

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

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/18/2013
NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An Abbreviated Survey investigating Complaint KY#00019589 was initiated and concluded on 01/18/13. KY#00019589 was substantiated with deficient practice identified.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bradford Square Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."		
F 226 SS-D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement policies and procedures that prohibited neglect of residents. Resident #1 had an altercation on 12/31/12 with another resident. Although the facility implemented interventions, those interventions failed to protect other residents from another altercation that occurred later that same day. The findings include: Review of the facility's "Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property Policy", dated 01/08 revealed it was the policy of the facility to make "every reasonable effort within its control" to prevent the abuse and neglect of residents. The policy states residents would be protected from other residents.	F 226	1. Resident #1 was transferred for evaluation and treatment on December 31, 2012. Center staff, nursing and non-nursing, re-educated on center's abuse policy, to include protecting residents from other residents, by the Assistant Director or Nursing, Housekeeping Supervisor, and/or Dietary Manager on January 19-30, 2013. 2. Allegations of abuse, neglect, mistreatment, and misappropriation of resident property, including resident to resident altercations, since December 1,	2/11/13	

RECEIVED
FEB - 7 2013
BY: [Signature]
2/11/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: Administrator (X8) DATE: 2/7/13

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 226: Continued From page 1

Review of Resident #1's medical record revealed the facility admitted Resident #1 on 07/01/05, with diagnoses which included Dementia with Behavioral Disturbance and Unspecified Reactive Psychosis. The facility assessed Resident #1, in an Admission Minimum Data Set, dated 11/16/12, as a 3/15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.

Review of Nursing Notes dated 12/30/12, revealed Resident #1 was sitting in the dining room at 5:20 PM when Resident #2 backed into Resident #1 in his/her wheelchair, at which time Resident #1 struck at Resident #2 hitting Resident #2 on the side of the head. There were no injuries from the incident. Further review of Nursing Notes revealed staff monitored Resident #1 more closely following the incident.

Review of a Reportable Allegation form, dated 01/04/13, revealed Certified Nursing Assistant (CNA) #4 heard what sounded like somebody strike somebody else on 12/31/12 in the television room. CNA #4 turned around and saw Resident #1 and Resident #3 together, with Resident #3 stating he/she "just hauled off and hit me." The form goes on to reveal Resident #1 was placed in "constant supervision" of staff.

Review of a second Reportable Allegation form, also dated 01/04/13, revealed Resident #1 struck Resident #2 in the dining room despite numerous staff members being present and providing direct supervision. Resident #2 suffered a superficial abrasion to the right chest and neck area as a result of being scratched by Resident #1. Resident #1 was placed on 1 on 1 supervision

F 226: 2012 will be reviewed by Director of Nursing and/or Administrator to determine center policy was followed as of February 10, 2013. Any concerns will be addressed with appropriate follow up.

3. Center staff, nursing and non-nursing, re-educated on center's abuse policy, to include protecting residents from other residents, by the Assistant Director or Nursing, Housekeeping Supervisor, and/or Dietary Manager on January 19-30, 2013.

4. Director of Nursing, Administrator, and/or Resident Service Director will review allegations of abuse, neglect, mistreatment, and misappropriation of resident property, including resident to resident altercations, to validate center policy was followed and residents protected for at least the next 3 months. A summary of findings will be submitted to the Performance Improvement Committee monthly for further review and recommendation.

The PIC will consist of, at a minimum, the Administrator, Director of Nursing and at least 3 other members of the Centers staff and the Medical Director at least Quarterly.

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F 226	<p>Continued From page 2 and kept out of reach of other residents at that time.</p> <p>Interview with CNA #5, on 01/18/13 at 2:58 PM, revealed she was assigned to Resident #1's hall, although no one was assigned to specific residents. CNA #5 revealed during report on the afternoon of 12/31/12 staff was told to keep an eye on Resident #1. CNA #5 revealed, when Resident #1 was having behavioral issues, staff tried to keep him/her calm, ensured there was no blockage in the hall that could result in bumping of wheelchairs, and kept Resident #1 away from anyone he/she may be confrontational with.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/18/13 at 2:25 PM, revealed she was observing Resident #1 and Resident #2 from the nurse's station, approximately thirty-five (35) feet from where they [Resident #1 and Resident #2] were talking. LPN #1 stated neither resident had raised voices, and she couldn't hear what was being said. LPN #1 stated when she observed Resident #2 point his/her finger at Resident #1, she got up to intervene, but couldn't get to Resident #1 before he/she struck Resident #2. LPN #1 revealed, earlier that afternoon staff had been told to keep Resident #1 within sight at all times, although LPN #1 didn't recall being told what had transpired earlier that date.</p> <p>Interview with the Administrator on 01/18/13 at 1:45 PM revealed she felt at the time the intervention put into place at 12:30 PM, increased supervision, was sufficient to protect Resident #1 and other residents from further conflict. The Administrator defined increased supervision as keeping a better eye on residents and ensuring</p>	F 226		
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F 226 Continued From page 3
they have room to maneuver without having to get too close to other residents, as well as more frequent checks and staff being aware of their location. The Administrator stated, in hindsight, the interventions were not clear, nor were they sufficient to prevent a further altercation from occurring on 12/31/12 at 4:45 PM, resulting in injury to Resident #2.

F 226

F 323
SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

F323

2/11/13

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.

1. Resident #1 was transferred for evaluation and treatment on December 31, 2012. Center staff, nursing and non-nursing, were re-educated on center's abuse policy to include providing supervision necessary to protect residents from other residents; and maintaining the residents' environment as free of accident hazards as much as possible, by the Assistant Director or Nursing, Housekeeping Supervisor, and/or Dietary Manager on January 19-30, 2013.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents. Resident #1 had an altercation on the afternoon of 12/31/12. The facility increased supervision, although not enough to prevent a second altercation from occurring on the evening of 12/31/12.

2. Incident/accidents, including resident to resident altercations, that occurred during the last 30 days will be reviewed to determine center had provided residents an environment as free from accident hazards as much as possible, and supervision as much as possible by the Director of Nursing and/or Administrator as of February 10, 2013.

The findings include:

Review of Resident #1's medical record revealed the facility admitted Resident #1 on 07/01/05, with diagnoses which included Dementia with Behavioral Disturbance and Unspecified Reactive

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F 323 Continued From page 4

Psychosis. The facility assessed Resident #1, in an Admission Minimum Data Set, dated 11/18/12, as a 3/15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.

Review of a Reportable Allegation form, dated 01/04/13, revealed Certified Nursing Assistant (CNA) #4 heard what sounded like somebody strike somebody else on 12/31/12 in the television room. CNA #4 turned around and saw Resident #1 and Resident #3 together, with Resident #3 stating he/she "just hauled off and hit me." The form goes on to reveal Resident #1 was placed in "constant supervision" of staff.

A second Reportable Allegation form, also dated 01/04/13, revealed Resident #1 struck Resident #2 in the dining room despite numerous staff members being present and providing direct supervision. Resident #2 suffered a superficial abrasion to the right chest and neck area as a result of being scratched by Resident #1. Resident #1 was placed on 1 on 1 supervision and kept out of reach of other residents at that time.

Interview with CNA #5, on 01/18/13 at 2:58 PM, revealed she was assigned to Resident #1's hall, although no one was assigned to specific residents. CNA #5 revealed during report on the afternoon of 12/31/12, staff was told to keep an eye on Resident #1. CNA #5 revealed, when Resident #1 was having behavioral issues, staff tried to keep him/her calm, ensured there was no blockage in the hall that could result in bumping of wheelchairs, and kept Resident #1 away from other residents which triggered or fed into Resident #1's combative behaviors.

F 323 Any concerns will be addressed with appropriate follow up.

In addition, the Director of Nursing and Administrator conducted center rounds to determine the residents environment was as free from accident hazards as much as possible, and adequate supervision was being provided for residents on January 18, 2013 as well as February 7, 2013. There were no noted concerns with environment and/or supervision.

3. Center staff, nursing and non-nursing, were re-educated on center's abuse policy to include providing supervision necessary to protect residents from other residents; and maintaining the residents' environment as free of accident hazards as much as possible, by the Assistant Director of Nursing, Housekeeping Supervisor, and/or Dietary Manager on January 19-30, 2013.

4. Director of Nursing, Assistant Director of Nursing, Administrator, and/or Resident Service Director will review incident/accidents, including resident to resident altercations, within 72 hours of event, to validate center had provided residents an environment as free from accident hazards as much as

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F 323	Continued From page 5 Interview with Licensed Practical Nurse (LPN) #1, on 01/18/13 at 2:25 PM, revealed she was observing Resident #1 and Resident #2 from the nurse's station, approximately thirty-five (35) feet from where they [Resident #1 and Resident #2] were talking. LPN #1 stated neither resident had raised voices, and she couldn't hear what was being said. LPN #1 stated when she observed Resident #2 point his/her finger at Resident #1, she got up to intervene, but couldn't get to Resident #1 before he/she struck Resident #2. LPN #1 revealed, earlier that afternoon staff had been told to keep Resident #1 within sight at all times, although LPN #1 didn't recall being told what had transpired earlier that date. Interview with the Administrator, on 01/18/13 at 1:45 PM, revealed she felt at the time the intervention put into place at 12:30 PM, increased supervision, was sufficient to protect Resident #1 and other residents from further conflict. The Administrator defined increased supervision as keeping a better eye on residents and ensuring they have room to maneuver without having to get too close to other residents, as well as more frequent checks and staff being aware of where they are. The Administrator recognized these interventions were clear, nor were they sufficient to prevent a further altercation from occurring on 12/31/12 at 4:45 PM.	F 323	possible, and supervision as much as possible 5 times a weekly for 4 weeks, three times weekly for 4 weeks, then weekly for 4 weeks. A summary of findings will be submitted to the Performance Improvement Committee monthly for further review and recommendation.		