

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

PRINTED: 01/11/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 12/22/2011 |
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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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INITIAL COMMENTS

F 000

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

F 157
SS=G

A Recertification Survey was conducted 12/18/11 through 12/22/11. Deficiencies were cited with the highest Scope and Severity of a "G".
483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

F 157

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

F157
1. Resident #1 was discharged by the attending physician on 12/19/11.
2. A medical record review for current residents will be completed by 1/31/12 by the Director of Nursing, Assistant Director of Nursing, MDS and Unit Managers to determine notification to a resident's physician had occurred for any resident who had encountered a change in condition, other reportable event, accident, altered treatment and transfer discharge, over the last 30 days. Any identified concerns will be addressed.

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

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JAN 27 2012

1/31/12

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John Barth</i> | TITLE <i>Administrator</i> | (X6) DATE 1/27/12 |
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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 157 | <p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policies, it was determined the facility failed to ensure the Physician was notified when there was a change in a resident's physical health and a need to alter treatment for one (1) of twenty-seven (27) sampled residents, (Resident #1). On 11/11/11 the facility's Dietitian identified Resident #1 experienced a significant weight loss of 5.5% in seven (7) days. Although the Dietitian made dietary recommendations on 11/11/11, there was no documented evidence the Physician was notified of the recommendations. In addition, although the resident exhibited poor food and fluid intake from admission on 11/04/11, there was no documented evidence the Physician was notified of the significant weight loss or the decrease in food/fluid consumption. On 11/15/11 the facility transferred the resident to the hospital related to critical laboratory values and was diagnosed with Acute Renal Failure, Dehydration, Hypotension, and a Urinary Tract Infection.</p> <p>The findings include:</p> <p>Review of the "Hydration Policy", dated 01/08, revealed the nurse was to notify the Physician upon identification of resident hydration concerns and document this notification in the Interdisciplinary Progress Notes.</p> <p>Review of Resident #1's medical record revealed diagnoses which included Dementia, and Diabetes Mellitus. Review of the admission Physician's orders, dated 11/04/11, revealed an order for Lasix 20 milligrams (diuretic medication)</p> | F 157 | <p>3. Re-education for Licensed Nurses regarding physician notification of resident change of condition to include dietary recommendations and weight loss, other reportable event, accident, altered treatment and transfer discharge, will be completed as of 1/31/12 by the Director of Nursing and/or Unit Managers.</p> <p>4. The Director of Nursing Services, Assistant Director of Nursing Services, and/or Unit Managers will review new orders and 24 Hour reports to identify residents who have a change of condition other reportable event, accident, altered treatment and transfer discharge, dietary recommendations or significant weight loss and determine that physician notification has occurred 5 times weekly for 4 weeks, then weekly for 2 months. A summary will be provided by the Director of Nursing Services to the Performance Improvement Committee monthly for review and further recommendation.</p> | |
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| F 157 | <p>Continued From page 2 every day. Review of Resident #1's admission weight on 11/04/11 revealed a weight of 120.2 pounds.</p> <p>Review of Resident #1's Functional Performance Record Meal Intake, revealed the following:</p> <p>On 11/06/11, the resident refused all meals and drank 240 milliliters (ml's) of fluid.</p> <p>On 11/06/11, the resident refused breakfast and lunch and consumed 25% of supper and drank 360 ml's.</p> <p>On 11/07/11, the resident consumed 75% for breakfast, 50% for lunch and 50% for supper, and drank 720 ml's.</p> <p>On 11/08/11, had no documentation for breakfast or lunch, and the resident refused supper and drank 120 ml's.</p> <p>On 11/09/11, the resident consumed 25% for breakfast, 25% for lunch and 25% for supper and drank 840 ml's.</p> <p>On 11/10/11, the resident refused breakfast, refused lunch and consumed 25% for supper and drank 1580 ml's.</p> <p>On 11/11/11, there was no documentation for breakfast and lunch and the resident refused supper and drank 720 ml's. The resident's weekly weight on 11/11/11 revealed a weight of 113.8 pounds which was a significant weight loss of 5.6% in seven (7) days. (Refer to F-325)</p> <p>Review of the "Nutrition Therapy Assessment",</p> | F 157 | | |

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| F 167 | <p>Continued From page 3</p> <p>dated 11/11/11, revealed the Dietitian's dietary recommendations included House Shakes twice a day and increased fluids provided by dietary. Further review revealed the supplements would provide an extra 480 ml's of fluids per day. The Assessment stated the resident's estimated fluid requirement was 1500 ml's to 1650 ml's per day.</p> <p>Interview with the Dietitian, on 12/20/11 at 3:00 PM, revealed she had five (5) to seven (7) days to see new admissions and she had completed the Nutritional Assessment on 11/11/11. She stated, in reviewing Resident #1's meal intakes she noted the resident was eating so little, she went straight to supplements and also recommended an increase in fluids on the meal trays. Continued interview revealed she placed her dietary recommendations in the Unit Managers mail box on 11/11/11.</p> <p>However, review of the Physician's Orders revealed there was no documented evidence of orders related to the dietary recommendations written on 11/11/11 and no documented evidence the Physician was notified.</p> <p>Interview, on 12/20/11 at 2:30 PM, with the Unit Manager/Licensed Practical Nurse (LPN) #13, revealed the dietary recommendations were to be placed in her mail box by the Dietitian and she was responsible for notifying the Physician of the recommendations. Further interview revealed the 11/11/11 recommendations were made on a Friday and she probably would not have checked her mailbox for the recommendations until Monday, 11/14/11. She indicated a two (2) to three (3) day turn around for notification to the Physician of dietary recommendations was a long</p> | F 167 | | |
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| F 157 | <p>Continued From page 4</p> <p>time and she did not remember ever receiving the 11/11/11 recommendations in her mailbox.</p> <p>Interview, on 12/22/11 at 10:00 AM, with the Director of Nursing (DON) revealed the Dietitian should have communicated the dietary recommendations verbally to nursing on 11/11/11 and the Physician should have been notified of the recommendations the same day.</p> <p>Further review of the Resident Functional Performance Record Meal Intake revealed on 11/12/11, the resident consumed 25% for breakfast and refused lunch and supper. On 11/13/11, the resident refused breakfast, refused lunch and consumed 25% for supper. On 11/14/11, the resident refused breakfast, refused lunch.</p> <p>Continued review of the Physician's orders revealed orders dated 11/07/11 for a Complete Metabolic Panel (CMP). Review of the laboratory values on 11/08/11 revealed abnormal values for Blood Urea Nitrogen (BUN) 82-Critical (normal range 7-29). New orders were obtained 11/08/11 to repeat the CMP on 11/09/11. Review of the CMP drawn 11/09/11 revealed abnormal values for BUN-84 Critical (normal range 7-29), and Creatinine 1.4 High (normal range 0.7-1.3). Further orders were obtained on 11/10/11 for a Basic Metabolic Panel (BMP) on 11/15/11. Review of the BMP on 11/15/11 revealed abnormal laboratory values for BUN-145 Critical (normal range of 7-29), and Creatinine-2.5 High (normal range of 0.7-1.3).</p> <p>Review of Physician's Orders received 11/15/11 revealed orders to transfer the resident to the</p> | F 157 | | |

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| F 157 | <p>Continued From page 5</p> <p>emergency room related to the critical BUN level. Review of the hospital record revealed the resident was admitted to the hospital with diagnoses of Elevated Troponin, Acute Renal Failure, Dehydration, Hypotension, and a Urinary Tract Infection (Refer to F-327).</p> <p>Review of the Hospital Discharge Summary, dated 12/01/11, revealed the resident was dehydrated on admission and was hypotensive (low blood pressure). The resident received intravenous fluids and was transferred to the Intensive Care Unit where he/she received dialysis. Per the Summary the resident was also treated for a Urinary Tract Infection. The discharge diagnoses included Elevated Troponin which was felt due to renal failure, Acute Renal Failure, Dehydration, Coronary Artery Disease, Hypotension, and Urinary Tract Infection.</p> <p>Interview, on 12/20/11 at 2:30 PM and 12/22/11 at 10:00 AM, with Unit Manager/Licensed Practical Nurse (LPN) #13, revealed she only reviewed the meal consumption if she was notified that a resident was not eating or drinking well. Continued interview revealed she had not notified the Physician related to the resident's decreased food and fluid intake until 11/16/11 prior to the resident going to the hospital. There was no documented evidence in the record that she or any nurse had notified the Physician of the low intake prior to 11/16/11.</p> <p>Interview, on 12/20/11 at 3:30 PM, with LPN #14 revealed she had been assigned to Resident #1 a few times after admission and she had encouraged staff to feed him/her due to weakness. However, she stated she was not</p> | F 157 | | |
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| F 157 | <p>Continued From page 6</p> <p>informed Resident #1 was eating/drinking poorly and had not notified the Physician.</p> <p>Interview with Certified Nursing Assistant (CNA) #10, on 12/21/11 at 9:30 PM, revealed Resident #1 did not eat well and had to be fed. She stated he/she ate about 25% for meals and refused snacks; however, would sometimes ask for milk between meals. Further interview revealed she notified the nurses of the poor intake and documented the meal intakes on the record each day.</p> <p>Interview, on 12/22/11 at 9:15 AM, with RN #4, who was assigned to Resident #1 several times from admission until hospitalization on 11/15/11, revealed she was aware the resident was not eating and drinking and had notified the Nurse Practitioner on 11/08/11; however, had not documented this in the medical record. Interview, on 12/21/11 at 3:15 PM, with the Nurse Practitioner revealed she did not remember being notified of Resident #1's decreased food and fluid intake and if she had been notified she would have documented this in her notes.</p> <p>Interview, on 12/20/11 at 5:10 PM and on 12/22/11 at 10:00 AM, with the Director of Nursing (DON) revealed Resident #1 should have been identified to be a nutritional/hydration risk from the meal intakes and observations of the resident during meals. She further stated the Physician should have been made aware of this resident's decreased food and fluid intakes and weight loss.</p> <p>Interview, on 12/21/11 at 12:45 PM, with Resident #1's Physician revealed he did not remember being informed of the resident's decreased food</p> | F 157 | | |
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F 167

Continued From page 7
and fluid intake and if he was informed he would have documented this in the medical record. Further interview revealed he would have written Physician's orders to encourage two (2) to three (3) liters of fluids per day. He stated he had drawn labs for a baseline on 11/07/11 and the lab results on 11/08/11 for the increased BUN could indicate dehydration. Further interview revealed he did not remember being notified of dietary recommendations or of the resident's weight loss prior to the resident being hospitalized on 11/15/11. He further stated for some reason this resident's nutrition and hydration status was not addressed with him or the Nurse Practitioner per record review until 11/15/11 when the resident was transferred to the hospital.

F 167

F 246
SS=D

483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review it was determined the facility failed to ensure one (1) of twenty-seven (27) sampled residents, Resident #6's needs were accommodated related to the call light not being within reach. Observation revealed the call light was lying on the floor, out of the resident's reach.

F 246

- F246
1. The call light for Resident #6 was placed within the reach of the resident by the Certified Nursing Assistant on 12/20/11.
 2. Center rounds to determine if resident call lights were within resident reach was completed on 12/23/11 by the Administrator.
 3. Re-education will be completed for Administrative, Nursing, Housekeeping, Dietary, and Maintenance Staff by 1/24/12 by the Director of Nursing Services and/or Unit Managers. Re-education will include maintaining call lights within reach for residents and that they are appropriately secured to prevent call lights from inadvertently becoming out of a resident's reach.

1/24/12

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| F 246 | <p>Continued From page 8</p> <p>The findings include:</p> <p>Record review revealed Resident #6 was admitted to the facility on 5/10/10 with diagnoses which included Palliative Care, Schizophrenia, Diabetes Mellitus, Major Depressive Disorder, Cardiac Dysrhythmia and Degenerative Disc Disease.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 10/21/11, revealed the facility assessed the resident as having severely impaired cognition, requiring assistance of 2 (two) for bed mobility and requiring total care.</p> <p>Observation, on 12/20/11 at 8:25 AM, revealed Resident #6 was in the bed with the head of the bed elevated. Observation revealed the large touch type pressure button call bell was lying on the floor at the right side of the resident's bed, out of the resident's reach.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #15 and Licensed Practical Nurse (LPN) #2, on 12/20/11 at 10:20 PM, revealed Resident #6 would not be able to reach the call light lying on the floor and the call light should be lying on the resident's bed or lap within the resident's reach.</p> | F 246 | <p>4. Center rounds to determine call light placement within reach of residents will be conducted 3 times weekly by the Administrator, Social Services Director, Assistant Social Services Director, Activity Director, Health Information Management Coordinator, Concierge, Registered Dietician and MDS Coordinators for 4 weeks, then weekly for 2 months. A summary will be provided by the Director of Nursing Services and/or Assistant Director of Nursing Services to the Performance Improvement Committee monthly for review and further recommendation.</p> | |
| F 323 SS-E | <p>483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> | F 323 | | |

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| F 323 | <p>Continued From page 9</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 the environment remains as free of accident hazards as is possible. Observation on initial tour, on 12/28/11 at 3:00 PM, revealed unlocked cabinets in the tub rooms containing toiletries, and razors. There were also razors observed in residents' rooms left at the sink and a pair of bandage scissors left on the bedside table in a resident's room.</p> <p>The findings include:</p> <p>Observation on initial tour, on 12/28/11 at 3:00 PM, revealed the following:</p> <p>Room 208-a razor on the sink.</p> <p>Room 216- bandage scissors on the bedside table.</p> <p>Tub Room on the 100 Hall- unlocked cabinet which contained razors, two (2) bottles of Medline Shampoo with a label that stated; for external use only, avoid contact with eyes, and a bottle of antiperspirant which stated; keep out of the reach of children, if swallowed call poison control.</p> <p>Tub Room on the 300 Hall- unlocked cabinet containing razors, and a bottle of antiperspirant which stated; keep out of the reach of children, if</p> | F 323 | <p>F323</p> <p>1. The razor in room 208 was removed by the Certified Nursing Assistant on 12/18/11. The bandage scissors in room 216 were removed by the Certified Nursing Assistant on 12/18/11. The razors, shampoo, and antiperspirant in the 100 tub room were removed by the Certified Nursing Assistant on 12/18/11. The razors and antiperspirant in the 300 hall tub room were removed by the Certified Nursing Assistant on 12/18/11.</p> <p>2. Center rounds were completed on 12/19/11 by the Director of Nursing Services, MDS Coordinators, Unit Managers, Social Services Director, Activity Director, Customer Care Specialist, and Administrator to determine items that could pose a hazard to residents were secured. Any identified items were addressed. Locked storage bins have been placed in all tub rooms for storage of razors and toiletries to provide an environment as free of accident hazards as possible on 1/18/12 by the Maintenance Director.</p> <p>3. Re-education will be completed for Nursing Staff by 1/24/12 by the Director of Nursing Services and/or Unit Managers to include proper storage of items and to maintain an environment as free of accident hazards as possible</p> | 1/31/12 |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WOODSPOINT DRIVE FLORENCE, KY 41042 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 323 | Continued From page 10 swallowed call poison control. Interview, on 12/18/11 at 5:30 PM, with the Director of Nursing (DON), revealed the nurses should be doing rounds to check for items left in the tub rooms and residents' rooms which could be hazardous and were accessible to residents. She further stated the cabinets in the Tub Rooms were to be kept locked. | F 323 | 4. Center rounds to determine proper storage of items that could pose a hazard to residents are securely stored, and that each resident receives adequate supervision and assistive devices to prevent accidents will be conducted 3 times weekly by the Administrator, Social Services Director, Assistant Social Services Director, Activity Director, Health Information Management Coordinator, Concierge, Registered Dietician and MDS Coordinators for 4 weeks, then weekly for 2 months. A summary will be provided by the Director of Nursing Services and/or Assistant Director of Nursing Services to the Performance Improvement Committee monthly for review and further recommendation. | |
| F 326 SS=G | 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure that a resident maintains acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible for one (1) of twenty-seven (27) sampled residents, (Resident #1). Resident #1 had a significant weight loss of 5.5% from 11/04/11 until 11/11/11. Although the Dietitian was aware of the weight loss and made dietary recommendations on 11/11/11, there was no | F 325 | | |

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| F 325 | <p>Continued From page 11</p> <p>documented evidence the facility acted on the dietary recommendations in an attempt to prevent further weight loss.</p> <p>In addition, there was no documented evidence the facility followed their Nutrition Policy and Clinical at Risk Team Meeting Policy. Although Resident #1 refused most meals from admission on 11/04/11 through 11/15/11, there was no documented evidence staff identified this resident's risk for decline in nutritional status, developed a Plan of Care to promote food and fluid intake, documented the resident's poor food and fluid on the Twenty-four (24) Hour Report, discussed the resident's poor food and fluid intake in the Clinical at Risk Meetings, provided ongoing monitoring of the resident's food consumption, or notified the Physician of the resident's poor food intake and weight loss as per facility policy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Nutrition Management Program" dated 01/08, revealed the interdisciplinary (IDT) team was to identify persons at risk for dehydration and or decline in nutrition status, develop individualized care plans to promote food and fluid intake and weight stabilization, identify new instances of unplanned weight loss, document the change in condition, and evaluate the effectiveness of the interventions. Further review revealed any changes in the clinical condition of a resident was to be recorded on the Twenty-four (24) Hour Report to be distributed to the Dietitian to screen for changes in condition which may affect nutrition or hydration. The Physician and family</p> | F 325 | <p>F325</p> <p>1. Resident #1's was discharged by the attending physician on 12/19/11.</p> <p>2. Reviews of dietary recommendations made within the past 30 days were completed as of 1/13/12 by the Registered Dietician to determine physician notification occurred and interventions implemented as ordered. Review of current residents' weight status will be completed by 1/24/12 by the Registered Dietician to determine nutritional needs are met and individualized care plans are in place. Any identified concerns will be addressed.</p> <p>3. Re-education for Licensed Nurses and Certified Nursing Assistants will be completed by 1/24/12 by the Director of Nursing Services and/or Unit Managers. Education will include the Nutrition Management Program; intake documentation; reporting poor resident intake on the 24-Hour Report and to the Registered Dietician; the center process for dietary recommendations; care plan development regarding significant weight loss; and physician notification. The Registered Dietician was re-educated by the Administrator on 1/5/12 to communicate dietary recommendations involving resident's with significant weight loss, or compromised nutritional status directly to the Licensed Nurse.</p> | 1/31/12 |
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| F 325 | <p>Continued From page 12</p> <p>were to be notified as applicable. Continued review revealed there was to be a weekly Clinical at Risk Evaluation Process (CARE) and the nurse was to conduct ongoing monitoring to validate that resident food consumption was documented accurately.</p> <p>Review of the "Clinical At Risk Team Meeting Policy", dated 01/08, revealed prior to the meetings, residents were to be identified if at risk related to unplanned weight loss and new admissions were to be taken to the meeting weekly for four weeks. Further review revealed the residents' charts, and care plans were to be discussed and a summary of the discussion with interventions was to be documented in the IDT Notes. The licensed nurse was to communicate the findings to the staff.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 11/04/11 with diagnoses which included Dementia, and Diabetes Mellitus. Review of the Interim Plan of Care, dated 11/04/11, revealed there was no Plan of Care related to nutrition. Record review revealed Resident #1's admission weight on 11/04/11 was 120.2 pounds.</p> <p>Review of the Resident Functional Performance Record Meal Intake, revealed the following:</p> <p>On 11/05/11, the resident refused all meals.</p> <p>On 11/06/11, the resident refused breakfast and lunch and consumed 25% of supper.</p> <p>On 11/07/11, the resident consumed 50% for breakfast and 50% for supper.</p> | F 325 | <p>4. The Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers and/or Registered Dietician will review new orders and 24 Hour Report to identify residents with nutritional concerns. The Unit Managers will review the residents' food/fluid intake documentation three times weekly to identify residents at nutritional risk and communicate any concerns to the Registered Dietician. The Unit Managers or designee will include residents identified with significant weight change for review at the weekly Clinical At Risk Evaluation (CARE) meeting to review that appropriate interventions, physician notification and individualized care plans are in place. The Director of Nursing Services, Assistant Director of Nursing Services, and/or Registered Dietician will complete an audit weekly for 4 weeks then monthly for 2 months to determine residents identified with a significant weight change have appropriate interventions, individualized care plans, and dietary recommendations have been addressed. Identified concerns will be addressed and a summary will be presented to the Performance Improvement Committee monthly for further review and recommendations.</p> | |
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| F 325 | <p>Continued From page 13</p> <p>On 11/08/11, the resident had no documentation for breakfast or lunch, and the resident refused supper.</p> <p>On 11/09/11, the resident consumed 25% for breakfast, 25% for lunch and 25% for supper.</p> <p>On 11/10/11, the resident refused breakfast, refused lunch and consumed 25% for supper.</p> <p>On 11/11/11, there was no documentation for breakfast and lunch and the resident refused supper. Review of the weekly weight on 11/11/11 revealed a weight of 113.8 pounds, a weight loss of 8.6 pounds in seven (7) days, which was a significant weight loss of 5.5%. Review of the Nutrition Therapy Assessment, dated 11/11/11, revealed the dietary recommendations included House Shakes twice a day and increased fluids provided by dietary. Review of the Physician's Orders revealed there was no documented evidence of orders related to the dietary recommendations written 11/11/11.</p> <p>Record review revealed no documented evidence of the development of a care plan to address the significant weight loss and no evidence the facility notified the Physician.</p> <p>On 11/12/11, the resident consumed 25% for breakfast and refused lunch and supper.</p> <p>On 11/13/11, the resident refused breakfast, refused lunch and consumed 25% for supper.</p> <p>On 11/14/11, the resident refused breakfast, refused lunch, and consumed 100% for supper.</p> | F 325 | | |
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| F 325 | <p>Continued From page 14</p> <p>On 11/15/11 the resident was transferred to the hospital with diagnoses of Elevated Troponin, Acute Renal Failure, Dehydration, Hypotension, and a Urinary Tract Infection.</p> <p>Interview with Certified Nursing Assistant (CNA) #10, on 12/21/11 at 9:30 PM, revealed the resident did not eat well and had to be fed. She stated Resident #1 ate about 25% and refused snacks a lot but would sometimes ask for milk between meals. She further stated she would notify the nurses of the poor intake and document the meal intakes on the Meal Intake Form.</p> <p>Interview with the Dietitian, on 12/20/11 at 3:00 PM, revealed the aides recorded the meal intakes and she reviewed them when it was time for an initial, quarterly, significant change or yearly MDS Assessment. She stated if there was decreased intake the nurses were to notify her verbally or send a Communication Form which she had not received for this resident. She further stated she had five (5) to seven (7) days to see new admissions and she had completed her Nutritional Assessment on 11/11/11. She stated, when she reviewed the resident's meal intakes, she noted the resident was eating so little she went straight to supplements and recommended an increase in fluids on the trays. She further stated she placed the dietary recommendations in the Unit Manager's mailbox.</p> <p>Interview, on 12/20/11 at 2:30 PM, with the Unit Manager/Licensed Practical Nurse (LPN) #13, revealed there was a two (2) to three (3) day turn around on dietary recommendations. She stated the dietary recommendations were to be placed</p> | F 325 | | |
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| F 325 | <p>Continued From page 15</p> <p>in her mail box by the Dietitian and she was responsible for calling the Physician with the recommendation. Continued interview revealed the 11/11/11 recommendations for Resident #1 were made on a Friday and she probably would not have checked her mailbox for the recommendations until 11/14/11. Continued interview revealed a two (2) to three (3) day turnaround for notification to the Physician of dietary recommendations was a long time and she did not remember ever receiving the 11/11/11 recommendations in her mailbox.</p> <p>Interview, on 12/22/10 at 10:00 AM, with the Director of Nursing (DON) revealed the Dietitian should have communicated the dietary recommendations verbally to nursing the day they were written and the Physician should have been notified of the recommendations also on 11/11/11.</p> <p>Further review revealed there was no documented evidence the facility had taken action on the Dietitian's recommendation on 11/11/11 when she identified the resident's significant weight loss. Additionally, there was no evidence of the development of a care plan related to weight loss.</p> <p>Interview, on 12/20/11 at 2:30 PM and 12/22/11 at 10:00 AM, with Unit Manager/LPN #13, revealed it would have been the staff nurses' responsibility to initiate the nutrition care plan during an acute situation such as this when the resident was not eating well. She stated she was unaware of the Hydration/Nutrition Policy and only reviewed the meal consumption if a Certified Nursing Assistant (CNA) notified her a resident was not eating or drinking well. She further stated as far as she</p> | F 325 | | |
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| F 325 | <p>Continued From page 16</p> <p>knew, it was the Diptilian's responsibility to review the meal intakes. Continued interview revealed she had notified the Physician related to the residents decreased food and fluid intake on 11/15/11, prior to the resident going to the hospital; however, could find no documentation in the record where she or any nurse had notified the Physician of the low intake prior to 11/15/11.</p> <p>Interview, on 12/20/11 at 3:30 PM, with LPN #14 revealed she had been assigned to the resident a few times after admission and she had encouraged staff to feed him/her due to weakness. She stated she was unaware the resident was eating/drinking poorly prior to hospitalization on 11/15/11.</p> <p>Interview, on 12/21/11 at 8:50 PM, with Registered Nurse (RN) #8 revealed she had taken care of Resident #1 a few times on the night shift from 7:00 PM until 7:00 AM on 11/04/11 through 11/15/11; however, she was never notified of the resident losing weight and did not receive information in report related to the resident not eating and drinking. She stated the evening/night shift nurses did not review meal consumption for the residents and did not review fluid intake unless they were on strict Intake and Output.</p> <p>Interview, on 12/22/11 at 9:15 AM, with RN #4 who worked the day shift, revealed the nurses were to chart on the residents every shift for seventy-two (72) hours for new admissions. She stated she was assigned to Resident #1 several times from admission until hospitalization on 11/15/11. She further stated she was aware the resident was not eating and drinking and notified</p> | F 325 | | | |

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| F 325 | <p>Continued From page 17</p> <p>the Nurse Practitioner on 11/08/11; however, did not document this in the medical record. Interview, on 12/21/11 at 3:15 PM, with the Nurse Practitioner revealed she did not remember being notified of the resident's decreased intake and stated if she had been notified she would have documented this in her notes. Continued interview revealed she did not think she was aware of the resident's poor food/fluid intake prior to that date, even though she was assessing and documenting on the resident in the medical record during the initial seventy-two (72) hour period. She stated she should have inquired about the resident's meal consumption while doing the required seventy-two (72) hour charting after admission. Continued interview revealed the nurses did not review the meal consumption's for the residents routinely. However, she stated she did document the resident's low intake on the 24 Hour Report.</p> <p>Interview, on 12/20/11 at 5:10 PM and on 12/22/11 at 10:00 AM, with the Director of Nursing (DON), revealed Resident #1 should have been identified at nutritional risk from the meal intakes and observation of the resident at meal times. She further stated a Plan of Care should have been implemented to address this resident's nutritional status and the Physician should have been made aware of this resident's decreased intakes and weight loss. Continued interview revealed the nurses were to chart on residents every shift for seventy-two hours (72) after admission and should be talking to the CNA's for information related to the residents' nutritional status while doing the assessment and documentation. Continued interview revealed the nurses were to document in the Nurses Notes</p> | F 325 | | |
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| F 325 | <p>Continued From page 18</p> <p>and on the 24 Hour Report if a resident was not eating and drinking well. Review of the 24 Hour Report revealed the resident was on the report when a new Physician's Order was written; however, there was no documentation related to the poor food/fluid intake. Further interview revealed new admission charts and care plans were to be brought to the morning meeting every day for 72 hours and the Nurses Notes were reviewed as well as the Resident Functional Performance Record which included the meal intake sheets. She stated this resident's decreased intake may not have been discussed because there was no documentation in the Nurses Notes to alert the IDT of the decreased food and fluid intake.</p> <p>Continued interview, revealed any resident with weight loss was to be discussed in the weekly CARE Meeting and interventions were to be initiated and implemented to assist in preventing weight loss. Review of the CARE Meeting minutes from 11/10/11 revealed the resident's labs and Physician's Orders were discussed, a note was written that the Physician was aware of poor intake; however, there was no documented evidence the resident's poor intake was evaluated for interventions to assist with nutrition. She stated, she was unaware until this survey that there was nobody responsible for routine monitoring of the residents' meal consumption records and there was no effective system in place to ensure staff was following the Nutrition Policy.</p> <p>Interview, on 12/21/11 at 12:46 PM, with Resident #1's Physician revealed he did not recall being informed of the resident's decreased food intake</p> | F 325 | | |

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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042 |
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| F 325 F 327 SS=G | <p>Continued From page 19</p> <p>and if he had been notified he would have documented this in his Physician's Progress Notes. Further interview revealed he did not remember being notified of dietary recommendations or of the resident's weight loss prior to the resident being hospitalized on 11/15/11. He stated, for some reason this resident's nutrition status was not addressed with him or the Nurse Practitioner per record review.</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review it was determined the facility failed to ensure each resident was provided with sufficient fluid intake to maintain proper hydration and health for one (1) of twenty-seven (27) sampled residents (Resident #1). Resident #1 had poor fluid intake from admission on 11/04/11; however, there was no documented evidence the facility implemented their "Hydration Policy" or "Clinical at Risk Team Meeting Policy". Although the resident had risk factors for dehydration including abnormal labs, weight loss, poor fluid intake, and the use of diuretics, there was no documented evidence this resident was identified at risk for dehydration and no documented evidence a Plan of Care was initiated to promote fluid intake. In addition, there was no documented evidence staff provided ongoing monitoring of the resident's fluid intake or notified the Physician of the resident's poor fluid</p> | F 325 F 327 | <p>F327</p> <ol style="list-style-type: none"> 1. Resident #1 was discharged by the attending physician on 12/19/11. 2. An audit will be completed by 1/22/12 by the Registered Dietician for current residents to determine their hydration status, a care plan is initiated as necessary, the need for monitoring of fluid intake and physician notification as necessary. Any identified concerns will be addressed. 3. Re-education for Licensed Nurses and certified nursing assistants will be completed by 1/24/12 by the Director of Nursing Services and/or Unit Managers. Education will include the Hydration Policy; intake documentation; reporting poor resident intake on the 24Hour Report and to the Registered Dietician; a care plan is initiated as necessary; the need for | 1/25/12 |

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| F 327 | <p>Continued From page 20</p> <p>intake. On 11/15/11 the facility transferred Resident #1 to the hospital where he/she was admitted to the hospital with diagnoses of Elevated Troponin, Acute Renal Failure, Dehydration, Hypotension, and a Urinary Tract Infection.</p> <p>The findings include:</p> <p>Review of the facility "Hydration Policy" dated 01/08, revealed the Dietician was to determine the residents daily fluid needs and was to document this on the medical Nutrition Therapy Assessment. The interdisciplinary team (IDT) would review residents who had the following conditions as defined as risk factors for dehydration; weight loss, abnormal lab values, dependence on staff for the provision of fluids, limited fluid intake, use of diuretics, and residents who did not meet their estimated fluid need for three consecutive days and were evidencing fluid depletion. Further review revealed the Registered Nurse (RN) was to assess the need for Intake and Output (I & O) monitoring. If the resident was identified for monitoring of I & O, the nurse ensured that intake and output of fluids were documented on the Total I & O Record. The 11-7 nurse was to tally the twenty-four (24) hour Intake of fluids on the I & O Record and evaluate variances. The Policy stated, the nurse was to notify the Physician upon identification of resident hydration concerns, document this notification in the Interdisciplinary Progress Notes and initiate an appropriate care plan.</p> <p>Review of the "Clinical At Risk Team Meeting Policy", dated 01/08, revealed newly admitted residents were discussed and reviewed for</p> | F 327 | <p>monitoring of fluid intake; and physician notification as necessary; and the center process for dietary recommendations. The Registered Dietician was re-educated by the Administrator on 1/5/12 to communicate dietary recommendations regarding resident's with compromised hydration status directly to the Licensed Nurse.</p> <p>4. The Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers and/or the Registered Dietician will review new orders and 24 Hour reports to identify residents with hydration concerns and/or risk factors. The Unit Managers will review residents' food/fluid intake documentation three times weekly to identify residents at hydration risk and communicate any concerns to the Registered Dietician. The Unit Managers/designee will include residents identified with hydration risk factors and/or decreased fluid intake on the roster for the weekly Clinical At Risk Evaluation (CARE) meeting to review, physician notification and appropriate interventions and care plans are in place. The Director of Nursing Services, Assistant Director of Nursing Services, and/or Registered Dietician will complete an audit weekly for 4 weeks then monthly for 2 months to determine residents identified with a hydration concerns have appropriate interventions, individualized care plans, and dietary recommendations have been addressed. Identified concerns will be addressed and a summary will be presented to the Performance Improvement Committee monthly for further review and recommendations.</p> | |

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| F 327 | <p>Continued From page 21</p> <p>identified risks and potential risks weekly for four weeks. Further review revealed the residents charts, and care plans were to be reviewed and a summary of the discussion with interventions was to be documented in the IDT Notes. Also, the licensed nurse was to communicate the findings to the staff.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 11/04/11 with diagnoses which included Dementia, and Diabetes Mellitus. Review of the Physician's Orders on admission, dated 11/04/11, revealed orders for Lasix 20 milligrams (diuretic medication) every day. Review of the Interim Plan of Care, dated 11/04/11, revealed there was no Plan of Care related to the risk of dehydration, and there was no documented evidence of a Plan of Care related to hydration prior to the residents hospitalization 11/15/11.</p> <p>Review of the Resident Functional Performance Record Meal Intake, revealed the following:</p> <p>On 11/05/11, the resident consumed 240 milliliters (ml's) of fluids.</p> <p>On 11/06/11, the resident consumed 720 ml's of fluids.</p> <p>On 11/07/11, the resident consumed 720 ml's of fluids. Review of the Physician's orders revealed an order on 11/07/11 for a Completed Metabolic Panel (CMP). Review of the laboratory values on 11/08/11 revealed abnormal values for Chloride -97 Low-(normal range 98-108), Blood Urea Nitrogen (BUN) 82-Critical (normal range 7-29). New orders were received 11/08/11 to repeat the</p> | F 327 | | |

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| F 327 | <p>Continued From page 22 CMP on 11/09/11.</p> <p>On 11/08/11, the resident consumed 120 ml's of fluids.</p> <p>On 11/09/11, the resident consumed 840 ml's of fluids. Review of the CMP drawn 11/09/11 revealed abnormal values for BUN-84 Critical (normal range 7-29), and Creatinine 1.4 High (normal range 0.7-1.3).</p> <p>On 11/10/11, the resident consumed 1560 ml's of fluids. Orders were obtained on 11/10/11 for a Basic Metabolic Panel (BMP) on 11/15/11.</p> <p>On 11/11/11 the resident consumed 720 ml's of fluids.</p> <p>Review of the Nutritional Therapy Assessment, dated 11/11/11, completed by the Dietician, revealed the residents estimated fluid requirement was 1500 ml's to 1650 ml's per day. Further review of the meal consumption record revealed the resident did not meet the estimated fluid requirement for five (5) consecutive days from 11/8/11 through 11/09/11. Further review revealed the dietary recommendations included House Shakes twice a day and increased fluids provided by dietary. Further review revealed the supplements would provide an extra 480 ml's of fluids per day. However, review of the Physician's Orders revealed there was no documented evidence of orders related to the dietary recommendations written on 11/11/11.</p> <p>Review of the BMP on 11/15/11 revealed abnormal laboratory values for BUN-145 Critical (normal range of 7-29), and Creatinine-2.5 High</p> | F 327 | | |

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| F 327 | <p>Continued From page 23 (normal range of 0.7-1.3).</p> <p>Review of Physician's Orders received 11/15/11 revealed orders to send the resident to the emergency room related to the critical BUN level.</p> <p>Review of the Hospital Discharge Summary, dated 12/13/11, revealed the resident was dehydrated on admission and was hypotensive (low blood pressure). The resident received intravenous fluids and was transferred to the Intensive Care Unit where he/she received dialysis. Per the Summary the resident was also treated for a Urinary Tract Infection. The discharge diagnoses included Elevated Troponin which was felt due to renal failure, Acute Renal Failure, Dehydration, Coronary Artery Disease, Hypotension, and Urinary Tract Infection.</p> <p>Interview with CNA #10, on 12/21/11 at 9:30 PM, revealed Resident #1 did not eat well and had to be fed. She stated Resident #1 ate about 25% and refused snacks frequently. She indicated she would notify the nurses of the poor food and fluid intake.</p> <p>Review of the medical record revealed there was no documented evidence the facility had identified this resident's risk for dehydration and implemented a Plan of Care in an attempt to promote fluid intake even though the resident did not meet his/her fluid requirement from 11/05/11 through 11/09/11, had abnormal labs, had weight loss, and was receiving a diuretic.</p> <p>Interview, on 12/20/11 at 2:30 PM and on 12/22/11 at 10:00 AM, with Unit Manager/Licensed Practical Nurse (LPN) #13,</p> | F 327 | | | |

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| F 327 | <p>Continued From page 24</p> <p>revealed it would have been the staff nurses' responsibility to initiate the nutrition/hydration care plan during an acute situation such as this when the resident was having poor fluid intake. She further stated the admitting nurse should look at risk factors for the resident and Resident #1 was at risk for dehydration related to his/her diagnosis of Dementia. Continued interview revealed she was unaware of the Hydration/Nutrition Policy and did not routinely review meal and fluid consumption. She further stated, she had notified the Physician related to the residents decreased food and fluid intake; however, could find no documentation in the chart where she or any nurse had notified the physician of the poor fluid intake prior to 11/15/11. Continued interview revealed the resident should have been placed on Intake and Output monitoring to ensure the total fluid intake was monitored daily by the night shift nurses.</p> <p>Interview with LPN #14, on 12/20/11 at 3:30 PM, revealed she had been assigned to the resident a few times after admission and she had encouraged staff to feed him/her due to weakness. She further stated she was unaware the resident was eating/drinking poorly prior to hospitalization on 11/15/11.</p> <p>Interview with Registered Nurse (RN) #6, on 12/21/11 at 8:50 PM, revealed she was assigned to the resident a few times on the night shift from 7:00 PM until 7:00 AM on 11/04/11 through 11/15/11; however, she did not receive information in report related to the resident not eating and drinking. She further stated the evening/night shift nurses did not review meal and fluid consumption for the residents and did</p> | F 327 | | |
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| F 327 | <p>Continued From page 25</p> <p>not review fluid intake unless they were on strict Intake and Output.</p> <p>Interview with RN #4, on 12/22/11 at 9:15 AM, revealed she worked the day shift and was assigned to the resident several times from admission until hospitalization 11/15/11. She stated the nurses were to chart on the residents every shift for seventy-two (72) hours for new admissions. Continued interview revealed she was aware the resident was not eating and drinking and notified the Nurse Practitioner on 11/08/11, however, had failed to document this in the medical record. Interview, on 12/21/11 at 3:15 PM, with the Nurse Practitioner revealed she did not remember being notified of the resident's decreased food and fluid intake and stated if she had been notified she would have documented this in her notes. Further interview revealed she did not think she was aware of the resident's poor food/fluid intake prior to 11/08/11, even though she was assessing and documenting on the resident in the medical record. RN #4 stated, she should have inquired about the resident's meal consumption while doing the required seventy-two (72) hour charting on admission. Further interview revealed the nurses did not review the meal and fluid consumption routinely.</p> <p>Interview, on 12/20/11 at 5:10 PM and on 12/22/11 at 10:00 AM, with the Director of Nursing (DON), revealed Resident #1 should have been identified to be at risk for dehydration from the meal intakes and observation of the resident during meals and a Plan of Care should have been implemented to address the resident's risk for dehydration. She further stated if a resident did not meet their estimated fluid requirement, a</p> | F 327 | | |
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| F 327 | <p>Continued From page 26</p> <p>clinical reason should be identified and the resident should have been placed on Intake and Output to ensure the fluid intake was monitored. Continued interview revealed the Physician should have been notified of Resident #1's decreased intakes. She stated, the nurses were to chart on residents every shift for seventy-two hours (72) after admission in the Nurses Notes and should include information related to the resident's fluid consumption if the resident was drinking poorly. She further stated, if a resident was not drinking well, this should be documented on the Twenty-four (24) Hour Report which was taken to the morning meetings. Review of the 24 Hour Report revealed no documentation related to the resident's poor fluid intake.</p> <p>Continued interview revealed new admissions charts and care plans were to be brought to the morning meeting every day for 72 hours and the Nursing Notes were reviewed, as well as the Resident Functional Performance Record, which included the food and fluid consumption by the interdisciplinary team (IDT). She indicated this resident's decreased intake may not have been discussed because there was no documentation in the Nurses Notes to alert the IDT of the decreased food and fluid intake.</p> <p>Further interview revealed residents with poor fluid intake were to be discussed in the weekly CARE Meeting and interventions were to be initiated and implemented to assist in preventing dehydration. Review of the CARE Meeting minutes for 11/10/11 revealed the resident's labs and Physician's Orders were discussed; however, there was no documented evidence the resident's fluid intake was evaluated. Continued interview</p> | F 327 | | |
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| F 327 | <p>Continued From page 27</p> <p>revealed she was unaware until this survey that there was nobody responsible for routine monitoring of the residents' meal consumption records for fluid intake and there was no effective system in place to ensure staff were following the Hydration Policy.</p> <p>Interview, on 12/20/11 at 3:00 PM, with the Dietitian revealed she reviewed meal intakes for fluid consumption for an initial, quarterly, significant change or yearly MDS Assessment. She stated if there was poor food or fluid intake the nurses were to notify her verbally or send a Communication Form; however, she had not received communication from nursing related to this residents poor intake prior to her Nutritional Assessment which she completed on 11/11/11. She stated, when she reviewed the resident's meal intakes prior to the assessment, she recommended an increase in fluids on the trays. She stated she left the recommendation in the mailbox for the Unit Manager.</p> <p>Interview, on 12/20/11 at 2:30 PM, with the Unit Manager/Licensed Practical Nurse (LPN) #13, revealed she did not remember ever receiving the 11/11/11 recommendations in her mailbox.</p> <p>Interview, on 12/22/10 at 10:00 AM, with the Director of Nursing (DON), revealed the Dietitian should have communicated the dietary recommendations verbally to nursing the day they were written and the Physician should have been notified of the recommendations on 11/11/11. (Refer to F-157).</p> <p>Interview, on 12/21/11 at 12:45 PM, with Resident #1's Physician revealed he did not remember</p> | F 327 | | |
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| F 327 | Continued From page 28 being informed of the resident's decreased fluid intake and if he had been notified he would have documented this in the medical record. Continued interview revealed he would have written Physician's Orders to encourage two (2) to three (3) liters of fluids per day. He further stated he had drawn labs for a baseline on 11/07/11 and the lab results on 11/08/11 for the increased BUN could indicate dehydration. Further interview revealed he did not remember being notified of dietary recommendations prior to the resident being hospitalized on 11/15/11. He stated for some reason this resident's hydration status was not addressed with him or the Nurse Practitioner per record review until 11/15/11 when the resident was transferred to the hospital. | F 327 | | |
| F 371 88-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 and interview, it was determined the facility failed to ensure food was prepared and distributed under sanitary conditions. Observation during initial tour revealed serving utensils were stored in a disorderly fashion. Observaton during the dining | F 371 | F371 1. The scoops and ladles were removed from the drawer, re-washed, the drawer cleaned, and the scoops and ladles restocked in an organized fashion by the Nutritional Services Director on 12/19/11. Hair nets for dietary staff were repositioned to completely cover hair on 12/22/11. 2. The center recognizes residents benefit from proper sanitary conditions in the kitchen. 3. The Nutritional Services Director was re-educated by the Administrator on 12/23/11 regarding the correct use of hair nets. Dietary staff were re-educated on 12/30/11 by the Nutritional Services Director on proper storage of utensils in drawers and the proper wearing of a hairnet 4. The Administrator, Registered Dietician, and/or Nutritional Services Director will conduct kitchen sanitation audits 2 times weekly for 4 weeks, then 1 time monthly for 2 months. A summary of findings will be presented to the Performance Improvement Committee monthly for review and further recommendations. | 1/31/12 |

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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY, 41042 |
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| F 371 | <p>Continued From page 29</p> <p>service revealed six (6) of seven (7) dietary staff not wearing hairnets in an effective way to prevent contamination, and wet serving bowls were used during the 12/19/11 lunch meal service.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation, on 12/18/11 at 3:10 PM, revealed scoops and ladles stored in a drawer in a disorderly fashion. Handles were not facing a uniform direction, and were mixed among the serving side of utensils. <p>An interview with the Dietary Services Manager, on 12/19/11 at 11:00 AM, revealed scoops and ladles should be stored in such a way that the handles are readily accessible to prevent infection control concerns.</p> <ol style="list-style-type: none"> 2. Observation, on 12/19/11 at 11:10 AM, revealed six (6) of seven (7) dietary staff to be wearing hair nets that did not completely cover their hair. Cook #1 was observed to have hair that stuck out the back and sides of her hair net. Dietary Aide (DA) #1 was observed to have loose hair sticking out the front of her hair net. DA #2 and DA #5 were observed to have hair sticking out the front, back, and sides of their hair nets. DA #3 was observed to have hair sticking out the front and sides of her hair net. An unidentified male dietary aide was observed to have hair sticking out the sides of his hair net, as well as a mustache and beard that were not covered. <p>An interview with the Dietary Services Manager (DSM), on 12/20/11 at 8:30 AM, revealed there was some confusion regarding the regulation,</p> | F 371 | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 12/22/2011 |
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| F 371 F 441 SS=F | <p>Continued From page 30 with the DSM under the impression that hair that was short or neat need not be completely obscured by a hair net.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and</p> | F 371 F 441 | <p>F441 1. Indwelling catheter care was completed for resident #5 using proper infection control technique on 12/19/11 by the Certified Nursing Assistant. The treatment was completed for resident #12 using proper infection control technique on 12/20/11 by the Licensed Nurse. Indwelling catheter care was completed for resident #9 using proper infection control techniques on 12/20/11 by the Certified Nursing Assistant. Tube feed graduates and piston syringes from rooms 201A, 210B, 219, and 315 were replaced, labeled, dated, and stored appropriately on 12/18/11 by the Licensed Nurse. The Identified urinals, urine graduates, and bed pans from rooms 203, 208A, 210B, 214, and 218 were replaced, labeled and stored appropriately on 12/18/11 by the Certified Nursing Assistant. The tube feeding formula and the tubing were replaced for resident #9 on 12/18/11 by the licensed nurse. Meal trays were removed from room 116A on 12/18/11 by the Certified Nursing Assistant. The 100 soiled utility closet was locked on 12/18/11 by the Certified Nursing Assistant. The soiled rags were removed from the 300 shower room on 12/18/11 by the Certified Nursing Assistant. The soiled wash cloth was removed from the bathroom of room 305 and the back of the toilet cleaned on 12/18/11 by the Certified Nursing Assistant.</p> <p>2. Center rounds were completed on 12/19/11 by the Administrator and Director of Nursing Services to identify any other Infection Control concerns. Any identified concerns were addressed.</p> <p>3. Re-education for Nursing Staff will be</p> | 1/31/12 |

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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042 | |
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| F 441 | <p>Continued From page 31</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to ensure infection control policies were implemented and followed by staff.</p> <p>Observation on initial tour revealed tube feeding graduates and syringes which were outdated or undated, urine graduates which were unlabeled, urinals on the floor, bed pans on the floor, soiled wash cloths on the bathroom floors and on the backs of toilets, an unlocked dirty utility room containing biohazard bags, tube feeding hanging and dripping due to no end cap, and old meal trays left in a residents' rooms.</p> <p>Further observation revealed improper infection control technique related to glove usage and hand hygiene following indwelling catheter care for Resident #5; improper infection control related to glove usage and hand hygiene during a treatment for Resident #12; and improper infection control technique with indwelling catheter care for Resident #9.</p> <p>The findings include:</p> | F 441 | <p>completed by 1/31/12 by the Director of Nursing Services and/or Unit Manager. Education will include the facility's Infection Control Program; guidelines to prevent the development and transmission of infections; pericare/indwelling catheter care; dating, labeling and proper storage of resident care supplies; hand washing and glove usage, and education that meal trays are not left in resident rooms.</p> <p>4. Infection Control Surveillance rounds will be completed weekly by the Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, and/or Nursing Supervisors for 4 weeks, then monthly for 2 months. The Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, and/or Nursing Supervisors will complete random observations, of no meal trays left in rooms, pericare and/or indwelling catheter care skills with nursing staff weekly for 4 weeks, then 3 times monthly for 2 months. The Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, and/or Nursing Supervisors will complete random treatment observations with licensed nurses weekly for 4 weeks, then 2 times monthly for 2 months. A summary of findings will be presented at monthly P1 meeting for review and further recommendations.</p> | |

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| F 441 | <p>Continued From page 32</p> <p>1. Review of the "Lippincott Manual of Nursing Practice, Eighth Edition, 2008, revealed tube feeding equipment (graduated containers and catheter tipped syringe) should be rinsed with warm water, and left to dry. Further review revealed it should be replaced every twenty-four (24) hours or per facility policy in order to limit bacterial contamination.</p> <p>Observation of initial tour, on 12/18/11 at 3:00 PM, revealed the following:</p> <p>Room 201 A had a tube feeding graduate dated 11/28/11, Room 210 B had a tube feeding graduate, and syringe unlabeled and undated, Room 219 had a tube feeding graduate dated 10/12/11, and Room 315 A had a tube feeding graduate and syringe unlabeled and undated.</p> <p>Interview and rounds with the Director of Nursing (DON), on 12/18/11 at 5:30 PM, revealed the night shift was to change the tube feeding graduates and syringes every twenty-four (24) hours and the facility used the "Lippincott Manual of Nursing Practice" as a reference related to tube feedings.</p> <p>2. Further observation on initial tour, on 12/18/11 at 3:00 PM, revealed the following:</p> <p>The soiled utility closet on the 100 Hall was left unlocked which contained two (2) biohazard bags and two (2) soiled linen carts accessible to residents.</p> <p>Room 116 A was noted to have a breakfast tray on the chair beside the resident and a lunch tray</p> | F 441 | | |
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| F 441 | <p>Continued From page 33 on the bedside table beside the resident.</p> <p>The Shower Room on the 300 Hall was noted to have soiled rags in the floor.</p> <p>Room 305 bathroom was noted to have a soiled wash cloth containing a brown substance on the back of the toilet.</p> <p>Room 203 was noted to have a urine graduate in the bathroom which was unlabeled.</p> <p>Room 208 A was noted to have a urinal on the floor.</p> <p>Room 210 B was noted to have a bed pan on the floor under the bed which was not bagged.</p> <p>Room 214 bathroom was noted to have a urine graduate which was unlabeled.</p> <p>Room 218 bathroom was noted to have a urine graduate which was unlabeled.</p> <p>Further interview and rounds with the DON, on 12/18/11 at 5:30 PM, revealed the urine graduates and urinals should be labeled, and the bedpans should be labeled and bagged. She further stated the soiled utility room should be kept locked to ensure it was not accessible to residents. Continued interview revealed the meal trays should be picked up promptly when the residents were finished eating. She stated the wash cloths should not be left in the bathroom floors or on the backs of toilets due to infection control reasons.</p> <p>3. Review of the facility's Policy and Procedures</p> | F 441 | | |
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| F 441 | <p>Continued From page 34</p> <p>for Hand Washing, dated 07/1/08, policy # 12.2, revealed hand washing would be performed by staff before and after giving personal care to patients and/or self.</p> <p>Observation, on 12/19/11 at 10:30 AM, of indwelling catheter care for Resident #5 revealed Certified Nursing Assistant (CNA) #16, completed the catheter care, removed the soiled gloves and opened a cabinet door to obtain a brief. She then donned new gloves, applied the brief, removed Nitrashield Cream from her pocket and applied the Cream to the resident's buttocks. Further observation, revealed she placed the Cream back in her pocket, pulled up the resident's covers, and picked up the bed remote to raise the head of the bed prior to removing the soiled gloves and washing her hands.</p> <p>Interview with CNA #16, on 12/19/11 at 10:45 AM, revealed she should have removed the soiled gloves and washed her hands after completing the catheter care and prior to opening the cabinet to obtain a brief. She further stated she should have removed her soiled gloves after applying the Cream to the resident's buttocks and washed her hands before placing the Cream in her pocket. She acknowledged she had contaminated objects in the room by failing to wash her hands after removing the soiled gloves and by pulling up the resident's covers and handling the bed remote with the soiled gloves.</p> <p>4. Observation of a skin assessment for Resident #12, on 12/20/11 at 2:50 PM, revealed the resident was red under the bilateral breast. Licensed Practical Nurse (LPN) #3, explained the rash was due to a yeast infection. The LPN proceeded to clean the rash area to remove older</p> | F 441 | | | |

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| F 441 | <p>Continued From page 35</p> <p>medicated powders. After cleaning the rash area the LPN applied fresh medicated powder to the area. The LPN did not change her gloves or wash her hands after removing the old medicated powder.</p> <p>Interview, on 12/22/11 at 2:56 PM, with LPN #3 revealed she did not change her gloves after cleaning the old powder of the resident's rash area. The LPN stated she should have changed her gloves and washed her hands prior to applying the new medicated powder to the resident's rash.</p> <p>Interview, on 12/22/11 at 4:00 PM, with the Infection Control Nurse revealed staff should have changed gloves and washed hands after cleaning old medications from the resident's rash and before applying new medications to the area.</p> <p>5. Review of the facility's Policy and Procedures titled "Peri Care/Incontinence Care", dated 03/10, revealed with all procedures staff were to wash hands, put on gloves, maintain privacy, and follow standard precautions. Further review of the policy, revealed male residents peri care was to start at the tip of the penis, cleansing using a circular motion from the meatus outward, using a clean wash cloth before providing catheter care as well as cleansing the scrotum area.</p> <p>Observation, on 12/20/11 at 9:10 AM, revealed Certified Nursing Assistant (CNA) #3, entered Resident #9's room and immediately donned gloves without washing hands, and began perineal care. The CNA was observed to cleanse groin, to scrotum, to penis, then to catheter. CNA #3 failed to change cloths between groin, scrotum to penis and catheter care as per facility policy.</p> | F 441 | | | |

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| F 441 | <p>Continued From page 36</p> <p>Interview with CNA#3, on 12/20/11 at 9:20 AM, revealed she had washed her hands while providing care in another resident's room prior to providing care for Resident #9. Additionally, CNA #3, stated that the order of performing perineal care, was to start at the groin and work your way up and then perform catheter care.</p> <p>Interview, on 12/20/11 at 9:30 AM, with Licensed Practical Nurse (LPN) #3/Unit Manager, revealed hand washing was to be performed when entering or exiting a residents room, before and after donning gloves, and anytime direct care was performed. Additionally LPN #3 revealed the order of perineal care/catheter care was to clean the scrotum area then the penis, then the catheter using a clean wash cloth between areas.</p> <p>6. Review of the "Lippincott Manual of Nursing Practice, Eighth Edition, 2008, revealed after intermittent feeding is completed, cover end of feeding tube with plug or clamp to prevent leakage.</p> <p>Observation during initial tour, on 12/18/11 at 4:15 PM, revealed Resident #9 had a full container of tubing feeding hanging on an intravenous (IV) pole with the tubing draped over the IV pole and fluid dripping from tip. There was no cap covering the end of the tubing. The container was dated 12/18/11 14:25.</p> <p>During an interview with Licensed Practical Nurse (LPN) # 4, on 12/18/11 at 4:45 PM, she stated the tubing should not have been hung yet as the tube feeding was not due to be administered until 7:00 PM. She further stated there should have been</p> | F 441 | | |

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| F 441 | Continued From page 37 an end cap covering the end of the tubing so that it did not drip when it was not connected to the resident. | F 441 | | |

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| F 000 | <p>INITIAL COMMENTS</p> <p>A Recertification Survey was conducted 12/18/11 through 12/22/11. Deficiencies were cited with the highest Scope and Severity of a "G".</p> <p>A Revisit Survey was conducted 02/22/12 through 02/25/12. The facility was found to be in compliance with deficiencies cited during the 12/22/11 Standard Survey. However, 42 CFR 483.75, F-502 was cited at a scope and severity of a "D".</p> <p>AMENDED Statement of Deficiency (SOD) issued 03/08/12. 483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to ensure laboratory services were obtained to meet the needs of its residents for one (1) of fourteen (14) sampled residents (Resident #32). The facility received a Physician's Order for a Basic Metabolic Panel (BMP) to be obtained for Resident #32 on 02/06/12; however, there was no documented evidence the lab was drawn. In addition, the facility's system to ensure a lab was not missed failed to identify the missed lab.</p> <p>The findings include:</p> | F 000 | <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, BridgePoint Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F502</p> <p>1. The physician and family of resident #32 were notified on 2/23/12 that the lab ordered for 2/6/12 was not obtained. The physician for resident #32 ordered the lab be obtained and it was drawn on 2/23/12 by the contract phlebotomist. The results were reported to the family and physician. No new orders were given by the physician specific to the lab results. RN #4 was re-educated on center process of obtaining labs, including entering lab orders into Point Click Care, completing the Lab Requisition Form and placing it into the corresponding date in the file box, and placing the lab request in the Lab</p> | 2/27/12 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John Quattrone</i> | TITLE <i>Administrator</i> | (X8) DATE 3/15/12 |
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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 502 | <p>Continued From page 1</p> <p>A Policy and Procedure related to the laboratory process was requested; however, not provided.</p> <p>Interview, on 02/23/12 at 11:15 AM, with the Director of Nursing (DON), revealed when a Physician's Order was received for a lab, the nurse was to complete a Lab Requisition Form and place it in the file box under the date of the month the lab was to be drawn. She further stated the lab was also to be logged in on the Lab Tracker Book which was kept at the nurses station and brought to the morning meeting each morning Monday through Friday to verify the labs were collected as ordered.</p> <p>Review of Resident #32's medical record revealed diagnosis which included Dementia and Chronic Kidney Disease.</p> <p>Review of the Basic Metabolic Panel (BMP), collected on 02/01/12, revealed abnormal values including Potassium 6.0 High (reference range 3.5-5.0), Total Carbon Dioxide (CO2) 32 High (reference range 2-31), Glucose 184 High (reference range 70-100), Blood Urea Nitrogen 35 High (reference range 7-29), and Creatinine 1.4 High (reference range 0.6-1.0).</p> <p>Review of the Physician's Orders, received on 02/01/12, revealed an order to administer Kayexalate (Sodium Polystyrene Sulfonate) (medication which removes potassium by exchanging sodium ions for potassium ions in the intestine) fifteen (15) grams powder by mouth at this time 12:00 PM for Hyperkalemia (greater than normal amounts of potassium in the blood). The Physician's Orders also ordered to recheck the BMP in the AM on 02/02/12. Review of the</p> | F 502 | <p>Tracker Book on 2/23/12 by the Assistant Director of Nursing.</p> <p>2. The Director of Nursing, Assistant Director of Nursing, and Unit Managers reviewed current resident physician orders on 2/23/12 to determine labs had been obtained per physician orders. Additionally, the Director of Nursing contacted the lab provider on 2/23/12 and requested a summary of lab requests since 2/1/12. An audit was completed on 2/23/12 by the Director of Nursing, Assistant Director of Nursing and Unit Managers to reconcile physician lab orders of current residents and the summary report provided by the lab to determine there were no identified omitted labs.</p> <p>3. A lab tracking calendar has been implemented in the Clinical Stand Up Meeting to allow the Director of Nursing to track future lab orders and completion of the labs drawn as ordered.</p> <p>Licensed nurses were re-educated by the Assistant Director of Nursing as of 2/26/12 regarding obtaining labs as ordered, including the center process of entering lab orders into Point Click Care, completing the Lab Requisition</p> | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 02/25/2012 |
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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042 |
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| F 502 | <p>Continued From page 2</p> <p>BMP collected on 02/02/12, revealed abnormal values including Potassium 5.2 High, Glucose 162 High, BUN 39 High, and Creatinine 1.2 High.</p> <p>Review of the Physician's Orders, dated 02/02/12, revealed orders to recheck the BMP on 02/06/12. Further review of the medical record revealed there was no documented evidence the ordered BMP was obtained or results were received.</p> <p>Interview, on 02/23/12 at 11:30 AM, with Registered Nurse (RN) #4 revealed she was aware of the procedure to transcribe the lab order to the Lab Requisition Form and the Lab Tracker Book, and was unsure why she had failed to do it. She further stated she had input the order in the computer under treatment orders.</p> <p>Interview, on 02/23/12 at 11:15 AM, with the Director of Nursing (DON), revealed she called the lab company and the BMP which was scheduled to be drawn on 02/06/12 was not drawn. Continued interview revealed Registered Nurse (RN) #4 was the nurse who had received the order for the BMP to be drawn on 02/06/12. She stated, after talking with RN #4, she realized the nurse failed to make out the Lab Requisition Form and failed to transcribe the lab to the Lab Tracker Book.</p> <p>Further interview, on 02/23/12 at 11:40 AM, with the DON revealed the Physician's Orders were reviewed every morning from a computer list. She stated this was the "fail safe" to ensure all labs were obtained as ordered. However, after checking the computer, she stated RN #4 had input the order under "other". She explained the</p> | F 502 | <p>Form and placing it into the corresponding date in the file box, and placing the lab request in the Lab Tracker Book on the respective nursing unit.</p> <p>4. The completion of labs will be reviewed daily in Clinical Stand Up Meeting Monday-Friday by the Director of Nursing and/or Assistant Director of Nursing. The Director of Nursing and/or Assistant Director of Nursing will report findings of these reviews to the Performance Improvement (PI) Committee monthly for three (3) months for further review and recommendation (PI Committee includes Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Dietician, Unit Managers, H/R Director, and Maintenance Director).</p> <p>Date of Compliance 2/27/12</p> | |
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| F 502 | Continued From page 3 computer list of Physician's Orders only recognized orders which were input under Medication Administration Record (MAR), Treatment Administration Record (TAR) or laboratory. | F 502 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 12/20/2011 |
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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042 |
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| K 000 | <p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: Construction Date 6/10/69</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) Story, Type III (000) Unprotected</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Dry SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel Generator.</p> <p>A life safety code survey was initiated and concluded on 12/20/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred fifty-one (151) beds and the census was one hundred thirty-two (132) the day of the survey.</p> | K 000 | <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, BridgePoint Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p style="text-align: center;">RECEIVED JAN 20 2012</p> | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 1/20/12 |
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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 000 K 027 SS=F | <p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke doors that would close and resist the passage of smoke. The deficient practice affected seven (7) of nine (9) smoke compartments, staff and all residents. The facility has the capacity for one hundred fifty-one (151) beds with a census of one hundred thirty-two (132) on the day of survey.</p> <p>Findings include:</p> <p>Observation, on 12/20/11 between 9:30 AM and 2:30 PM, revealed that the doors in the smoke barriers had astragals installed on doors and no door coordinators so doors could completely close to resist the passage of smoke as required by NFPA Code. Doors in smoke barriers are required to be self closing to resist the passage of smoke. The doors identified were located 100</p> | K 000 K 027 | <p>K027</p> <p>1. 100 Hall, 200 Front Hall, 200 Back Hall, 300 Front Hall, and 300 Back Hall door coordinators were installed on 1/12/12 by the contractor and the Maintenance Director.</p> <p>2. Other smoke compartment doors were visually inspected throughout the center by the Maintenance Director and Life Safety Inspector on 12/20/11 to determine proper requirements are met regarding self-closing and resistance of the passage of smoke. In addition, the Maintenance Director re-checked center smoke compartment doors on 1/18/12.</p> <p>3. The Maintenance Director was re-educated by the Administrator on 1/18/12 on Life Safety Code requirements for doors to be self closing and resist the passage of smoke.</p> | 1/25/12 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165090 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 12/20/2011 |
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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042 |
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| K 027 | <p>Continued From page 2 Hall, 200 Hall, 300 Front Hall, Back 300 Hall, and Back 200 Hall.</p> <p>Interview with the facility Maintenance Supervisor, on 12/20/11 at 10:30 AM, revealed the facility was not aware the doors were required to have a door coordinator installed on the doors.</p> <p>NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition)</p> <p>2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.</p> | K 027 | <p>4. The Maintenance Director will inspect the door coordinators monthly for 3 months to determine proper operation. A summary of findings will be submitted to the Performance Improvement Committee monthly for further review and recommendation.</p> | 1/25/12 |
| K 029 SS=D | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> | K 029 | <p>K029 A self closing device was installed on food storage door in the kitchen on 1/6/12 by the Maintenance Director.</p> <p>2. Other doors were visually inspected throughout the facility by the Maintenance Director on 1/18/12 to determine proper requirements are met regarding separation of a hazardous area from other areas of the facility in accordance with NFPA Standards.</p> <p>3. The Maintenance Director was re-educated on Life Safety Code Standards regarding proper separation of a hazardous area from other areas of the center on 1/18/12 by the Administrator.</p> <p>4. The Maintenance Director will audit doors of the facility monthly for 3 months to determine proper separation of a hazardous area from other areas of the center. A summary of findings will be submitted to the Performance</p> | 1/25/12 |

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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042 | | |
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| K 029 | Continued From page 3 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 findings include: Observation, on 12/20/11 at 1:35 PM, with the Maintenance Director revealed the door leading into the food storage in the kitchen area did not have a self closing device installed per NFPA Life Safety Code. Interview, on 12/20/11 at 1:35 PM, with the Maintenance Director, revealed he was unaware of this requirement. This was also confirmed with the Administrator during the exit interview. Reference: NFPA 101 (2000 edition) 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. | K 029 | Improvement Committee monthly for further review and recommendation. | 1/25/12 | |

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| K 029 | Continued From page 4 The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (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 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 029 | | |
| K 062 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 | K 062 | | |

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| K 062 | <p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained, according to NFPA standards.</p> <p>The findings include:</p> <p>Observation, on 12/20/11 at 12:28 PM, revealed a sprinkler head located in the medication room 300 back hall was located too close to the wall, less than four (4) inches. Also at 12:42 PM identified four (4) corroded sprinkler heads at front canopy. The observations were confirmed with the Maintenance Director.</p> <p>Interview, on 12/20/11 at 12:42 PM, with the Maintenance Director, revealed he was unaware of these requirements.</p> <p>Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any</p> | K 062 | <p>K062</p> <p>1. Sprinkler head in the 300 Back Hall medication room was relocated on 1/4/12 by the contractor and the Maintenance Director. The sprinkler heads under the front canopy were replaced on 1/4/12 by the contractor and the Maintenance Director. 1/25/12</p> <p>2. Sprinkler heads were visually inspected throughout the facility by the Maintenance Director on 1/18/12 to determine proper maintenance in accordance with NFPA Standards.</p> <p>3. The Maintenance Director was re-educated on Life Safety Code Standards regarding maintenance of automatic sprinkler system on 1/18/12 by the Administrator.</p> <p>4. The Maintenance Director will inspect sprinkler heads monthly for 3 months to determine proper maintenance in accordance with NFPA Standards including that heads are free from corrosion, foreign materials, paint, and physical damage. A summary of findings will be submitted to the Performance improvement Committee monthly for further review and recommendations.</p> |

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| K 062 | Continued From page 8 sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. | K 062 | | |
| K 072 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions according to NFPA standards. The deficiency has the potential to affect seven (7) of nine (9) smoke compartments, all residents, staff, and visitors. The facility is licensed for one hundred fifty-one (151) beds; the census on the day of the survey was one hundred thirty-two (132). The findings include: | K 072 | K072 1. Storage locations for the medication carts were identified by the Administrator, Director of Nursing Services, and Maintenance Director and carts were relocated on 1/18/12. 2. The Administrator completed center rounds on 1/18/12 to determine that each corridor was free of any obstruction. 3. Licensed Nurses and Kentucky Medication Aides will be re-educated by 1/24/12 by the Administrator, Director of Nursing Services and/or Unit Managers on proper storage of medication carts when not in use and the importance of maintaining an egress that is free of obstruction or impediments. 4. The Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers and/or Nursing Supervisors will complete center rounds weekly for 4 weeks then monthly for 2 months to determine that corridors are free from any obstruction. A summary of findings will be submitted to the Performance Improvement Committee monthly for review and further recommendations. | 1/25/12 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188090 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 12/20/2011 |
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| NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042 |
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| (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 |
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| K 072 | <p>Continued From page 7</p> <p>Observation during the Life Safety Code survey tour, on 12/20/11 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed medication carts were stored and not in use near rooms 211, 210, 209, 108, 104, 112, 114, and 120. The items observed in the corridors were stored and not in use for a period of more than 30 minutes. Means of egress must be kept clear at all times in case of fire or other emergency.</p> <p>Interview with the Maintenance Director, on 12/20/11 at 2:30 PM, confirmed the items were stored in the corridors and indicated that they did not have enough room. This was also confirmed with the Administrator at exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> | K 072 | | |
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