

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

PRINTED: 09/28/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/09/2010
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NAME OF PROVIDER OR SUPPLIER  BRADFORD SQUARE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 318 SS=D	<p>A Recertification/Abbreviated Survey was conducted on 09/07 -09/10 and a Life Safety Code Survey was conducted on 09/08/10. Deficiencies were cited with the highest scope and severity of a "F". ARO # KY00015265 and ARO # KY00015266 were unsubstantiated with no deficiencies cited.</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure appropriate treatment and services to increase or prevent further decrease in range of motion for one (1) of nineteen (19) sampled residents (Resident #1). Resident #1 was receiving no treatment, including splint application, for a contracture of the left hand which was present on admission.</p> <p>The findings include:</p> <p>Resident #1 was admitted on 06/25/10 with diagnoses which included Parkinson's Disease and Depression. Review of the Nursing Assessment dated 06/25/10 revealed Resident #1 had a contracture of the left hand and functional</p>	F 318	<p style="text-align: center;"><b>RECEIVED</b> OCT 22 2010 BY: _____</p> <ol style="list-style-type: none"> <li>1. Resident #1 received orders on 9/8/2010 for Occupational Therapy (OT) to evaluate and treat for contracture management and splint application. Resident continues to be treated by OT as of 9/30/10.</li> <li>2. All residents have the potential to be affected but none were found to be negatively affected. The Nursing management team reviewed all residents on or before 10/6/2010 with decline in ROM triggers to ensure appropriate interventions are in place.</li> <li>3. The Director of Nursing and/or Administrator will re-educate nursing and therapy staff on process for therapy and</li> </ol>	10/22/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathy Jones, NHA</i>	TITLE <i>Administrator</i>	(X8) DATE <i>10/20/2010</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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F 318	<p>Continued From page 1</p> <p>limitation in range of motion. Continued review revealed a Stage II pressure ulcer on the left hand was present on admission. Review of the Resident Assessment Protocol Summary (RAPS) dated 07/08/10 revealed the pressure ulcer on the left hand was due to the contracture.</p> <p>Review of the admitting Physician Orders revealed instructions for Occupational Therapy to see Resident #1 five (5) times a week for twelve (12) weeks, with treatment to include contracture management and splinting of the left hand.</p> <p>Observation of Resident #1 throughout the survey revealed no splint in place at any time. Continued observation revealed the left hand was contracted with the fingertips pressing into the palm of the hand. Very limited voluntary movement of the left arm and hand was noted.</p> <p>Interview with Certified Nursing Assistant (CNA) #11 on 09/09/10 at 4:00 PM revealed the aide had seen the resident wearing a splint on the left hand, but not recently. The aide further stated day shift "used to" apply the splint.</p> <p>Interview on 09/09/10 at 2:15 PM with the Occupational Therapist, who had cared for Resident #1, revealed the resident was discharged from Occupational Therapy (OT) with the understanding the resident was going home. The therapist reported the resident's spouse had been trained on applying the splint and assisting with range of motion (ROM) exercises prior to discharging the resident from therapy. Continued interview revealed the spouse became ill and plans for the resident's discharge were cancelled. However, the OT department was not aware of the change in discharge plans. The therapist</p>	F 318	<p>restorative referrals, change of condition and communication process to ensure appropriate interventions in place to prevent decline in range of motion. Education will be completed by October 6, 2010.</p> <p>4. The Assistant Director of Nursing will audit the therapy discharges and restorative program weekly during CARE meeting to ensure all residents have the appropriate interventions in place to prevent decline in range of motion. The Director of Nursing will report trends to the Performance Improvement Committee monthly for 3 months and thereafter as indicated by findings.</p>		

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F 318	Continued From page 2 further stated had she known, the resident could have been referred to restorative nursing for continued ROM exercises and splint application.  Observation of the therapist's evaluation of Resident #1 on 09/09/10 at 2:20 PM revealed the resident's left little fingernail was pressing into the palm of the hand. Although the pressure ulcer present on admission had healed, a crescent-shaped pressure indentation was visible on the resident's left palm. The therapist, based on her evaluation, reported the resident had not suffered a decline in ROM since last measured. However, the resident was not able to tolerate the splint without the reintroduction of therapeutic exercises and "building up" to tolerance.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the residents' environment remained free	F 323	F323  1. No specific residents were identified to be affected. The biohazard room door lock on 100 unit was fixed on 9/8/2010.  2. All residents have the potential to be affected; however, none were found to be negatively affected. During an environmental round on 9/8/2010 completed by DNS and maintenance supervisor all	10/22/2010

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F 323	Continued From page 3 of accident hazards as evidenced by an unsecured Bio Hazard room on the 100 Unit in which infectious waste and full sharps containers were stored.  The findings include:  Review of the facility's policy, dated October 2009, revealed Biohazardous waste was to be stored in a locked area with limited access.  Observation on 09/08/10 at 10:36 AM revealed an unsecured Bio Hazard room on the 100 Unit. Inside the Bio Hazard room were stacked Bio Hazard barrels, some of which contained used infectious waste bags. Observation also revealed a sharps container which was sitting on the floor next to the Bio Hazard barrels, just inside the room.  A review of facility MDS records revealed that Resident #14, as well as three (3) unsampled residents, triggered as wander risks, "seemingly oblivious to needs or safety." One of these unsampled residents had a room on the 100 Unit.  In an interview on 09/08/10 at 2:35 PM the DON stated most staff know the code to the Bio Hazard room, from housekeeping, dietary and nursing staff. The DON stated the policy was to keep the door secured, and employees were trained to keep the door secure. The DON expressed knowledge of the importance of keeping the Bio Hazard room secure for resident safety.	F 323	hazardous areas were checked to ensure the doors were secured.  3. The Director of Nursing and the Administrator will re-educate staff on safety awareness as it relates to securing the access to hazardous areas. Education was completed by 10/6/2010.  4. The Maintenance Director and/or housekeeping supervisor will conduct rounds 3 times a week for 4 weeks and monthly times 2 months to ensure that all potential hazardous areas are secured. The Maintenance Director will report trends to the Performance Improvement Committee monthly for 3 months, and thereafter as findings indicate.		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364	F 364  1. No specific residents were	10/22/2010	

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F 364	<p>Continued From page 4</p> <p>value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to prepare food which was palatable, and at the proper temperature. As evidenced by residents' concerns and improper hot and cold holding temperatures on residents' tray line.</p> <p>The findings included:</p> <p>1. Observation on 09/07/10 at 5:00 PM revealed ground fried bologna held at a temperature of one hundred (100) degrees Fahrenheit, Pureed fried bologna held at a temperature of eighty-four (84) degrees Fahrenheit and, pureed carrots held at a temperature of one hundred- thirty degrees Fahrenheit. Tomato soup was held at a temperature of one hundred degrees Fahrenheit and Ambrosia (a fruit salad) held at a temperature of forty six (46) degrees Fahrenheit. German potato salad was noted to be held at a temperature of fifty-four (54) degrees Fahrenheit. These items were observed to be distributed to Residents during the evening meal.</p> <p>Interview with Cook #3, on 09/07/10 at approximately 5:00 PM, revealed her goal for temperatures on tray line was one hundred-fifty (150) degrees Fahrenheit through one hundred-seventy (170) degrees Fahrenheit.</p> <p>Observation of the test tray revealed point of service temperatures of fried bologna was</p>	F 364	<p>identified. Residents were offered an alternative during the meal referenced.</p> <p>2. All residents have potential to be affected. None were found to be negatively affected. Resident conducted a food committee during survey to discuss potential concerns. Residents' weights reviewed by 9/13/2010 by DNS to ensure no adverse effects related to palatable food concerns.</p> <p>3. A resident food committee meeting was held on September 28, 2010 to identify food related concerns. The Nutritional Services Director and the Administrator will be conducting the food committee twice weekly for 3 months and thereafter as findings indicate. The Nutritional Services Director and/or the Administrator will educate dietary staff and nursing staff on tray line temperatures for hot and cold food. Education will be completed by 10/6/2010.</p>	

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F 364	Continued From page 5 ninety-five (95) degrees Fahrenheit, green beans one-hundred ten (110) degrees Fahrenheit, and carrots ninety-five (95) degrees Fahrenheit. The German potato salad was seventy (70) degrees Fahrenheit and the Ambrosia was served with a temperature of sixty (60) degrees Fahrenheit. During tasting the food items from the tray it was noted the cooked carrots were tough.  Interview with the Dietary Manager on 09/07/10 at 6:27 PM revealed his expectations for the point of service temperatures were ten (10) degrees Fahrenheit from the starting temperature on tray line.  Interview with the Dietary Manager at 09/09/10 at 10:50 AM revealed his goal for temperatures for hot foods or tray line was one hundred-fifty (150) degrees and cold foods should have been forty (40) degrees Fahrenheit.  Interview during the Resident Group Meeting revealed residents expressed concerns related to their food being served cold and tough. Also, Interviews with residents through out the survey revealed food was often served cold.  Observation on 09/07/10 at 5:55 PM revealed fifteen (15) out of twenty-three (23) residents observed did not eat the carrots served during the evening meal.	F 364	4. The cook will test holding temperatures each meal within 10 minutes of the start of tray line as well as midway through the meal service to ensure proper holding temperatures. Food will not be placed on the steam table no more than 1 hour prior to start of meal service. The Nutritional Services Director and/or Administrator will conduct test tray audits 3 times a week for 4 weeks then monthly for 2 months. Trends will be reported to the Performance Improvement Committee monthly for 3 months and thereafter as findings indicate by the Nutritional Services Director.	
F 371 SS=F	483.35(l) 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	F 371	F371  1. No specific residents were identified. The booster heater on the dish machine was repaired on 9/8/2010.	10/22/2010

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F 371	<p>Continued From page 6 under sanitary condilions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. As evidenced by the dishwasher was observed to remain below the required sanitizing temperature for seven (7) full cycles, as well as multiple recordings of temperature below sanitizing levels on facility records. Inappropriate hand sanitation and glove usage.</p> <p>The findings include:</p> <p>1. Observation on 09/07/10 at 1:25 PM through 1:30 PM revealed the heat sanitizing dishwasher remained below the required rinsing temperature for seven (7) full cycles before reaching the one hundred eighty (180) degrees Farenheit required for heat sanitizing.</p> <p>Interview with Dietary Aide #2 on 09/07/10 at 1:29 PM revealed the dishwasher had to be reset after it sat for a while without running. He further indicated it would take a couple of cycles before the dishwasher would reach the correct temperature.</p> <p>Interview with the Dietary Manager on 09/09/10 at 10:50 AM revealed the kitchen had been having an issue with the booster heater needing to be reset after having not been ran through</p>	F 371	<p>2. All residents had the potential to be affected, however none were found to be negatively affected. An immediate re-education by the Nutritional Services Director was completed on 9/8/2010 for dietary employees. A dietary round was completed on 9/8/2010 by the Nutritional services director to identify any possible concerns.</p> <p>3. The dietary staff will be re-educated by 10/21/10 regarding overall dietary sanitation expectations by the Nutritional Services Director and/or Administrator. The routine cleaning schedule and responsibilities lists were updated by the Nutritional Services Director to ensure all sanitation areas are addressed. and posted to be visible for dietary staff.</p> <p>4. Nutritional Services Director and/or Administrator will conduct dietary rounds 3 times a week for 4 weeks and</p>	
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F 371	Continued From page 7 washing/rinsing cycle. He further indicated it had been occurring just that week and the facility was having a contract company come in to work on it today.  Review of the dishwasher temperature log revealed from 08/01/10 through 09/06/10 seventeen (17) occasions when the minimum required rinsing temperature for heat sanitation was not reached based on staff documentation.  2. Observation on 09/07/10 at 5:35 PM revealed Dietary Aide #4 handed a package of crackers to a nursing aide. She was then observed to take off her gloves, use her bare hands to lift the trash can lid and then she was noted to put on a new pair of gloves without having washed her hands.  Interview with the Dietary Manager on 09/09/10 at 10:50 AM revealed Dietary Aide #4 should have washed her hands prior to applying new gloves.  Review of facility policies revealed a policy entitled, "Food Preparation," dated 07/08. The first procedure was noted to be, the nutrition services department insures that all staff practice proper hand washing technique and practice proper glove use.	F 371	monthly for 2 months to ensure infection control program is effective and sanitation is completed per regulatory requirements. The Nutritional Services Director will report trends to the Performance Improvement Committee monthly for 3 months and thereafter as findings indicated.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F 431  1. No specific residents were identified. The refrigerator on hall three and four was assessed to be in proper working order as of 9/10/2010.  2. All residents have the potential	10/22/2010	

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F 431	Continued From page 8  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure drugs and biologicals were stored under proper temperature controls. Temperatures in the medication refrigerator for Halls three and four did not fall within acceptable parameters.  The findings include:  Observation of the medication refrigerator for Halls three and four, on 09/09/10 at 3:10 PM,	F 431	to be affected; however, none were found to be negatively affected. DNS assessed medication refrigerators in the center to ensure compliance with appropriate temperatures on 10/4/10 All areas used for medication storage were also audited by DNS for proper storage conditions on 10/10/2010  3. The Director of Nursing and the Administrator will re-educate all nursing staff on the proper storage of drugs and biologicals including refrigerators, medication carts, and med rooms. Education will be completed on or before 10/6/2010. The Unit Manager and Weekend Supervisor will assess the appropriate storage of medications daily.  4. The Assistant Director of Nursing will complete weekly reviews for 4 weeks and monthly for 2 months of appropriate medication storage and to ensure temperatures are within appropriate parameters	

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F 431	Continued From page 9 revealed the temperature to be 62 degrees Fahrenheit (F). Review of the Refrigeration Checklist revealed the temperature to be at or above 62 degrees on seven (7) of eight (8) days during the month of September. Continued review of the checklist revealed the following: "Temp must be maintained at or below 41F."	F 431	for medications. The Director of Nursing will report trends to Performance Improvement Committee for 3 months and thereafter as findings indicate.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	F 441  1. No specific residents were identified. The expired intravenous (IV) catheters were disposed of on 9/9/2010. RN #6 was re-educated on 9/8/10 regarding proper hand washing technique during medication administration.  2. All residents have the potential to be affected; however, no residents were found to be negatively affected. An audit was conducted by the Central supply manager of all supplies was completed on 9/10/2010 to ensure no expired supplies were available for use. The Infection Control meeting held	10/22/2010	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/09/2010
NAME OF PROVIDER OR SUPPLIER  BRADFORD SQUARE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 10</p> <p>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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe and sanitary environment to help prevent the transmission of disease and infections. Observation revealed staff failed to perform handwashing between residents during medication administration and expired intravenous (IV) catheters were found in both medication rooms.</p> <p>The findings include:</p> <p>1. Prior to Medication Pass observation on 09/08/10 at 12:20 PM, Registered Nurse (RN) #8 was observed to administer medications which had been prepared prior to surveyor arrival. Medications for two (2) unsampled residents had been placed in individual cups, labelled with the resident's names. The RN carried both cups into the first room and administered one resident's medication. Without handwashing, the nurse took the second cup into another room and administered the pills to the resident. Subsequently, during the official Medication Pass</p>	F 441	<p>monthly has not identified any trends related to nosocomial infection-transmission from one resident to another.</p> <p>3. The Director of Nursing and/or the Administrator will re-educate nursing staff on infection control policy and procedures including general hand washing and process of monitoring supply expirations by 10/21/10. The Director of Nursing will educate the unit managers of this responsibility by 10/21/10 All nurses will complete a hand washing competency by 10/21/10.</p> <p>4. The Assistant Director of Nursing will conduct infection control rounds weekly for 4 weeks then monthly for 2 months. The Assistant Director of Nursing and/or DNS will conduct an observation of medication pass and Treatment observation to ensure infection control policy and procedures are followed every week for 4 weeks, then every month for 2 months. The Director of</p>	

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F 441	<p>Continued From page 11</p> <p>observation at 12:30 PM, RN #6 gathered medications for a resident who could not be roused. The medications were wasted. The nurse did not wash hands prior to preparing and administering medications to the next resident. Continued observation of two (2) more residents revealed the nurse did handwashing appropriately.</p> <p>Interview with RN #6 on 09/08/10 at 12:55 PM revealed the nurse did not wash hands after wasting the pills because they weren't actually administered to the resident. Continued interview revealed the nurse knew handwashing between residents should occur every time. The nurse stated "it was my mistake...I will do it from now on."</p> <p>2. Observation of the medication room for Halls one and two on 09/09/10 at 4:55 PM revealed ten (10) expired IV catheters. Interview with the Unit Manager revealed she was unaware who was to check supplies for expiration dates. She did not believe the task was assigned to anyone specifically. The Unit Manger stated she was ultimately responsible for ensuring sterile (unexpired) supplies were available when needed.</p> <p>Observation of the medication room for Halls three and four on 09/09/10 at 5:00 PM revealed eleven (11) expired IV catheters. Interview with RN #2 on 09/09/10 at 5:05 PM revealed the nurse did not know if anyone was specifically checking expiration dates for IV catheters. The nurse stated, "I don't know who is responsible...it should be all of us." Interview with the Unit Manager on 09/09/10 at 5:10 PM revealed she was unaware the IV catheters had expiration dates.</p>	F 441	Nursing will report trends to the Performance Improvement Committee monthly for 3 months and thereafter as findings indicate.	
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F 514 SS=D	<p><b>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure clinical records were maintained for one (1) of nineteen (19) sampled residents (Resident #3). There was no evidence of Resident #3's Quarterly Restrictive Device Evaluation had been completed quarterly.</p> <p>The findings include:</p> <p>Resident #3 was admitted with diagnoses which included Dementia, Depression, and Arthritis. Review of the resident's current active Physician Orders revealed instructions for a "Velcro seatbelt to wheelchair related to dementia, as evidenced by decreased safety awareness."</p> <p>Review of Resident #3's Care Plan revealed interventions related to the use of an alarming Velcro seatbelt when up in wheelchair, due to the</p>	F 514	<p><b>F 514</b></p> <ol style="list-style-type: none"> <li>Resident #3's assessments and clinical documentation were updated to be accurate and organized, by the nurse on 9/10/2010.</li> <li>All residents have the potential to be affected; however, none were found to be negatively affected. All residents' assessments were reviewed and updated to reflect current resident status by the Unit managers/DNS on or before 10/21/2010.</li> <li>The Director of Nursing and/or the Administrator will re-educate nursing staff on timely completion of assessments to reflect residents' status on or before 10/21/2010. Policies regarding assessment completion will be reviewed with all nurses to include all comprehensive assessments including admission and routine updates by the Administrator and/or the DNS on or before 10/21/10.</li> </ol>	10/22/10
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F 514	<p>Continued From page 13</p> <p>resident's decreased safety awareness and attempts at unassisted transfers.</p> <p>Observation of Resident #3 throughout the current survey revealed a seatbelt was in place whenever the resident was up in the wheelchair.</p> <p>Review of the Restrictive Device Evaluation form revealed the Resident #3 was assessed for a Velcro alarming seatbelt to the wheelchair on 07/16/09. Continued review of the form revealed the Quarterly Review was completed on 09/17/09 and 11/25/09. The next review was not until six (6) months later, on 05/24/10. During the annual survey, on 09/09/10, no subsequent review had been completed since May of 2010.</p> <p>Interview with the Unit Manager where Resident #3 resided, on 09/09/10 at 2:00 PM, revealed she was ultimately responsible for ensuring the restraint evaluations were completed in a timely manner. She stated the floor nurses completed the assessments based on a calendar developed by the Minimum Data Set (MDS) assessment coordinator. She could not explain why the assessments had not been done when they were due. She stated she did realize some of the paperwork on the unit had fallen behind.</p>	F 514	<p>4. The Director of Nursing will Conduct a weekly review of at least 3 residents reviewing assessments for 4 weeks and monthly for 2 months of 3 residents to ensure clinical assessments are accurate, accessible and organized and completed timely. A report of trends will be presented to the Performance Improvement Committee monthly for 3 months and thereafter as findings indicate.</p>	
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K 000	INITIAL COMMENTS	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bradford Square Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 018 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p style="text-align: center;"><b>RECEIVED</b> OCT 04 2010 BY: _____</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of doors located in the corridor according to NFPA standards.</p>	K 018	<p>K 018</p> <p>1. All resident room doors # 105, 106, 111, 112, 113, 114 and 200 hall and 300 hall were reviewed with administration and tracking will be fixed by October 31, 2010 to enable the doors to be used safely during an emergency. The curtains have been tied back when not in use to prevent the closure of the doors.</p>	10/7/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathy Jones, NHA</i>	TITLE Administrator	(X8) DATE 10/4/10
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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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K 018	Continued From page 1 The findings include:  Observation on 09/08/2010 at 12:50 AM, revealed resident room doors #105, #106, #111, #112, #113 and #114 had privacy curtains which prevented the door from closing without manually moving the curtain. Further observation revealed the same situation for all resident rooms located on the 200 Hall and 300 Hall. Doors must be able to close without impediments so residents will be protected from smoke in the event of a fire.  Interview on 09/08/2010 at 12:50 AM, with the Maintenance Director, revealed he was not aware of the privacy curtains causing problems with the closing of the residents' room doors.	K 018		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exits according to NFPA standards.  The findings include:  Observation on 09/08/2010 at 10:30 AM, revealed three (3) exits contained delayed egress locks which did not open within fifteen (15) seconds,	K 038	2. All residents have the potential to be affected; however, none were found to be negatively affected. All residents' rooms were audited to ensure all privacy curtains are tied back when not in use to allow closure of the doors.  3. The Director of Nursing and Administrator will re-educate staff on the safe closure of doors. Staff is to pull the curtains back that are on the corridor side of the resident room when care is completed. All staff re-education will be completed by Oct. 6, 2010.  4. Daily rounds by the maintenance and housekeeping supervisors will be done 5 times weekly for 4 weeks to ensure the process is occurring and doors are closing properly. Identified problems will be rectified immediately. Maintenance will conduct weekly audits for 4 weeks and monthly for 2 months of all resident doors at varying times	

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K 038	<p>Continued From page 2</p> <p>when checked. The observation was confirmed with the Maintenance Director. Exits must be maintained to ensure they function properly to allow residents, staff, and visitors to leave the building in the event of an emergency. Interview on 09/08/2010 at 10:30 AM, with the Maintenance Director, revealed he was unaware of the delayed egress for the three (3) exits were not working.</p> <p>Reference: NFPA 101 2000 edition</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released</p>	K 038	<p>of the day to ensure compliance with door closures. Maintenance will report trends to the Performance Improvement Committee monthly for 3 months and thereafter as indicated by findings. Non-compliance with this process will result in reeducation and /or disciplinary action as indicated.</p> <p>5. Completion date is 10/7/2010.</p> <p>K 038</p> <ol style="list-style-type: none"> <li>No residents were identified. The Maintenance Director called the manufacturer on 9/10/2010 and the manufacturer assisted in completion of work that allowed the egress on the 3 exit doors to open within 15 seconds.</li> <li>All residents have potential to be affected; however, none were found to be negatively affected.</li> </ol>	10/7/10

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K 038	Continued From page 3 by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFFPA 101 LIFE SAFETY CODE STANDARD	K 038	3. The Administrator, Director of Nursing and/or Assistant Director of nursing will re-educate all staff on the proper egress on the exit doors. Re-education will be completed by 10/6/2010.	
K 072 SS=E	Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure corridors were maintained free from obstructions for instant use in the case of fire or other emergency, according to NFPA standards. Corridors must be kept clear for the use of exits and handrails in the event of an emergency.  The findings include:  Observation on 09/08/2010 at 9:53 AM, revealed the 100 Hall had one (1) linen cart, one (1) patient lift, and two (2) soiled linen carts which were unattended and not in use. Further observation	K 072	4. The Director of Maintenance will conduct random audits of exit doors 5 times weekly for 4 weeks, then monthly for 2 months with alternating doors. Identified problems will be corrected immediately. The Director of Maintenance will present trends to the Performance Improvement Committee monthly for 3 months and thereafter as indicated by findings.  5. Completion date is 10/7/2010.  K072  1. No residents were identified. The linen carts, medication carts and lifts were removed from hallway on 9/9/2010.	10/7/10

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K 072	Continued From page 4 revealed that on the 300 and 400 Hallways there was medication carts and patient lifts which were not in use or unattended. The observations was confirmed with the Maintenance Director. Interview on 09/08/2010 at 9:53 AM, with the Maintenance Director, revealed that items were routinely left in the hallways because of the lack of storage areas.	K 072	2. All residents have the potential to be affected; however, none were found to be negatively affected.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was according to NFPA standards.  The findings include:  Observation on 09/08/2010 at 12:40 PM, revealed a time clock located in the Laundry Room was plugged into a multiplug adapter. Further observation revealed an extension cord was used to supply electrical power to a water heater on the 400 Hall Mechanical Room. The observations was confirmed with the Maintenance Director. Extension cords and multiplug adapters cannot be used in the place of permanent wiring.  Interview on 09/08/2010 at 12:40 PM, with the Maintenance Director, revealed he was unaware	K 147	3. The Director of Nursing and/or the Administrator will re-educate all employees on keeping linen carts, medication carts and lifts, off hallways unless in use. All staff will be re-educated by October 6, 2010 on storage process of all carts and lifts.  4. The Assistant Director of Nursing and or Unit Manager will conduct rounds of the facility corridors 3 times weekly for 2 weeks, and monthly for 2 months to ensure carts and lifts are not stored in hallway. The Director of Nursing will report trends to the Performance Improvement Committee monthly for 3 months and thereafter as indicated by findings. Identified issues will be corrected immediately. Non-compliance with this process will result in re-education	

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K 147	Continued From page 5 of the time clocks wiring, and the use of the extension cord supplying power to the water heater  Reference: NFPA 70 (1999 Edition).  400-8. Uses Not Permitted  Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code	K 147	and/or disciplinary action as indicated.  5. Completion date is 10/7/2010.  <b>K 147</b>  1. No residents identified. The time clock was relocated to and plugged into the wall outlet on 9/8/2010. The extension cord found by the water heater was not in use and was taken out of the facility on 9/8/2010.  2. All residents had the potential to be affected; however, none were negatively affected.  3. The Director of Nursing and/or Administrator will re-educate staff on not using extension cords and multi-plug adaptors per regulation. Education will be completed on or by 10/6/2010.  4. The Director of Maintenance will conduct rounds throughout the facility weekly for 4	10/7/10