Further review of the facility's fall investigation revealed the bed notification alarm was not sounding due the alarm not being activated.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2, on 06/11/15 at 2:10 PM, revealed SRNA #8 asked for assistance in getting Resident #5 off the floor. SRNA #2 stated the resident was on the floor by the bed and the resident's bed alarm was not on.</p> <p>Interview with SRNA #8, on 6/12/15 at 1:15 PM, revealed a housekeeping staff member notified her Resident #5 had fallen out of bed. SRNA #8 stated the bed alarm was not activated or sounding.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 6/11/15 at 1:30 PM, revealed she expected any resident with a bed alarm to have the alarm turned on when the resident was in bed.</p> <p>2. Record review revealed the facility admitted Resident #3 on 03/25/15 with diagnoses which included Constipation, Muscular Dystrophy, Recurrent Urinary Tract Infections (UTI's) and Urinary Retention. Review of the admission MDS assessment, dated 05/30/15, revealed the facility assessed Resident #3's cognition as cognitively intact with a BIMS score of (fifteen) 15, which indicated the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan titled "Health Maintenance", dated 04/06/15, revealed an intervention dated 04/06/15 to review bowel</p>	F 282	<p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u></p> <p>[1] The Resident Care Coordinator will audit the report, "No BM In 9 Shifts" Monday thru Friday to determine any residents not documented as having a bowel movement during the previous nine shifts. These residents will be added to the Bowel Monitoring Report for follow up. Alert and oriented residents will be asked if they have had a bowel movement and if they have, documentation will be made in the nurses notes or as a late entry into the kiosk by the MDS Coordinator. Residents who have not had a bowel movement in the previous nine shifts will have interventions instituted according to the physician orders and/or the resident's care plan. Any resident that does not orders for a bowel enhancing intervention, will have their physician notified by the licensed nurse for orders for a bowel enhancing intervention.</p> <p>[2] A copy of the Bowel Monitoring Record will be given to the Licensed nurses by the Resident Care Coordinator or the Unit Manager Monday thru Friday for the administration of bowel enhancing interventions or physician notification.</p> <p>[3] The Resident Care Coordinator or the Unit Manager will follow up on the Bowel Monitoring Record the next day to determine if the bowel enhancing</p>	07/24/15

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F 282	<p>Continued From page 17</p> <p>and bladder records to ensure having routine bowel movements. The facility was unable to produce documentation to show where they had reviewed bowel and bladder records to ensure Resident #3 was having routine bowel movements.</p> <p>Review of Resident #3's Elimination Records, revealed Resident #3 had no documented bowel movements for twelve (12) days from the date of admission to the facility on 03/25/15 through 04/06/15 when he/she was admitted to the hospital due to a Gastrointestinal Bleed.</p> <p>Review of Resident #3's Admission Physician Orders, dated 03/25/15, revealed an order for Mag Citrate one (1) bottle as needed (PRN) for no bowel movement after three (3) days, Dulcolax 10 milligrams (mg) suppository PRN daily for constipation, and a Fleets Enema every day PRN for constipation. However, review of the Resident #3's March and April 2015 Medication Administration Records (MAR's) revealed none of the ordered PRN medications were administered from 03/25/15 through 04/06/15 as ordered by the physician for signs and symptoms of constipation and or lack of bowel movement.</p> <p>Interview with MDS Coordinator/Registered Nurse (RN) #5, on 06/11/15 at 09:40 AM, revealed she expected care plans to be followed.</p> <p>Interview with Assistant Director of Nursing (ADON), on 06/11/15 at 3:25 PM, revealed she expected all staff to follow the care plan for each resident.</p> <p>Interview with Assistant Director of Nursing (DON)/ Registered Nurse (RN) #3, on 06/11/15 at</p>	F 282	<p>interventions were successful. The residents will remain on the Bowel Monitoring Record until the bowel enhancing interventions are successful.</p> <p>[4] All Licensed Nurses were educated by the Staff Development Coordinator beginning on 6/19/15 on the Bowel Monitoring Record, use of bowel enhancing interventions, and physician notification.</p> <p>[5] All nursing assistants were educated by the Staff Development Coordinator beginning on 6/19/15 regarding documentation of residents' bowel movements.</p> <p>[6] Licensed Nurses were educated by the Staff Development Coordinator beginning on 6/19/15 regarding following the resident's care plan interventions for promoting bowel function.</p> <p>[7] Licensed Nurses and Nursing Assistants were educated by the staff development coordinator beginning on 6/19/15 regarding checking the bed and chair alarms for placement and functioning according to the resident's Care Plan and Nurse Aide Data Sheets every shift.</p> <p>[8] On Saturdays and Sundays, the Licensed Nurse will be responsible for auditing the residents to determine any residents who have not had a bowel movement in the past 72 hours. The residents will have their names added to the Bowel Movement Monitoring Record for follow up.</p>	07/24/15	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 18 09:15 AM, revealed she expected for staff to follow the comprehensive care plans.	F 282	<u>Monitoring Measures To Maintain On-Going Compliance</u> The Resident Care Coordinator will be responsible for bringing the the results of the Bowel Monitoring Record to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director] monthly times six months for discussion and action planning as needed.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to ensure each resident received and the facility provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (1) of fifteen (15) sampled residents (Resident #3). The facility failed to monitor for lack of bowel movements per Resident #3's care plan and failed to provide physician ordered as needed (PRN) laxatives when the resident did not have a bowel movement for twelve (12) days. The findings include: Review of facility's policy, Comprehensive Care Plans, revised 04/03/13, revealed the facility's care plan approaches will be communicated to staff for use in providing direction of care.	F 309	<u>F309 Highest Well Being Corrective Measures for Resident(s) Identified In The Deficiency</u> [1] The "No BM IN 9 Shifts" report was audited by the Resident Care Coordinator on 06/12/15 to determine if Resident #3 had a bowel movement during the previous nine shifts. <u>How Other Resident's Who May Been Affected By This Practice Were Identified.</u> [1] 100% audit of all residents conducted on 06/12/15 by the Resident Care Coordinator to determine any	07/24/15

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F 309	Continued From page 19 Record review revealed the facility admitted Resident #3 on 03/25/15 with diagnoses which included Constipation, Muscular Dystrophy, Recurrent Urinary Tract Infections (UTI's) and Urinary Retention. Review of the admission Minimum Data Set (MDS) assessment, dated 05/30/15, revealed the facility assessed Resident #3's cognition as cognitively Intact with a Brief Interview of Mental Status (BIMS) score of (fifteen) 15, which indicated the resident was interviewable. Review of the Comprehensive Care Plan titled "Health Maintenance", dated 04/06/15, revealed an intervention, dated 04/06/15, to review bowel and bladder records to ensure having routine bowel movements (BM). The facility was unable to produce documentation to show where they had reviewed bowel and bladder records to ensure Resident #3 was having routine bowel movements. Review of Resident #3's Elimination Records, revealed Resident #3 had no documented bowel movements for twelve (12) days from the date of admission to the facility on 03/25/15 through 04/06/15 when he/she was admitted to the hospital due to a Gastrointestinal Bleed. Review of Resident #3's March and April 2015 Medication Administration Records (MAR's) revealed none of the ordered PRN medications were administered from 03/25/15 through 04/06/15 as ordered by the physician for signs and symptoms of constipation and or lack of bowel movement and the facility was unable to provide documentation to show the bowel and bladder records had been reviewed. Interview with Licensed Practical Nurse (LPN) #6,	F 309	residents who had not had a bowel movement in the previous nine shifts. <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] The Resident Care Coordinator will audit the report, "No BM In 9 Shifts" Monday thru Friday to determine any residents not documented as having a bowel movement during the previous nine shifts. These residents will be added to the Bowel Monitoring Report for follow up. Alert and oriented residents will be asked if they have had a bowel movement and if they have, documentation will be made in the nurses notes or as a late entry into the kiosk by the MDS Coordinator. Residents who have not had a bowel movement in the previous nine shifts will have interventions instituted according to the physician orders and/or the resident's care plan. Any resident that does not orders for a bowel enhancing intervention, will have their physician notified by the licensed nurse for orders for a bowel enhancing intervention. [2] A copy of the Bowel Monitoring Record will be given to the Licensed nurses by the Resident Care Coordinator or the Unit Manager Monday thru Friday for the administration of bowel enhancing interventions or physician notification. [3] The Resident Care Coordinator or	07/24/15	

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F 309	<p>Continued From page 20</p> <p>on 06/11/15 at 08:10 AM, revealed she expected State Registered Nurse Aides (SRNA) to report to her if any residents had went three (3) or more days without a BM so that she could assess the resident and administer a PRN medication for constipation or lack of a bowel movement. LPN #6 stated a BM log/report was obtained every morning by the Unit Manager Monday through Friday to monitor for residents having a lack of a BM for follow up and that after morning report the Unit Manager would take the report to each unit for follow up to be done for any resident that has not had a BM in three (3) or more days. LPN #6 revealed the nurse would assess the resident, administer PRN medications as ordered and if there was none ordered, the physician would be notified in regards to the signs and symptoms of constipation or lack of a bowel movement.</p> <p>Interview with Unit Manager/LPN #4, on 06/11/15 at 09:05 AM, revealed she expected for the SRNA's to report to the nurse in charge any residents that have gone three (3) or more days without a BM so the nurse could assess the resident and administer a PRN medication and/or notify the physician if no PRN medications were ordered. The Unit Manager stated the unit managers pull a no BM in the last nine (9) shifts report daily Monday through Friday and take the report to the morning meeting. The Unit Manager stated the report was then discussed in the morning meeting and after the morning meeting, the report was taken to the units for the nurses to follow up with any resident that has been nine (9) or more shifts without a BM.</p> <p>Interview with Assistant Director of Nursing (ADON)/Registered Nurse #3, on 06/11/15 at 09:15 AM, revealed she expected the the SRNA's</p>	F 309	<p>the Unit Manager will follow up on the Bowel Monitoring Record the next day to determine if the bowel enhancing interventions were successful. The residents will remain on the Bowel Monitoring Record until the bowel enhancing interventions are successful.</p> <p>[4] All Licensed Nurses were educated by the Staff Development Coordinator beginning on 6/11/15 on the Bowel Monitoring Record, use of bowel enhancing interventions, and physician notification.</p> <p>[5] All nursing assistants were educated by the Staff Development Coordinator beginning on 6/11/15 regarding documentation of residents' bowel movements.</p> <p>[6] On Saturdays and Sundays, the Licensed Nurse will be responsible for auditing the residents to determine any residents who have not had a bowel movement in the past 72 hours. The residents will have their names added to the Bowel Movement Monitoring Record for follow up.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u></p> <p>The Resident Care Coordinator will be responsible for bringing the the results of the Bowel Monitoring Record to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing Assistant Director</p>	07/24/15	

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F 309	Continued From page 21 to report to the nurse in charge, any residents that have gone three or more days/nine (9) or more shifts without a BM so the nurse could assess the resident, administer a PRN medication and chart this in the nurses notes. The ADON stated the unit managers pull a no BM in the last nine (9) shifts report daily Monday through Friday and take the report to the morning meeting. The ADON revealed the report was then discussed in the morning meeting and after the morning meeting, the report was taken to the units for the nurses to follow up with any resident that has been nine (9) or more shifts without a BM.	F 309	of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director] monthly times six months for discussion and action plan development as needed.		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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 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 review of the facility's policy, it was determined the facility staff failed to ensure an indwelling catheter drainage bags were not touching the floor for four (4) of fifteen (15) sampled residents (Resident #1, #2, #3, #9) and one (1) unsampled resident (Resident A) to	F 315	F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER <u>Corrective Measures for Resident(s) Identified In The Deficiency</u> [1] Residents # 1, #2, #3, #9, #A, Foley Catheter drainage bags were placed in a dignity bag on 06/11/15 by the Resident Care Coordinator.	07/24/15	

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F 315	<p>Continued From page 22</p> <p>prevent possible urinary tract infections (UTI).</p> <p>The findings include:</p> <p>Review of the facility's policy "Infection Prevention and Control", revised 12/19/13, revealed it was the policy of the facility to provide a safe, sanitary, and comfortable environment and the facility would provide precautionary measures to prevent the spread of potential infection.</p> <p>1. Record review revealed Resident #2 was admitted on 05/11/12 with diagnoses which included Non Insulin Dependent Diabetes Mellitus, Schizophrenia, Alzheimer's, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, Senile Dementia, and Disorder of Bone/Cartilage. Review of Resident #2's Minimum Data Set (MDS) assessment, dated 05/13/15, revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of one (1), which indicated the resident was non-interviewable.</p> <p>Observation of Resident #2, on 06/09/15 at 12:05 PM, revealed the resident was laying in bed on his/her right side with eyes closed and an Indwelling Urinary Catheter was attached to a bed-side drainage bag which was laying on the floor.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1, on 02/24/15 at 3:25 PM, revealed she worked the second shift and had just gotten to work. She stated she was aware Resident #2 should not have his/her catheter bag on the floor due to the risk of infection.</p>	F 315	<p><u>How Other Resident's Who May Be Affected By This Practice Were Identified</u></p> <p>[1] 100% of residents with Foley Catheters were audited on 06/11/15 by the Resident Care Coordinator to determine if the Foley Catheter drainage bags were inside a dignity bags.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u></p> <p>[1] 100% of residents with Foley Catheters will be audited by the Director of Nursing, Resident Care Coordinator, or Unit Manager daily times five days; three times a week times three weeks; one time a week times three weeks; every other week times three weeks; monthly times three months.</p> <p>[2] All nursing staff were educated by the Staff Development Coordinator beginning on 6/11/15 regarding keeping the Foley Catheter drainage bags in the dignity bags.</p>	07/24/15	

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F 315	<p>Continued From page 23</p> <p>2. Record review revealed the facility admitted Resident #3 on 03/25/15 with diagnoses which included Muscular Dystrophy, Recurrent Urinary Tract Infections (UTI's) and Urinary Retention. Review of Resident #3's MDS assessment, dated 05/30/15, revealed the facility assessed Resident #3's cognition as cognitively intact with a BIMS score of (fifteen) 15, which indicated the resident was interviewable.</p> <p>Observation of Resident #3, on 06/09/15 at 6:52 AM and 12:10 PM, revealed the resident was laying in bed on his/her back with an Indwelling Urinary Catheter in place attached to a bed-side drainage bag which was laying on the floor.</p> <p>3. Record review revealed the facility admitted Resident #9 on 05/28/15 with diagnose which included General Weakness, Urinary Tract Infection, and Urinary Retention. Review of Resident #9's MDS assessment, dated 06/04/15, revealed the facility assessed Resident #9's cognition as cognitively intact with a BIMS score of fourteen (14), which indicated the resident was interviewable.</p> <p>Observation of Resident #9 on 06/09/15 at 06:30 AM, revealed the resident was laying in bed on his/her right side with eyes open with an Indwelling Urinary Catheter in place attached to a bed-side drainage bag which was laying on the floor.</p> <p>4. Record review revealed the facility admitted Resident #1 on 11/22/13 with diagnosis which included Cerebrovascular Accident (CVA), and Pressure Ulcer stage four (4) to sacrum. Review of the quarterly MDS assessment, dated 05/29/15, revealed the facility assessed Resident</p>	F 315	<p><u>Monitoring Measures To Maintain On-Going Compliance</u> The Director of Nursing will be responsible for bringing the results of the Foley Catheter drainage bag audit to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director] monthly times six months.</p>	07/24/15	

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F 315	<p>Continued From page 24</p> <p>#1's cognition as severely impaired with a BIMS score of zero (0).</p> <p>Observation of Resident #1, on 06/09/15 at 6:20 AM, revealed the resident was laying in bed on his/her right side with an indwelling urinary catheter connected to a bedside drainage bag containing golden yellow urine, which was laying on the floor.</p> <p>Review of Physicians Orders revealed Resident #1 was treated for urinary tract infections (UTI) on the following dates: on 04/13/15, 05/12/15 and 06/08/15. In addition the resident was admitted to a local hospital with diagnosis to include UTI and Sepsis on 05/12/15.</p> <p>5. Record review revealed the facility readmitted Unsampled Resident A on 06/08/15 with diagnoses which included Dementia without behavioral disturbance, Palliative Care, Dysphagia, Adult Failure to Thrive, and Encephalopathy. Review of the quarterly MDS, dated 04/22/15, revealed the facility assessed Unsampled Resident A's cognition as severely impaired with a BIMS score of four (4).</p> <p>Observation of Unsampled Resident A, on 06/09/15 at 6:25 AM, revealed the resident was laying in bed asleep on his/her right side with an indwelling urinary catheter connected to bedside drainage bag attached to bed frame, laying on floor.</p> <p>Interviews on 06/11/15 with State Registered Nursing Assistant (SRNA) #3 at 7:42 AM, SRNA #4 at 7:55 AM, and SRNA #6 at 8:50 AM revealed Indwelling Urinary Catheter Drainage Bags were not to be on the floor. The SRNAs stated the</p>	F 315		07/24/15
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F 315	Continued From page 25 urinary drainage bags being on the floor could cause the residents to have an infection. Interview with Registered Nurse (RN) #14, on 06/09/15 at 06:32 AM, revealed she expected the Urinary Drainage Bags to be off the floor at all times because there was a potential for infection if a drainage bag was on the floor. Interview with the Unit Manager/Licensed Practical Nurse (LPN) #4, on 06/11/15 at 9:05 AM, revealed urinary drainage bags were never to be on the floor due infection control issues and the potential for causing infections. She further stated it was the nurses and CNA's responsibilities to ensure urinary drainage bags were not on the floor and this should have been found and corrected during care and during rounds. Interview with the Staff Development Coordinator (SDC), on 06/11/15 at 2:35 PM, revealed urine drainage bags should not touch the floor. She stated, "I would expect urine drainage bags to be attached to the bed frame and not be on the floor, it is a concern with infection control". Interview with the Assistant Director of Nursing (ADON)/ RN #3, on 06/11/15 at 9:15 AM, revealed if urinary drainage bags were on the floor it would be a potential for an infection and urinary drainage bags were never to be on the floor. She also stated she expectdc all direct care nursing staff to be aware of this and catch this and to correct it.	F 315			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	07/24/15	

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F 323	<p>Continued From page 26</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 and review of the facility policy it was determined the facility failed to ensure the residents' environment was free of accident hazards. Observations of the medication rooms revealed the doors were left propped open on Hall I and Hall II, a sharps container was left unattended at the nursing station and there were three wet saturated areas on the floor surface of Hall I for approximately twenty (20) minutes. In addition, the facility failed to ensure an assistive device was activated to prevent falls for one (1) of fifteen (15) sampled residents (Resident #3).</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's "Storage and Expiration Dating of Medications" policy revealed the facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible to residents and visitors. <p>Observations, on 06/09/15 at 12:10 PM and 1:30 PM, and on 06/10/15 at 10:20 AM and 11:00 AM, revealed the Medication Room (med room) door on Hall I was propped open.</p>	F 323	<p><u>Corrective Measures for Resident(s) Identified In The Deficiency</u> [1] Resident #3's bed alarm was checked for proper functioning by Staff Development Coordinator on 6/30/15.</p> <p><u>How Other Resident's Who May Been Affected By This Practice Were Identified</u> 100% audit of residents' bed alarms and chairs alarms was conducted on 6/30/15 by Resident Care Coordinator to ensure proper placement and proper functioning.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] Licensed nurses were educated by the Staff Development Coordinator beginning on 6/15/15 regarding keeping the medication room door shut and not propping open the door. [2] Licensed nurses were educated by the Staff Development Coordinator beginning on 6/15/15 regarding keeping the small portable sharps containers out of the reach of residents. [3] Licensed nurses were educated by the Staff Development Coordinator on 6/15/15 regarding the discontinuation of the use of the small sharps containers and the process of disposing of used lancets, needles, and glucose meter test strips in the sharps containers in the residents' rooms or the</p>	07/24/15
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F 323	<p>Continued From page 27</p> <p>Observation of the Hall II medication room, on 06/10/15 at 7:25 AM and 06/11/15 at 8:00 AM revealed the door was propped open.</p> <p>Interviews on 06/11/15 with Licensed Practical Nurse (LPN) #9 at 10:52 AM, LPN #6 11:00 AM, LPN #10 at 11:06 AM, LPN #11 at 11:30 AM, Registered Nurse (RN) #3 at 12:20 PM, and RN #4 at 12:27 PM revealed the medication room doors were not supposed to be propped open.</p> <p>Interview with Staff Development Coordinator (SDC), on 06/11/15 at 2:35 PM, revealed all facility doors should be closed and not propped open. The SDC stated she expected the medication room doors to be closed at all times and never propped open.</p> <p>Interview with the Maintenance Director, on 06/10/15 at 2:47 PM, revealed there should be no objects blocking a door and the doors should not be propped open.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 06/11/15 at 3:25 PM, revealed she expected all medication room doors to remain closed and not be propped open.</p> <p>Interview with the Administrator, on 06/11/15 at 12:46 AM, revealed she expected the the residents' rights to be in a safe environment and free from accidents/hazards to be followed at all times and medication room doors should not be propped open.</p> <p>2. Review of the facility's Biomedical Waste (Clinical Practice Guidelines) policy, not dated, revealed indoor storage areas shall have</p>	F 323	<p>sharp's containers on the medication carts.</p> <p>[4] All staff educated by the Staff Development Coordinator beginning on 6/22/15 regarding cleaning up spills on the carpet when the spill occurs.</p> <p>[5] Audit is being conducted by the Maintenance Director, Maintenance Assistant, or Director of Nursing to check for spills on the carpets, doors being propped open, and to check for small portable sharp's containers being left out where residents can get to them, until the facility finishes using the small portable sharps containers.</p> <p>[6] Licensed nurses and nurse aides were educated by the Staff Development Coordinator beginning on 6/15/15 regarding checking alarm placement and functioning every shift.</p> <p>[7] Audits will be conducted of the residents' bed and chair alarms by the Director of Nursing; Resident Care Coordinator; Unit Managers to check for placement and functioning of the bed and chair alarms weekly times three; every other week times three weeks; monthly times three.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u> The Maintenance Director will be responsible for bringing the results of the audits of the carpets for wet areas, doors being propped open, and sharps</p>	07/24/15	

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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 28</p> <p>restricted access and be designated by signs. Sharps shall be discarded at the point of origin into single use or reusable sharps containers. Sharp containers will be emptied when full. Sharps containers must be sealed when full, to avoid injury, containers should not be overfilled.</p> <p>Observation of Hall II nursing station, on 06/10/15 at 08:35 AM, revealed a sharps container sitting on the nurses station ledge unattended with the lid open and syringes exposed.</p> <p>Interview with LPN #3, on 06/10/15 at 08:50 AM, revealed the sharps container was the one (1) used when doing insulin injections that morning and it should never be left unattended or with the lid off the top. LPN #3 stated the sharps container should have been in the locked medication room when not in use and this was a safety issue for visitors, residents and staff.</p> <p>Interview with LPN #2, on 06/10/15 at 08:55 AM, revealed any portable sharps container should never be left unattended or left with the lid off it and it should have been placed in the medication room after it was done being used. She further stated this was inappropriate due to the used syringes were a hazard and it was a potential for injury to residents, staff and visitors.</p> <p>Interview with ADON/RN #3, on 06/11/15 at 09:15 AM, revealed she expected the portable sharps containers to be properly put up after use and should never be left unattended on the nurses station or on the hallway. The ADON stated this was a safety concern.</p> <p>3. Review of the facility's policy and procedure titled, "Incident/Accident", last revised 02/07/13,</p>	F 323	<p>containers to the Quality Assurance committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director], monthly times six months for discussion and action planning as needed.</p>	07/24/15	

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F 323	<p>Continued From page 29</p> <p>revealed it was the policy of the facility to provide a safe, clean, hazard free environment as is possible.</p> <p>Observation on 06/11/15 at 9:28 AM through 9:49 AM, revealed three wet saturated areas on the floor surface of Hall I near the nurses' station and in front of room 109. Further observation revealed several ambulatory residents walking in the hallway on and near the wet saturated areas of the floor.</p> <p>Interview with a laundry staff member, on 06/11/15 at 10:04 AM, revealed the areas should have been cleaned up immediately because a resident could have fallen.</p> <p>Interview with the Maintenance Supervisor, on 06/11/15 at 10:12 AM, revealed he would have expected the areas be cleaned up with a towel and a work order put in to make him aware in case the saturation was due to a leak. He also stated that it was a fall hazard for residents, staff, and visitors.</p> <p>Interview with the Housekeeping Supervisor, on 06/11/15 at 10:28 AM, revealed the wet areas on the floor could be a fall hazard for the residents and staff was expected to clean spills up and put in necessary work orders for possible leaks.</p> <p>4. Review of the Fall Prevention and Management Program policy and procedures, last revised 12/19/13, revealed it was the policy of the facility to promote a safe environment to assist in the prevention of falls for the resident and manage those that occur.</p> <p>Record review revealed the facility admitted Resident #5 on 04/02/14 with diagnoses which</p>	F 323		
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F 323	Continued From page 30 included Hypertension, Non-Alzheimer's Dementia, Depression, and Psychotic Disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/17/15, revealed the facility assessed Resident #5's cognition as severely impaired with a Brief Inventory of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable. Review of Resident #5's Comprehensive Care Plan, dated 01/05/15, and review of the Nurse Aide Data Plan revealed the resident was assessed at risk for falls with an intervention to use an alarm while in bed. Review of the facility's fall investigation, dated 05/03/15 at 1:00 PM, and interviews with SRNA #2 on 06/11/15 at 2:10 PM, and SRNA #8 on 06/12/15 at 1:15 PM, revealed Resident #5 fell out of bed and was found sitting upright on a mat beside his/her bed. The bed notification alarm was not sounding and it was determined the alarm had not been activated. Resident #5 sustained no injuries from the fall. Interview with LPN #8, on 6/11/15 at 1:30 PM, revealed she expected any resident with a bed alarm to have alarm turned on when the resident is in bed to notify staff if the resident attempted to get out of the bed. Interview with ADON, on 06/11/15 at 3:25 PM, revealed she expected all staff to activate the alarm when the resident was placed in bed.	F 323			
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334	F334 483.25(n) INFLUENZA AND PNEUMOCOCCOL IMMUNIZATIONS <u>Corrective Measures for Resident[s] Identified In The Deficiency</u> [1] Residents #5, #6, #9, #11, #12, and #13 were audited for the Pneumococcal Vaccination on 06/10/15 by the		

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F 334	<p>Continued From page 31</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>	F 334	<p>Regional Nurse to determine if each resident had a prior Pneumococcal vaccination, had refused the Pneumococcal vaccination, or needed to be offered the Pneumococcal vaccination. Each residents' Immunization Record was updated by the Regional Nurse to reflect each resident's Pneumococcal vaccine status.</p> <p><u>How Other Resident's Who May Been Affected By This Practice Were Identified</u></p> <p>[1] 100% audit of all residents' immunization records was conducted on 06/10/15 by the Regional nurse to determine any other residents who did not have documentation on their immunization record regarding their Pneumococcal vaccinations.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u></p> <p>[1] Licensed Nurses were educated by the Staff Development Coordinator beginning on 6/22/15 regarding the documentation of resident Pneumococcal vaccinations on the Immunization Record in the resident's chart and if a resident refuses a Pneumococcal vaccination to obtain a refusal and document on the Immunization Record the resident</p>		

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F 334	<p>Continued From page 32</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and the facility's policy review, it was determined the facility failed to ensure the medical record included documentation to indicate residents either received the pneumonia vaccine or did not due to medical contraindication or refusal for six (6) of fifteen (15) sampled residents (Residents #5, #6, #9, #11, #12 and # 13).</p> <p>The findings include: Review of the facility policy titled "Immunizations",</p>	F 334	<p>refused the Pneumococcal vaccination.</p> <p>[2] New admissions will be audited using the Admission Immunization Audit form by the Director of Nursing, Unit Manager, or the Resident Care Coordinator to ensure there is documentation on the resident's Immunization Record if the resident has had a Pneumococcal vaccine or has refused the Pneumococcal vaccine.</p> <p>[3] Resident Immunization Records will be audited monthly times three months to ensure each resident has documentation of receiving a Pneumococcal vaccine or that the resident has refused the Pneumococcal vaccination.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u> The Director of Nursing will be responsible for bringing the results of the Immunization Record audit and the results of the Admission Immunization Audit to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director] monthly times six months for discussion and action planning as needed.</p>		

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F 334	<p>Continued From page 33</p> <p>last revised 01/01/07, revealed it was the facility's policy that residents were encouraged to accept immunizations and/or vaccinations that help prevent infectious diseases, unless medically contraindicated. Further review of the policy revealed it was the facility's policy to obtain historical immunization information at the time of admission and an immunization record should be established and maintained in the clinical record.</p> <p>1. Record review revealed the facility admitted Resident #9 on 05/28/15 with diagnoses which included General Weakness, Urinary Tract Infection, and Urinary Retention. Further review of Resident #9's medical record, revealed there was no documentation or notation of whether or not Resident #9 received the pneumonia vaccine or did not due to medical contraindication or refusal.</p> <p>2. Record review revealed the facility admitted Resident #12 on 12/17/13 with diagnoses which included Hemiplegia, Hypertension and Diabetes Mellitus type II. Further review of Resident #12's medical record, revealed there was no documentation or notation of whether or not Resident #12 received the pneumonia vaccine or did not due to medical contraindication or refusal.</p> <p>3. Record review revealed the facility admitted Resident #13 on 05/26/15 with diagnoses which included Hemiplegia, Diabetes, Peripheral Vascular Disease, Hyperlipidemia and Hypertension. Further review of Resident #13's medical record, revealed there was no documentation or notation of whether or not Resident #13 received the pneumonia vaccine or did not due to medical contraindication or refusal.</p> <p>4. Record review revealed the facility admitted</p>	F 334		

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F 334	<p>Continued From page 34</p> <p>Resident #5 on 04/02/14 with diagnoses which included Hypertension, Non-Alzheimer's Dementia, Depression, and Psychotic Disorder. Further review of Resident #5's medical record, revealed there was no documentation or notation of whether or not Resident #5 received the pneumonia vaccine or did not due to medical contraindication or refusal.</p> <p>5. Record review revealed the facility admitted Resident #6 on 09/20/13 with diagnosis which included Hypertension, Peripheral Vascular Disease, and Non-Alzheimer's Dementia. Further review of Resident #6's medical record, revealed there was no documentation or notation of whether or not Resident #6 received the pneumonia vaccine or did not due to medical contraindication or refusal.</p> <p>6. Record review revealed the facility admitted Resident #11 on 06/05/15 with diagnosis which included End Stage Renal Disease and Hypertension. Further review of Resident #11's medical record, revealed there was no documentation or notation of whether or not Resident #11 received the pneumonia vaccine or did not due to medical contraindication or refusal.</p> <p>Interview with Unit Manager/Licensed Practical Nurse #4, on 06/11/15 at 9:05 AM, revealed she expected for staff who admitted residents to the facility to be sure immunization records, consents and or refusals were in place as part of the admission process.</p> <p>Interview with the Staff Development Coordinator (SDC), on 06/11/15 at 2:35 PM revealed it was the responsibility of the nurse working the unit to ensure residents immunization history was</p>	F 334			

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F 334	Continued From page 35 documented on the immunization record. The (SDC) stated, "I would expect for our residents' immunization history to be recorded in the medical record". Interview with the Assistant Director of Nursing (ADON), on 06/11/15 at 3:25 PM, revealed she would expect residents immunization history to be recorded in the medical record on the facility's immunization record.	F 334		
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, and review of the facility's policy and procedure, it was determined the facility failed to ensure food was served under sanitary conditions. During observation of tray line service, the Dietary Cook broke tray line twice and did not change her gloves and wash her hands prior to returning to the tray line to serve food. She also served fried eggs, waffles, and sausage patties with her gloved hands rather than using tongs.	F 371	F371 483.35(I)FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY <u>Corrective Measures for Resident[s] Identified In The Deficiency</u> [1] No residents were identified with this deficiency. <u>How Other Resident's Who May Been Affected By This Practice Were Identified</u> [1] No residents affected by this practice. <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] A food preparation audit was conducted by the Dietary Manager on 6/11/15 to make sure proper hand-washing and proper use of gloves was being done. [2] Dietary staff were educated by the Dietary Manager beginning on 6/11/15 regarding hand-washing, use of gloves, and infection control. [3] Food preparation audits are being	

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F 371	<p>Continued From page 38</p> <p>Review of the Census and Condition, dated 06/09/15, revealed there were seventy-four (74) residents in the facility with six (6) resident receiving nutrition per feeding tube.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Dietary Sanitation", revised 09/29/14, revealed the facility provides food obtained from approved sources that has been stored, prepared, and served under sanitary conditions. Food service staff follow procedures that reduce potential for food borne pathogens, in storing, preparing, and serving foods.</p> <p>Observation of tray line service, on 06/09/15 at 7:10 AM, revealed the Dietary Cook leaving the tray line to retrieve cereal bowls and to fry eggs without changing her gloves or washing her hands prior to returning to tray line to serve food. She also served fried eggs, waffles, and sausage patties with her gloved hands rather than using tongs. The Dietary Supervisor brought tongs to the tray line and left them for her to use and she continued to use her hands to serve food.</p> <p>Interview with the Dietary Cook, on 06/10/15 at 11:03 AM, revealed she knew she should have changed her gloves and washed her hands prior to returning to tray line and should have had a runner available to assist in getting what she needed instead of breaking tray line.</p> <p>Interview with the Dietary Supervisor, on 06/10/15 at 11:00 AM, revealed she had her back to the Dietary Cook and did not see her break tray line, but it was not all right for tray line to be broken. She stated the Dietary Cook should never leave</p>	F 371	<p>conducted by the Dietician and the Dietary Manager daily times five days; three times week times three weeks; one time week times three weeks; every other week times three weeks; monthly times three weeks.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u> The Dietary Manager will be responsible for bringing the results of the audits to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Coordinator, Activities Director, Dietary Manager and Maintenance Director] monthly times six months.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page 37 tray line during serving.	F 371			
F 372 SS=D	<p>Interview with the Registered Dietician, on 06/10/15 at 11:05 AM, revealed she spoke with the Dietary Cook in regards to her using her hands to serve food rather than the tongs and about her breaking tray line and not changing gloves or washing her hands.</p> <p>Interview with the Administrator, on 06/11/15 at 12:46 PM, revealed she expected the tray line staff to change their gloves and wash their hands if they become contaminated during meal service.</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure disposal of garbage/refuse was done properly. General observations and tour of the facility revealed the dumpster lids open on several occasions.</p> <p>The findings include: Review of the facility's policy, titled "Environment Maintenance", last revised 12/19/13, revealed the facility should provide a safe, clean, well maintained facility and grounds. The facility should be maintained and equipped to provide a sanitary, orderly, and comfortable environment that protects the health and safety of residents,</p>	F 372	<p>F372 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p><u>Corrective Measures for Resident(s) Identified In The Deficiency</u> [1] No residents identified in this deficiency.</p> <p><u>How Other Resident's Who May Been Affected By This Practice Were Identified</u> [1] No residents affected by this practice.</p> <p><u>Measures Implemented or Systems</u></p> <p><u>Altered to Prevent Re-Occurrence</u> [1] All staff educated by the Staff Development Coordinator beginning on 6/15/15 regarding keeping the dumpster lids closed at all times. [2] An audit is being conducted by the Maintenance Director, Maintenance Assistant, or Director of Nursing of the</p>		

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F 372	Continued From page 38 personnel, and the public. Garbage and trash will be stored in containers that are covered with lids and emptied on a regular basis. Observation during the general tour of the facility revealed the dumpster lids open on one (1) of two (2) dumpsters during two (2) days of observations on 06/09/15 at 8:00 AM and 11:00 AM and on 06/10/15 at 7:25 AM. Interview with the Maintenance Director, on 06/10/15 at 2:47 PM, revealed he expected the dumpster lids and doors to be kept closed at all times to prevent possible rodent infestation. Interview with the Administrator, on 06/11/15 at 12:46 PM, revealed she expected the dumpster lids to remain closed at all times to prevent pests.	F 372	dumpster lids to make sure they are closed daily times five days; three times week times three weeks; one time week times three weeks; every other week times three weeks; monthly times three months. <u>Monitoring Measures To Maintain On-Going Compliance</u> The Maintenance Director will be responsible for bringing the results of the dumpster audits to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director] monthly times six months for discussion and action planning as needed.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425	F425 483.60(a),(b) PHARMACEUTICAL SVC- ACCURATE PROCEDURES, RPH <u>Corrective Measures for Resident(s) Identified In The Deficiency</u> [1] No residents identified with this deficiency.	

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F 425	Continued From page 39 services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the manufacture's guidelines for the glucose monitoring system, it was determined the facility failed to ensure provision of pharmaceutical services related to blood glucose meter calibration to meet the needs of each resident. During general observations of the facility's medication carts and blood glucose monitoring logs, it was determined the log book for documentation of calibration of the blood glucose monitoring system was missing on Hall I and it was undetermined how long the book had been missing, therefore there was no documentation of Hall I's two (2) meters having been checked. The findings include: Review of the manufacturer's guidelines for the Professional Blood Glucose Monitoring System, not dated, revealed at least once per week the control solution test should be performed to verify the meter and test strips were working properly together. Review of the Hall I list of residents with a diagnosis of Diabetes, revealed there were eight (8) residents which required blood sugar monitoring. Review of the Medication Administration Records (MARS) for the eight (8) residents revealed no issues with elevated or decreased blood glucose readings.	F 425	<u>How Other Resident's Who May Be Affected By This Practice Were Identified</u> No residents affected by this deficiency. <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] The glucose meters on the 100 hall were checked with the quality controls on 06/10/15 by the Resident Care Coordinator and the high and low quality control checks were within normal limits. [2] Licensed Nurses were educated by the Staff Development Coordinator beginning on 6/11/15 regarding checking the glucose meters with the quality controls and documenting the results on the Glucose Meter Quality Control Record. [3] Glucose meter quality checks audits are being conducted by the Director of Nursing, Assistant Director of Nursing, Resident Care Coordinator, or Unit Manager to ensure the quality control checks of the glucose meters are within normal limits daily times five days; three times week times three weeks; one time week times one week; every other week times three; monthly times three. <u>Monitoring Measures To Maintain</u>	

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F 425	Continued From page 40 Interview with Registered Nurse (RN), Unit Manager #2, on 06/12/15 at 1:20 PM, revealed the log book was missing so she was unable to provide glucometer readings. The Unit Manager stated the night shift nursing staff was responsible for the calibration of the meters and the documentation and the Unit Manager was responsible for ensuring the meters were checked. The Unit Manager revealed it should have been reported to her the first night the log book was missing to ensure the blood glucose monitor calibrations were being completed. The Unit Manager completed meter testing at that time on both glucometers for Hall I and the readings were within normal limits. Interviews on 06/11/15 with Licensed Practical Nurse (LPN) #9 at 10:52 AM, LPN #6 at 11:00 AM, LPN #10 at 11:06 AM, Registered Nurse (RN) #3 at 12:20 PM, RN #4 at 12:27 PM, LPN #11 at 12:30 PM, LPN #3 on 06/09/15 at 2:40 PM, and LPN #2, on 06/10/15 at 8:30 AM, revealed the Glucometer checks needed to be completed daily to ensure the finger stick reading was accurate and to ensure the appropriate amount of insulin was administered, if applicable. Interview with the Administrator, on 06/11/15 at 12:46 PM, revealed she expected the glucose meter devices should be calibrated per the manufacturer's guidelines.	F 425	<u>On-Going Compliance</u> The Director of Nursing will be responsible for bringing the results of the Glucose Meter Quality Checks Audit to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Coordinator, Social Services Director] monthly times six months for discussion and action planning as needed.		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	F431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS <u>Corrective Measures for Resident[s] Identified In The Deficiency</u> No residents were identified in this deficiency.		

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F 431	<p>Continued From page 41</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure labeling of drugs related to liquids not being dated when opened in two (2) of three (3) medication carts.</p>	F 431	<p><u>How Other Resident's Who May Been Affected By This Practice Were Identified</u></p> <p>100% audit of all liquid medications was conducted on 06/18/15 by the Director of Nursing and the Unit Manager to check for open dates on the liquid medication bottles.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u></p> <p>[1] Audits will be conducted by the Director of Nursing, Unit Manager, or Resident Care Coordinator to check for the dating of liquid medications when they are opened. Audits will be conducted one time week times three weeks; every other week times three weeks; monthly times three weeks.</p> <p>[2] Licensed Nurses educated by the Staff Development Coordinator beginning on 6/11/15 regarding dating liquid medication bottles when opened.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u></p> <p>The Director of Nursing will be responsible for bringing the results of the liquid medication audits to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical</p>

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F 441	Continued From page 43 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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	by the Unit Manager. <u>How Other Resident's Who May Been Affected By This Practice Were Identified</u> [1] 100% audit of all residents' bed pans was conducted on 06/12/15 by Resident Care Coordinator to ensure the bed pans were clean and in bags. [2] Infection control rounds were initiated on 06/15/15 by the Assistant Director of Nursing to check for linens being on the floor and bed pans not clean and covered. <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] Infection control rounds will be conducted by the Unit Manager, Assistant Director of Nursing, Director of Nursing, MDS Coordinator, or MDS nurse daily times five days; three times week times three weeks; one time week times three weeks; every other week times three weeks; monthly times three months to audit for linens being on the floor and bed pans being left dirty or not stored in bags when not in use. [2] All nursing staff were educated by the Staff Development Coordinator on 6/11/15 regarding not placing linens on the floor and bed pans must kept clean and covered.		

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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 441	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of facility policy, and review of the facility's Clinical Nursing Skills (seventh edition), it was determined the facility failed to maintain an Infection Prevention and Control Program that would prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility by providing a sanitary environment to help prevent the development and transmission of infection. The facility failed to label, clean and store bed pans and wash basins properly after use and failed to ensure dirty linens were not left on the floor. The findings include: Review of the facility's policy "Infection Prevention and Control", revised 12/19/13, revealed it was the policy of the facility to provide a safe, sanitary, and comfortable environment. It further revealed the facility would investigate, control and attempt to prevent the development and transmission of infections. Review of the facility's Clinical Nursing Skills (seventh edition), page 232 under "using a bedpan and urinal", revealed staff should empty bedpan or urinal, clean equipment and return to proper area in clients room. 1. Observation of Resident #3's bathroom on 06/09/14 at 6:52 AM, revealed a bed pan sitting on the back of the commode, uncovered, unlabeled, with dried browning material in the bed pan. Next to the bed pan on the back of the	F 441	<u>Monitoring Measures To Maintain On-Going Compliance</u> The Director of Nursing will be responsible for bringing the results of the infection control rounds to the Quality Assurance committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Resident Care Coordinator/Staff Development Coordinator, MDS Coordinator, MDS Nurse, Maintenance Director, Medical Records Director, Admissions Director] monthly times six months for discussion and action planning if needed.		

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F 441	<p>Continued From page 45 commode was a toothbrush that was not labeled or covered.</p> <p>Interviews on 06/11/15 with State Registered Nursing Assistant (SRNA) #3 at 7:42 AM, SRNA #4 at 7:55 AM and SRNA #6 at 8:05 AM revealed bedpans were to be labeled so staff knew which resident's bedpan it was and bedpans were to be cleaned out after each use and stored in a bag.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 06/09/15 at 08:59 AM, revealed she expected for bedpans to be labeled with resident's name, cleaned out after use and placed in a bag for storage after being cleaned. LPN #3 stated it was inappropriate for resident toothbrushes to be stored on the back of the commode and this was an infection control problem that could lead to a resident getting sick.</p> <p>Interview with the Unit Manager/ LPN #4, on 06/11/15 at 8:05 AM, revealed she expected bedpans to be cleaned by nursing staff after resident's used them and the bedpans should be stored in a bag after they were cleaned. The Unit Manager stated bedpans should be labeled and toothbrushes were not to be stored on the back of the commode.</p> <p>Interview with the Assistant Director of Nursing (ADON)/RN #3, on 06/11/15 at 9:15 AM, revealed she expected bedpans to be cleaned by nursing staff after resident's used them and they were to be stored in a bag after they were cleaned. The ADON stated the bedpans should be labeled and toothbrushes were not to be stored on the back of the commode.</p> <p>2. Observation during tour of shared bathroom in</p>	F 441		

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F 441	<p>Continued From page 46</p> <p>for Room 100, on 06/09/15 at 6:15 AM and 9:50 AM, revealed a soiled washcloth, gown, and towel lying on the floor.</p> <p>3. Observation during tour of shared bathroom for Room 106, on 06/09/15 at 6:30 AM and 9:55 AM, revealed used linen (washcloth, towel, and gown) lying on the floor uncovered and two (2) wash basins, unlabeled and uncovered, stored underneath the sink.</p> <p>Interview with SRNA #1, on 06/09/15 at 1:50 PM, revealed the facility's process was to collect soiled linen and put the linen in a clear trash can liner. SRNA #1 stated there has never been a concern with putting dirty linen on the floor while doing resident care, but infection control could be a concern.</p> <p>Interview with RN #1, on 06/09/15 at 1:55 PM, revealed she would expect dirty linen to be put in a clear trash can liner, not on the floor.</p> <p>Interview with the Staff Development Coordinator (SDC), on 06/11/15 at 2:35 PM, revealed she would expect staff to put used linen in a clear bag if soiled and not on the floor and wash basins should be labeled and covered when not in use. The SDC stated "that is an infection control issue".</p> <p>Interview with the ADON, on 06/09/15 at 3:25 PM, revealed linen should not be on the floor at any time, all wash basins, and residents' personal hygiene articles should be labeled to identify resident and covered when not in use.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 959 HIGHPOINT DR. HOPKINSVILLE, KY 42240
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1976. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (200). SMOKE COMPARTMENTS: Seven (7) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1976, and upgraded in 2010 with 34 smoke detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1976. GENERATOR: Type II generators installed in 1976 and 2010. Fuel source is Diesel. A standard Life Safety Code Survey was conducted on 06/09/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred (100) beds with a census of seventy-three (73) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 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.	7/24/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: 7.6.15

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 discloseable 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 discloseable 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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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 018	Continued From page 2 staff and visitors. The findings included: Observation on 11:46 AM with the Environment Director, revealed the door of resident room 221 was being held open with a trash can. Interview with the Environment Director, revealed he was not aware items placed in front of resident room doors were an issue. Observation on 11:48 AM with the Environment Director, revealed the door of resident room 219 was being held open with a trash can. Interview with the Environment Director, revealed he was not aware items placed in front of resident room doors were an issue. Observation on 11:55 AM, with the Environment Director, revealed the door of resident room 351 was being held open with a trash can. Interview with the Environment Director, revealed he was not aware items placed in front of resident room doors were an issue. Reference: NFPA 101 (2000 Edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms,	K 018	<u>Monitoring Measures To Maintain On-Going Compliance</u> The Maintenance Director will be responsible for bringing the results of the audit to the Quality Assurance Committee (consisting of Administrator, Director of Nursing, Resident Care Coordinator/Staff Development, Unit Managers, Admissions Coordinator, Social Services Director, MDS Coordinator, MDS Nurse, Activities Director, Dietary Manager, Medical Records Coordinator, and Human Resources Director) monthly x 6 months for review by the Quality Assurance Committee.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 018	Continued From page 3 bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.	K 018			
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments.	K 029	K 029 NFPA 101 LIFE SAFETY CODE STANDARD <u>Corrective Measures for Resident[s] Identified In The Deficiency</u> No residents were identified with this deficiency. <u>How Other Resident's Who May Been Affected By This Practice Were Identified</u> No residents were affected by this deficiency. <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] The Dietary Manager removed the cardboard boxes, boxes of gloves, and boxed dry goods from her office on 06/09/15. [2] The Maintenance Director will audit the Dietary Managers office three times a week times three weeks to verify there are not cardboard boxes, boxes of gloves, or boxed dry goods in her office.	7/24/15	

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K 029	<p>Continued From page 4</p> <p>The findings included:</p> <p>Observation on 06/09/15 at 11:36 AM with the Environment Director, revealed the Dietary Manager office was being used to store combustible items (cardboard boxes, exam gloves and boxed dry goods). Further observation revealed the door of the Dietary manager Office was held open with a hinge placed under the door. Interview with the Environmental Director, revealed he was not aware of the requirements for the protection of hazardous areas.</p> <p>Reference; NFPA 101 (2000 Edition)</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> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having 	K 029	<p>[3] The Dietary Manager was re-educated by the Staff Development Coordinator on 6/11/15 regarding not storing any cardboard boxes, boxes of gloves, or boxes of dry goods in her office.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u> The Maintenance Director will be responsible for bringing the results of the audit to the Quality Assurance Committee [consisting of Administrator, Director of Nursing, Resident Care Coordinator/Staff Development, Unit Managers, Admissions Coordinator, Social Services Director, MDS Coordinator, MDS Nurse, Activities Director, Dietary Manager, Medical Records Coordinator, and Human Resources Director] monthly x 6 months for review by the Quality Assurance Committee.</p>	7/24/15

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K 029	Continued From page 5 jurisdiction (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 144 NFPA 101 LIFE SAFETY CODE STANDARD SS=F Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure emergency generators were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, one hundred (100) residents, staff and visitors. The findings include: Record review of the emergency generator logs on 06/09/15 at 12:45 PM with the Environmental Director, revealed the facility had no	K 029 K 144	K 144 NFPA 101 LIFE SAFETY CODE STANDARD <u>Corrective Measures for Resident(s) Identified In The Deficiency</u> No residents were identified with this deficiency. <u>How Other Resident's Who May Been Affected By This Practice Were Identified</u> No residents were affected by this practice <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] The Maintenance Director had a two hour load bank test conducted on the generator on 6/10/15. [2] The Maintenance Director will have an on-going calendar of when the next two hour load bank test is due.	7/24/15

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K 144	<p>Continued From page 6</p> <p>documentation the emergency generator was being load tested for not less than 30 percent of the EPS nameplate rating or had conducted a two (2) hour load bank test. Interview with the Environmental Director, revealed he was not aware the load percentage should be documented. Further interview revealed the facility had not conducted a two (2) hour load bank test since 04/24/14.</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.</p> <p>6-4 2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads</p>	K 144	<p><u>Monitoring Measures To Maintain On-Going Compliance</u></p> <p>The Maintenance Director will be responsible for bringing the results of the two hour load bank test of the generator to the next Quality Assurance Committee meeting after the two hour load bank test is conducted. The Quality Assurance Committee consists of: Administrator, Director of Nursing, Resident Care Coordinator/Staff Development Coordinator, Unit Managers, MDS Coordinator, MDS Nurse, Social Services Director, Admissions Director, Activities Director, Dietary Manager, Medical Records Coordinator, and Human Resources Director.</p> <p>7/24/15</p>

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K 144	Continued From page 7 at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144		