

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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
77038

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 11/15/2013
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NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating complaints KY#00020921 and KY#00020959 was initiated on 11/14/13 and concluded on 11/15/13. KY#00020959 was unsubstantiated. KY#00020921 was substantiated with deficiencies cited. The highest Scope and Severity cited was a "G".	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 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure services were provided in accordance with each residents' plan of care one (1) of three (3) sampled residents (Resident #3). Resident #3 was care planned to be transported to activities by activity staff or nursing personnel; however, the resident was transported by a Volunteer to his/her room on 10/24/13 without supervision of facility staff. Resident #3's right foot became entangled in the wheel and this resulted in Resident #3 experiencing fractures in his/her right lower leg area. (Refer to F323) The findings include: Review of the facility's policy titled, "Care Plan-Interdisciplinary", dated January 2008, revealed it was the policy of the facility to develop	F 282	1. Director of Nursing, Licensed Nurse managers and/or MDS Coordinators reviewed the resident and the care plans for resident #3 to determine that the care plan is reflective of current needs and being followed on 12-10-13. No concerns identified. 2. Director of Nursing, Licensed Nurse managers and/or MDS Coordinators reviewed the current residents and their care plan in the center on or before 12-16-13 to determine that the care plans are reflective of current needs and interventions are in place. Any concerns identified were addressed at that time.	12/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wendy Adkins</i>	TITLE NHA	(X6) DATE 12/20/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	<p>Continued From page 1</p> <p>an individualized plan of care for each resident utilizing the information gathered during each assessment. Continued review revealed the care plan was to be comprehensive for each resident including measurable objectives and timetables to meet resident's medical, nursing, mental and psychosocial needs.</p> <p>Review of the facility's policy titled, "Accidents/Incidents", dated January 2008, revealed it was the facility's policy to identify each resident at risk for accidents, and ensure each resident was adequately care planned and procedures implemented to prevent accidents.</p> <p>Review of Resident #3's medical record revealed the facility admitted the resident on 11/03/08, with diagnoses which included a Dementia with Behavior Disturbances, Wheelchair Dependence, Muscle Weakness and history of Traumatic Fracture of the Lower Leg. Review of Resident #3's Quarterly Minimum Data Set (MDS), dated 08/26/13, revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of two (2), which indicated severe cognitive impairment. Further review of the MDS revealed the facility assessed Resident #3 as needing limited assistance of one (1) while walking in room or corridor and extensive assistance of one (1) for locomotion on and off the unit.</p> <p>Review of Resident #3's Comprehensive Care Plan, with a revision date of 11/08/13, revealed a problem listed as "potential for social isolation" with an intervention which indicated Resident #3 would be transported to activities by activities or nursing staff.</p>	F 282	<p>3. The Director of Nursing, Administrator and/or Licensed Nurse Managers re-educated nursing, therapy, activities, social services and MDS coordinators on or before 12-16-13 on the expectation that the resident care plan interventions are to be implemented as directed on the care plan.</p> <p>4. Director of Nursing, Administrator and/or Licensed Nurse Managers will review 10 resident's care plans and the resident to determine that care plan interventions are in place and being followed weekly x 4 weeks, biweekly x4 weeks, monthly x 1 month. Any concerns identified will be corrected at that time. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation.</p> <p>5. Date of Completion - 12-17-13</p>	
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Continued From page 2

Interview with the Activities Director (AD) on 11/14/13 at 3:00 PM, revealed Volunteer #1 had been a volunteer at the facility since 2008 and had been oriented on how to propel a wheelchair during initial orientation. The AD stated she was responsible for assigning Volunteer #1's duties. She indicated she usually went with Volunteer #1 to transport residents to and from activities. In an additional interview with the Activities Director (AD) on 11/15/13 at 10:01 AM, she stated she had interviewed Volunteer #1 on 10/28/13 in regards to an injury of unknown origin. The AD stated at that time Volunteer #1 informed her, on 10/24/13 when she was transporting Resident #3 to his/her room the resident's ankle became entangled in the wheelchair wheel.

Interview with Volunteer #1 on 10/15/13 at 10:12 AM, revealed she had propelled Resident #3 in the wheelchair to his/her room after an activity the morning of 10/24/13. She stated during the transport back to Resident #3's room, the resident's foot became entangled in the wheelchair wheel. Volunteer #1 stated she did not report the incident to facility staff as she was unaware Resident #3's foot was injured after becoming entangled in the wheelchair wheel.

Interview with the Director of Nursing on 11/15/13 at 4:14 PM, revealed the Activity Director was responsible for the Volunteer Program and orientation of the volunteers to ensure resident safety. She stated it was her expectation that staff follow residents' care plans as per facility policy.

Interview with the Interim Administrator, on 11/15/13 at 2:25 PM, revealed her expectations would be for staff to follow all facility's policy

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F 282 F 323 SS=G	<p>Continued From page 3 which included care planning implementing.</p> <p>483.25(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> <p>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 residents' received adequate supervision to prevent accidents as evidenced by lack of supervision for one (1) of three (3) sampled residents (Resident #3) while being transported by a Volunteer which resulted in injury to the resident. Volunteer #1 was transporting Resident #3 in a wheelchair when the resident's foot became entangled in the wheel. Volunteer #1 did not report the information regarding Resident #3's foot becoming entangled in the wheelchair wheel to facility staff; therefore, assessment and treatment were delayed. There was no documented evidence Volunteer #1 had been properly trained in transporting residents and reporting incidents. Resident #3 sustained Acute Distal Tibia and Fibula (the two long bones in the lower leg) Fractures as a result of his/her foot becoming entangled in the wheel of the wheelchair.</p> <p>The findings include:</p>	F 282 F 323	<p>F323</p> <p>1. The Activity Director was re-educated on 11-14-13 by the Administrator to the Volunteer Policy. Volunteer #1 is no longer volunteering at the center as of 11-18-13. Resident #3 returned to facility on 10-28-13 continues to follow up with orthopedic surgeon as recommended.</p> <p>2. Current residents in the center were assessed by Assistant Director of Nursing and/or Unit Managers to determine that no resident had injury of unknown source or injury related to transport or handling by volunteers on 11-15-13. No other concerns were identified. An audit of center volunteers was completed by the Administrator to determine that any other volunteers for the center had a completed orientation check list and education regarding reporting injury or unusual occurrences on 12-11-13. No concerns identified.</p> <p style="text-align: right;">12/17/13</p>

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F 323	Continued From page 4 Review of the facility's policy and procedure titled, "Volunteer Program" dated 04/2010, revealed the Activity Director was responsible for coordinating the Volunteer Program and for maintaining current documentation in the volunteer's file. Continued review revealed education included safety and criteria for reporting residents' condition or concerns to the Activity Director or licensed nurse. Additional review of the policy revealed Volunteers were permitted to assist facility staff with activity programs. The Activity Director was to assign the Volunteer to specific duties which did not include direct resident care services; duties routinely performed by staff; and services which the Volunteer was not physically, emotionally or otherwise qualified to perform. Further review of the policy revealed a "Volunteer Orientation Checklist" was to be completed by Volunteers and given to the Activity Director. Review of the "Volunteer Orientation Checklist" revealed Volunteers initialed they understood safe and appropriate resident care techniques. Review of Resident #3's medical record revealed the facility admitted the resident on 11/03/08, with diagnoses which included Traumatic Fracture of the Lower Leg, Muscle Weakness, Functional Quadriplegia, Dementia with Behavior Disturbances and Wheelchair Dependence. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 08/26/13 revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of two (2) out of fifteen (15), which indicated severe cognitive impairment. Further review of the MDS revealed the facility had assessed Resident #3 as requiring limited assist of one (1) while walking in his/her room or in the corridor; and, extensive	F 323	3. The Director of Nursing, Administrator and/or Licensed Nurse Managers re-educated dietary, housekeeping, therapy, nursing, social services, front office staff, maintenance director, MDS coordinators, medical records, activity staff and volunteer on Accident/Incident Management including observing for potential hazards in the center, reporting possible injuries immediately, safety of resident while escorting in the wheelchair on or before 12-16-13. Future volunteers new to the center will be educated to the expectation of reporting injury or unusual occurrences to the Activity Director or nursing staff and an orientation check list completed before volunteering in the center by the Activity Director, Director of Nursing and/or Administrator.		

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F 323 Continued From page 5

assist of one (1) staff for locomotion on and off the unit. Review of the Significant Change MDS, dated 11/04/13, revealed the facility had assessed Resident #3 was totally dependent on staff for locomotion on and off the unit.

Review of Resident #3's Comprehensive Care Plan, with a revision date of 11/08/13, revealed a problem listed as potential for social isolation with goals that the resident would participate in two (2) to three (3) out of room activities per week. The interventions revealed Resident #3 would be transported to activities by activity and nursing staff.

Review of a "Condition of Change Documentation" form, dated 10/24/13 timed 4:35 PM, revealed Resident #3 to have edema to the right ankle. Review of a "Condition of Change Documentation" form, dated 10/24/13 at 6:45 PM, revealed Resident #3's right ankle continued to have edema and was noted to have "initiation of discoloration" to the inner ankle. Further review of the form revealed the Physician and Responsible Party were notified at 7:00 PM and the Physician ordered an X-ray. Review of a Nurse's Note dated 10/24/13 and timed 11:00 PM, revealed the X-ray results were a right bimalleolar (ankle) fracture with dislocation of the ankle and the Advanced Registered Nurse Practitioner (APRN) was notified and a message left with the results of the X-ray. Review of a Nurse's Note dated 10/24/13 timed 11:05 PM, revealed the Physician was notified and orders were received to transfer Resident #3 to the Emergency Room (ER) for evaluation and treatment. Resident #3 was transferred to the hospital where he/she was admitted to the hospital and diagnosed with an acute Distal Tibia and Comminuted (a fracture in

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4. Director of Nursing, Administrator and/or Licensed Nurse Managers will observe 10 residents to determine that they are adequately supervised to prevent accidents including but not limited to the expectation that residents are transported by facility staff and that care plan interventions are in place weekly x 4 weeks, biweekly x4 weeks, monthly x 1 month. The Administrator and/or Director of Nursing will audit the files for all volunteers monthly x 3 months to determine that orientation checklist and education on reporting injury or unusual occurrences is in place for volunteers. Any concerns identified will be corrected at that time. Activity Director and/or Administrator to observe volunteers weekly x 4 weeks, biweekly x 4 weeks, monthly x 1 month pending presence in the center. A summary of findings will be submitted to the Performance Improvement Committee by the Director of Nursing and/or Administrator monthly x3 months for further review and recommendation.

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F 323	Continued From page 6 which the bone is splintered or crushed) Fibular Fracture. Interview with the Activity Director (AD), on 11/15/13 at 10:01 AM, revealed she interviewed Volunteer #1 on 10/28/13 during the investigation into the injury of unknown injury of Resident #3. She stated during the interview Volunteer #1 informed her of an incident on 10/24/13 which involved Resident #3's right ankle becoming entangled in the wheelchair wheel when Volunteer #1 was transporting the resident to his/her room. Interview with Volunteer #1 on 10/15/13 at 10:12 AM, revealed she had propelled Resident #3's in the wheelchair to the resident's room after an activity in the morning on 10/24/13. Volunteer #1 stated, during the transport back to the resident's room, Resident #3's foot became entangled in the wheelchair wheel. She stated she did not report the incident because she was not aware Resident #3 had been injured when his/her foot became entangled in the wheel of the wheelchair. She stated she had since received education on reporting any issues to staff, and, was made aware she could no longer assist with transporting residents' in wheelchairs. Interview with the Activity Director, on 11/14/13 at 3:00 PM, revealed Volunteer #1 had been a volunteer at the facility since 2008. She stated Volunteer #1 had a list of duties assigned that included propelling resident wheelchairs, handing out newspapers, and helping to set up activities and clean up after activities. The Activity Director stated Volunteer #1 was the only volunteer who assisted residents to and from activities. She indicated Volunteer #1 would no longer be	F 323			

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F 323	<p>Continued From page 7</p> <p>allowed to assist residents to and from activities. Further interview revealed she did not have an orientation check off evaluation or competency check off for wheelchair safety for Volunteer #1 who had been transporting residents in wheelchairs. She stated she had not established continuing competency training for Volunteers to ensure safety measures and reporting of incidents were adhered to. Further interview revealed she had observed Volunteer #1 transporting residents and observed her using correct safety measures when doing so.</p> <p>Interview with the previous Activity Director, on 11/15/13 at 11:04 AM, revealed she was employed at the facility as Activity Director from 1996 through 2011. She revealed she had oriented Volunteer #1. The previous Activity Director stated Volunteer #1's orientation included an in-service and training on wheelchair and resident safety measures. Further interview revealed she completed a yearly competency check off and evaluation with Volunteer #1 until 2010.</p> <p>However, review of Volunteer #1's file revealed no documented evidence she had received orientation regarding wheelchair safety measures or reportable events. Further review revealed no documented evidence Volunteer #1 had received yearly or continued competency training or education on wheelchair safety or reportable events.</p> <p>Interview with the Director of Nursing, on 11/15/13 at 4:14 PM, revealed she had not trained or oriented the Volunteers. She stated the facility did not maintain yearly competency checks or evaluations to ensure Volunteer personnel were</p>	F 323		

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F 323	<p>Continued From page 8</p> <p>adhering to safety measures and reporting incidents. Continued interview revealed she maintained oversight of the Volunteer Program through observation of activities involving Volunteers, communication with Volunteers and staff, and supervision of staff and Volunteers. She stated she had observed Volunteer #1 in the past propelling resident wheelchairs using wheelchair and resident safety measures.</p> <p>Interview with the Interim Administrator, on 11/15/13 at 2:25 PM, revealed Volunteers were given orientation to the facility to include safety reporting and resident condition or concerns, as per facility policy. She stated paid employees had annual and as needed education and competencies; however, Volunteers did not have annual education and/or competencies. The Interim Administrator stated the Activities Director was to have oversight of the Volunteer Program to maintain a safe environment for residents.</p>	F 323		