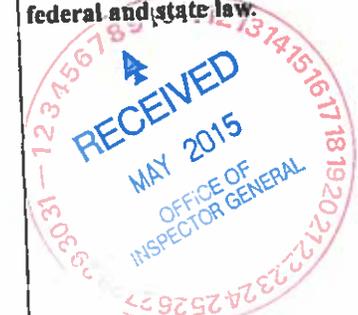


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2015
NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating complaints #KY23046, #KY23004 and #KY23058 was conducted on 04/02/15 through 04/08/15. Complaints #KY23046 and KY#23058 were substantiated with deficiencies cited at the highest Scope and Severity of a "G". Complaint #KY23004 was unsubstantiated with no deficiencies identified. Resident #1 was admitted to the facility on 09/17/14 with the diagnosis of Breast Cancer. Resident #1 began having increased pain on 02/04/15 and complained of pain for fifteen (15) days. However, there was no documented evidence the facility monitored the resident's pain or implemented the Interventions from the resident's Comprehensive Care Plan. On 02/18/15, the facility obtained a Computed Tomography (CT) for Resident #1 back and it was discovered he/she had a L-1 burst fracture (fracture of lower spine) and was transferred to the hospital on 02/20/15. Resident #1 was transferred back to the facility for palliative care and a consult for Hospice.	F 000		
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 observation, interview, record review, review of the facility's policy and procedures and	F 282	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.  F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN <u>Corrective Measures for Resident(s) Identified In The Deficiency</u> [1] Resident #1 was re-admitted to the facility on 3/30/15 with orders for Roxanol 20mg/5ml 0.25ml q 2 hrs as needed for pain, palliative care and Fentanyl Patch 25mcg. Resident #1 received seven doses of Roxanol for breakthrough pain from readmission on 03/30/15 to discharge from the facility	05/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Luome Couper

TITLE

Administrator

(X6) DATE

5-8-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are 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>hospital records it was determined the facility failed to provide care according to the resident's written plan of care for one (1) of three (3) sampled residents (Resident #1).</p> <p>Resident #1 was admitted to the facility on 09/17/14 with the diagnosis of Breast Cancer. The facility's care plan for Resident #1 included interventions to administer pain medication as ordered by the physician; notify the physician if the medications were ineffective; assess Resident #1's level of pain and provide comfort measures such as positioning, music and massage; and, to administer "Biofreeze" topically to the resident's back as needed for back pain. Resident #1 began having increased pain on 02/04/15 and complained of pain for fifteen (15) days; however, there was no documented evidence the facility monitored the resident's pain or implemented the interventions from the Comprehensive Care Plan.</p> <p>On 02/18/15, Resident #1 had a Computed Tomography (CT) and it was discovered he/she had a L-1 burst fracture (fracture of lower spine) and was transferred to the hospital on 02/20/15 and diagnosed with probable Necrotic Neoplasm (tumor). Resident #1 was transferred back to the facility for palliative care and a consult for Hospice.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Comprehensive Care Plans" last revised 04/03/13, revealed it was the facility's policy that each resident had a plan of care for assessed needs. Additional review revealed a care plan would be developed based on the resident's</p>	F 282	<p>on 04/07/15. Resident #1 was discharge from the facility to a group home on 04/07/15 per the original discharge plan.</p> <p><u>How Other Resident's Who May Been Affected By This Practice Were Identified</u> [1] On 04/09/15, the Unit Manager, Assistant Director of Nursing, and the Resident Care Coordinator/Staff Development Coordinator assessed 100% of the residents for sign/symptoms of pain or verbalization of pain using the Pain Analysis form for residents with a BIMS of 7 or greater and the Pain Analysis For Non-communicative/Advanced Dementia Residents form for residents with BIMS of less than 7. Any residents who verbalized pain or had signs/symptoms of pain, had physician notification done by the Unit Manager, Assistant Director of Nursing, or the Resident Care Coordinator/Staff Development Coordinator.</p> <p><u>Measures Implemented/ Systems Altered to Prevent Re-Occurrence</u> [1] Licensed nurses and nurse aides were educated by the Resident Care</p>	05/15/15	

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F 282	<p>Continued From page 2</p> <p>assessed needs. Care plan approaches will be communicate to staff for the use in providing direction for care. The plan of care would be reviewed and revised when indicated and based on the resident's response.</p> <p>Review of the facility's policy and procedure titled, "Pain Management", last revised 12/19/13, revealed the facility should manage a resident's pain in a manner that allowed the resident to attain or maintain their highest practicable level of physical, mental and psychosocial well-being. Further review revealed the residents would be evaluated for the presence of pain and the potential impact of pain on their activities of daily living. Based on the evaluation, the resident would recelve an individualize pain management plan. Additional review revealed non-pharmacological interventions would be utilized as appropriate or per the resident's preference to address the factors influencing pain and as an intervention to alleviate the pain. Additionally, medication would be administered based on the evaluated level of pain and the effectiveness of the interventions implemented to manage the resident's pain. The resident's pain medication would be adjusted according to the resident's response.</p> <p>Record review revealed the facility admitted Resident #1 on 09/17/14, with diagnoses which included Breast Cancer, Cerebral Palsy, Scoliosis, Anxiety, Pruritic Disorder and Intellectual Disability. Review of an Admission Minimum Data Set (MDS) assessment, dated 09/24/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) indicating the resident was not interviewable.</p>	F 282	<p>Coordinator/Staff Development Coordinator on the pain care plans and use of the interventions listed on the pain care plan for residents experiencing pain. This education was started on 04/09/15 and completed on 04/29/15.</p> <p>[2] All Licensed Nurses were educated and post-tested by the Resident Care Coordinator/Staff Development Coordinator beginning on 04/09/15 and ending on 04/29/15 on the Pain Management Policy including using the Pain Management Log to document resident's pain, treatment for pain and follow up of the effectiveness of the pain intervention and to notify the physician of a resident experiencing new pain or pain not controlled by the pain medication.</p> <p>[3] A copy of each resident's pain care plan was placed in front of each resident's MAR for the licensed nurses and certified medication technicians to reference for interventions that may be used when a resident verbalizes pain or shows s/s of pain.</p> <p>[4] A copy of each resident's pain care plan with the non-pharmacological interventions highlighted was placed with the residents' Nurse Aide Data Sheets.</p> <p>[5] Newly admitted/re-admitted residents will have a copy of their pain care plan placed in front of their Medication Administration Record and a copy with the non-pharmacological</p>	05/15/15	

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F 282	<p>Continued From page 3</p> <p>Further review revealed the facility had assessed Resident #1's pain presence as occurring occasionally and not interfering with sleep or activities.</p> <p>Review of a Comprehensive Care Plan, dated 10/01/14, revealed the facility assessed Resident #1 to have pain related to a surgical incision and he/she had a history of complaints of pain. Further review revealed the interventions were to administer medications as ordered by the physician, notify the physician if the medications were ineffective, assess Resident #1's level of pain and provide comfort measures such as positioning, music and massage, encourage the resident to report pain before it became unbearable; and to administer "Biofreeze" (gel pain medication) topically to the resident's back as needed for pain.</p> <p>Review of a Physician's Orders, dated 12/28/14, revealed an order for Biofreeze, apply topically to lower back three (3) times a day (TID) as needed for pain; a Physician's Order, dated 01/05/15, to administer Norco (combination pain medication containing a narcotic and acetaminophen (Tylenol) 7.5/325 milligrams (mg), one (1) tablet, three (3) times a day (TID) at 9:00 AM, 1:00 PM and 5:00 PM; and a Physician's Order dated 01/28/15, to administer Naproxen (pain medication) 500 mg two (2) times daily (BID) for back pain.</p> <p>Review of a Nurse's Note, dated 02/04/15 at 6:00 PM, (one (1) hour after the scheduled pain medication Norco was administered) revealed Resident #1 was crying and stating over and over, "My back hurts". Further review revealed Resident #1 was informed his/her pain</p>	F 282	<p>interventions highlighted with their Nurse Aide Data Sheet by the Licensed Nurses.</p> <p>[6] Newly admitted/re-admitted residents will be audited by the Unit Manager, Assistant Director of Nursing, or Resident Care Coordinator to ensure a copy of the resident's pain care plan have been placed in front of the resident's Medication Administration Record and with the resident's Nurse Aide Data Sheet with the non-pharmacological interventions highlighted. The results of the audit will be discussed during the Abbreviated Quality Assurance meeting Monday-Friday.</p> <p>[7] Licensed nurses will document on the Pain Management Log any non-pharmacological interventions implemented by the licensed nurse or nurse aide when a resident is experiencing pain. The Pain Management Logs will be reviewed during the Abbreviated Quality Assurance meeting Monday-Friday by the Director of Nursing, Assistant Director of Nursing, Unit Manager and Staff Development Coordinator for any follow up that is needed.</p> <p>[8] The Unit Manager, Assistant Director of Nursing, Director of Nursing, and the Staff Development Coordinator will audit the pain care plans to ensure they are in place in front of the residents' Mars and with the</p>	05/15/15	

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F 282	<p>Continued From page 4</p> <p>medication had been administered and it needed time to take effect. The nurse documented Resident #1 was asked if he/she would like to lie down in bed and informed the resident that sitting in the wheel chair for long periods of time would make his/her back hurt. Further review of the Nurse's Notes revealed the resident stated he/she did not want to go to bed and then began repeating, "My leg hurts, my back is killing me, I didn't sleep good last night". The nurse reminded the resident again when his/her last pain medication was given and the resident was satisfied for a while; however, he/she began crying and whimpering again. The nurse documented she observed the resident cursing to his/her baby doll in the hallway over and over. Further review of the Nurse's Notes revealed no documented evidence that the Biofreeze was applied to alleviate the resident's pain. Review of the resident's February 2015 Medication Administration Record (MAR) revealed no documented evidence the Biofreeze was applied as ordered or that the facility monitored the results of the resident's medication. In addition, further review of the record revealed no documented evidence the facility provided comfort measures, or notified the physician of the resident's continued pain after his/her pain medication was administered.</p> <p>Review of Nurse's Notes, dated 02/08/15 at 1:00 PM, 02/07/15 at 5:00 PM and 02/08/15 at 1:00 PM revealed Resident #1 was noted to be crying and complaining of back pain; and, on 02/09/15 at 10:15 AM, he/she complained of headache and back pain. Further review of the Nurse's Note, dated 02/07/15 revealed the "as needed" Biofreeze was applied at that time and Resident #1 was repositioned with a pillow placed behind</p>	F 282	<p>residents' NADS every week times four weeks; every other week times four weeks; and monthly times three months. [9]The Pain Management Logs will be placed with each resident's Narcotic Sign out sheets for easier access when documenting a resident experiencing pain. The narcotic book from each nursing station will be brought to the Abbreviated Quality Assurance Meeting Monday-Friday for review by the Director of Nursing, Assistant Director of Nursing, Unit Manager, and Staff Development Coordinator to ensure pain medications administered had follow up for effectiveness and documentation made on the Pain Management Log.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u> [1] The Assistant Director of Nursing, Resident Care Coordinator, or the Unit Manager will be responsible for making sure the pain care plans are in place in front of each resident's Medication Administration Record and with each resident's Nurse Aide Data Sheet with the non-pharmacological interventions highlighted. The Director of Nursing, Assistant Director of Nursing, Unit Manager, and Staff Development Coordinator will be responsible for</p>	05/15/15	

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F 282	<p>Continued From page 5</p> <p>his/her back. However, there was no documented evidence the Biofreeze was effective. In addition, review of the Nurse's Notes, dated 02/06/15 and 02/08/15, revealed the facility was unable to locate the page of the February 2015 MAR to show if the "as needed" Biofreeze was applied. There was no documented evidence the physician was notified if the medications were ineffective, the resident's level of pain was assessed, or comfort measures such as positioning, music and massage were offered, per the care plan.</p> <p>Review of a Nurse's Note, dated 02/10/15 at 3:15 PM, (two [2] hours and fifteen [15] minutes after the scheduled pain medication was administered), revealed Resident #1 began to refuse care and refused to get out of bed to socialize. It was documented Resident #1 was noted to have behaviors of scratching and rubbing his/her legs which caused bleeding. The resident was noted to be grinding his/her teeth, crying, and pulling his/her own hair out. Further review of the Nurse's Note, revealed Resident #1 had received the scheduled pain medication as ordered by the physician at 1:00 PM; however, there was no documented evidence to show if the Biofreeze was applied. Further record review revealed there was no documented evidence of ongoing monitoring to ensure the effectiveness of the medication and that comfort measures were provided, as per plan of care.</p> <p>Review of a Nurse's Note, dated 02/11/15 at 11:00 AM, revealed the resident was noted with repeated episodes of calling out that his/her legs hurt. The resident propelled himself/herself up and down the hallway in his/her wheelchair grinding his/her teeth together and making crying</p>	F 282	<p>making sure non-pharmacological interventions that are utilized when a resident is experiencing pain is documented on the Pain Management log. The Director of Nursing, Assistant Director of Nursing, Unit Manager, and Staff Development Coordinator will be responsible for auditing the Pain Management Logs during the Abbreviated Quality Assurance meeting Monday-Friday to ensure follow up by the Licensed nurse for the effectiveness of the pain medication is being documented on the Pain Management Log and the physician is being notified of any pain not being effectively controlled. The Director of Nursing will bring the results of the audits to the Monthly Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Resident Care Coordinator, Unit Manager, MDS Coordinator, Plant Services Director, Activities Director, Medical Records Director, Social Services Director, Admissions Coordinator] for review and development of action plan monthly x 6 months.</p>	05/15/15	

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F 282	<p>Continued From page 6</p> <p>sounds. Review of a Nurse's Note, dated 02/11/15 at 6:00 PM, revealed Resident #1 continued to state his/her back hurt. The Advanced Practice Registered Nurse was notified and a new order was received to send the resident to the hospital; however, the resident refused and the physician was made aware with no new orders received.</p> <p>Review of a Physician's Order, dated 02/13/15, revealed an order was obtained for Norco (Opiod pain medication) 10/325 every six (6) hours as needed.</p> <p>Review of a Nurse's Note, dated 02/14/15 at 6:40 PM, revealed Resident #1 refused to get out of bed and was curled up in a fetal position with the bed covers pulled up to his/her chin and refused to allow wound care. Resident #1 stated, "No, it hurts". Further review of the Nurse's Note revealed the "as needed" Norco was administered. However, there was no documented evidence Resident #1's level of pain and effectiveness of the medication was assessed, or that comfort measures such as positioning, music and massage were offered according to the care plan.</p> <p>Review of a Nurse's Note, dated 02/15/15 at 12:00 PM, revealed Resident #1 was up in his/her wheelchair crying and gnashing his/her teeth. Resident #1 was noted scratching at self and smeared blood along the hallway and the hand rails. In addition, Resident #1 screamed and used profanity. Resident #1 was taken to his/her room where his/her clothes and wound dressing were changed. Review of the February 2015 MAR revealed the "as needed" Norco was administered however, there was no documented</p>	F 282		

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F 282	Continued From page 7 evidence of continued monitoring to ensure the effectiveness of the medication and the degree of pain relief. In addition, there was no documented evidence comfort measures were provided. Review of a Nurse's Note, dated 02/15/15 at 6:30 PM, revealed Resident #1 placed him/her self on the floor in the hallway and stated he/she was hurting. There was no documented evidence in the Nurse's Note or on the February 2015 MAR to show if the "as needed" Biofreeze and Norco were provided to the resident. Further review of the record revealed there was no documented evidence of continued monitoring to ensure the effectiveness of the resident's medication management and degree of pain relief, as stated in the resident's care plan. Review of a Nurse's Note, dated 02/18/15 at 9:00 AM, revealed repeated episodes of crying out that the resident's back hurt and Resident #1 was noted making crying sounds and grinding his/her teeth. Review of the February 2015 MAR, revealed the PRN Norco was administered on 02/18/15 at 2:30 PM; however the facility was unable to provide documented evidence the as needed Biofreeze had been administered or the facility monitored the effectiveness of the medication. Review of a Physician's Order, dated 02/18/15, revealed a new order for a Computed Tomography (CT) scan (x-ray test that produces cross sectional images of the body using x-rays and a computer) of lumbar (lower back region) spine. Review of the CT Scan Report, dated 02/19/15, revealed Resident #1 had a L-1 burst fracture (traumatic spinal injury in which a vertebra breaks from a high-energy axial load	F 282			

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F 282	<p>Continued From page 8</p> <p>such as a car accident or fall from a great height) with significant subluxation (when one or more of the bones of spine move out of position and create pressure on or irritate spinal nerves).</p> <p>Review of a Physician's Order, dated 02/20/15, revealed new orders for a Neurosurgeon Consult and an order for a Fentanyl patch (adhesive patch containing an Opiod pain relieving agent) 25 micrograms (mcg) topically, and change every seventy-two (72) hours for severe back pain.</p> <p>Review of a Physician's Order, dated 02/20/15, revealed to transport Resident #1 to local hospital. Review of a Hospital Discharge Summary dated 02/26/15, revealed Resident #1 was transferred to another hospital and diagnosed with probable Necrotic Neoplasm (tumor with one (1) or more areas of necrosis, often related to tumor growth beyond the growth of the tumors vascular supply). Further review revealed Resident #1 would be transferred back to the facility with new orders for palliative care and a consult for Hospice.</p> <p>Interview with Wound Care Nurse, Licensd Practical Nurse (LPN #1) on 04/02/15 at 3:25 PM, revealed Resident #1 has chronic pain due to breast cancer. She further stated Resident #1's pain has gotten worse and the resident had become less active. She stated she was not usually Resident #1's primary nurse, but did see the resident when she provided his/her wound care treatments.</p> <p>Interview with Registered Nurse #1 (who documented the Nurse's Notes dated 02/05/15, 02/06/15, 02/07/15, and 02/08/15), on 04/08/15 at 11:50 AM, revealed Resident #1 had uncontrolled</p>	F 282			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 9 pain. She stated she did not apply the Biofreeze that was ordered as needed because the resident stated it did not help. She stated Resident #1 received a scheduled pain medication; however, it got to where it would not hold the resident over until time for the next dose was due. She stated she had provided back massages and repositioning which did relieve pain sometimes. Interview with Floor Nurse, LPN #2, on 04/06/15 at 8:30 AM, revealed Resident #1's pain had become worse since he/she was admitted to the facility. She further stated she would offer to reposition Resident #1; however, she did not recall offering music or massage to the resident per the care plan. Interview with Floor Nurse, LPN #3 on 04/16/15 at 11:20 AM, revealed Resident #1 had frequent complaints with back pain and had issues with back pain since admission. She stated the back pain got worse in February this year (2015). She stated she would administered the scheduled pain medication and offer to reposition Resident #1 and prop him/her up with pillows per the care plan. Interview with the Director of Nursing (DON), on 04/08/15 at 5:25 PM, revealed she expected the staff to follow the care plan. Interview with the Advance Practlce Nurse Practitioner (APRN), on 04/08/15 at 9:48 AM, revealed the facility staff reported to her on occasions that Resident #1 continued to have pain. She stated she was hesitant to continue to increase the pain medication and stated she felt that it was important to identify the underlying cause of the continued pain and not just increase the medication. She further stated she was not	F 282			

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F 282	Continued From page 10 aware Resident #1's pain was severe and uncontrolled; she stated she should have been notified. The APRN stated she expected the staff to continue to monitor for the effectiveness of the pain medication and to have provided comfort measures per the resident's Comprehensive Care Plan.	F 282		
F 309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedures it was determined the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of three (3) sampled residents (Resident #1) related to pain management.</p> <p>The facility admitted Resident #1 on 09/17/14 with the diagnosis of Breast Cancer. Resident #1 began having increased pain on 02/04/15 and complained of pain for fifteen (15) days. However, there was no documented evidence the facility monitored the resident's pain or</p>	F 309	<p>F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p><u>Corrective Measures For Resident(s) Identified In the Deficiency</u> [1]. Resident #1 was re-admitted to the facility on 3/30/15 with orders for Roxanol 20mg/5ml 0.25ml q 2 hrs as needed for breakthrough pain, Fentanyl Patch 25mcg every three days and palliative care. Resident #1 received seven doses of Roxanol between 03/30/15 and her discharge from the facility on 04/07/15. Resident #1 continued on her Fentanyl patch 25mcg/hr 03/30/15 to discharge from the facility on 04/07/15. Resident #1 was discharge from the facility to a group home on 04/07/15 per the original discharge plan.</p> <p><u>How Other Resident's Who May Have Been Affected by This Practice</u> [1] On 04/09/15, the Unit Manager, Assistant Director of Nursing, and the Resident Care Coordinator assessed</p>	05/15/15

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F 309	<p>Continued From page 11</p> <p>implemented the interventions from the residents' Comprehensive Care Plan. On 02/18/15, Resident #1 had a Computed Tomography (CT) and it was discovered he/she had a L-1 burst fracture (fracture of lower spine) and was transferred to the hospital on 02/20/15.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Pain Management", last revised 12/19/13, revealed the facility should manage a resident's pain in a manner that allowed the resident to attain or maintain their highest practicable level of physical, mental and psychosocial well-being. Further review revealed the residents would be evaluated for the presence of pain and the potential impact of pain on their activities of daily living. Further review revealed based on the evaluation, the resident would receive an individualize pain management plan. Additional review revealed non-pharmacological interventions would be utilized as appropriate or per resident's preference to address the factors influencing pain and as an intervention to alleviate the pain. Additionally, medication would be administered based on evaluated level of pain and the effectiveness of the interventions implemented to manage the resident's pain would be observed and adjusted according to the resident's response.</p> <p>Review of the facility's policy and procedure titled, "Comprehensive Care Plans" last revised 04/03/13, revealed it was the facility's policy that each resident had a plan of care for assessed needs. Additional review revealed a care plan would be developed based on the resident's assessed needs. Care plan approaches will be</p>	F 309	<p>100% of the residents for signs/symptoms or verbalization of pain using the Pain Analysis form for residents with a BIMS of 7 or greater and the Pain Analysis For Non-Communicative/Advanced Dementia Residents form for residents with a BIMS of less than 7. The Unit Manager, Assistant Director of Nursing, and the Resident Care Coordinator notified the physician of any resident verbalizing pain or having signs/symptoms of pain</p> <p><u>Measures Implemented Or systems Altered To Prevent Re-Occurrence</u></p> <p>[1] 100% of current residents will be assessed for pain by the Unit Manager, Assistant Director of Nursing, and the Resident Care Coordinator using the Pain Analysis form for residents with a BIMS of 7 or greater and using the Pain Analysis For Non-Communicative/Advanced Dementia Residents form for residents with a BIMS of less than 7. The pain assessments will be completed for 100% of the current residents one time a week for three weeks; every other week times two weeks; monthly time three months;</p> <p>[2] All Licensed Nurses were educated and post-tested by the Resident Care Coordinator/Staff Development Coordinator beginning on 04/09/15 and ending on 04/29/15 on the Pain Management Policy including using the Pain Management Log to document</p>	05/15/15

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F 309	<p>Continued From page 12</p> <p>communicate to staff for the use in providing direction for care. The plan of care would be reviewed and revised when indicated and based on the resident's response.</p> <p>Record review revealed the facility admitted Resident #1 on 09/17/14, with diagnoses which included Breast Cancer, Cerebral Palsy, Scoliosis, Anxiety, Pruritic Disorder and Intellectual Disability.</p> <p>Review of an Admission Minimum Data Set (MDS) assessment, dated 09/24/14, revealed the facility assessed the cognition of Resident #1 as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable. Further review revealed the facility assessed that Resident #1's pain interfered with his/her sleep and occurred occasionally.</p> <p>Review of a Comprehensive Care Plan, dated 10/01/14, revealed Resident #1 was assessed to have pain related to a surgical incision and a history of complaints of pain. The interventions the facility had put in place included to administer medications as ordered by the physician and to notify the physician if the medications were ineffective. Additionally, the staff was to assess Resident #1's level of pain, provide comfort measures such as positioning, music and massage, encourage the resident to report pain before it became unbearable and administer "Biofreeze" (gel pain med) topically to the resident's back as needed for back pain.</p> <p>Review of a Physician's Orders, revealed on 12/26/14 there was an order received for Biofreeze (gel for pain), apply topically to lower</p>	F 309	<p>resident's pain, treatment for pain and follow up of the effectiveness of the pain intervention and when to notify the physician of a resident experiencing pain.</p> <p>[3] All nurse aides were educated and post-tested by the Resident Care Coordinator/Staff Development Coordinator beginning on 04/08/15 and ending on 04/29/15 on non-verbal signs/symptoms of pain and the non-pharmacological pain interventions listed on the Pain Care Plans.</p> <p>[4] Licensed nurses will be educated and post-tested on the Pain Management Policy by the Resident Care Coordinator or Assistant Director of Nursing monthly times three months beginning May 2015.</p> <p>[5] Nurse aides will be educated and post-tested on non-verbal signs/symptoms of pain and the non-pharmacological pain interventions by the Resident Care Coordinator/Staff Development Coordinator or Assistant Director of Nursing monthly times three months beginning May 2015.</p> <p>[6] During orientation, newly hired Licensed Nurses will be educated by the Resident Care Coordinator/Staff Development Coordinator on the Pain Management Policy and notification of the physician when a resident is having pain.</p>	05/15/15	

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F 309	<p>Continued From page 13</p> <p>back three (3) times a day (TID) as needed for pain; on 01/05/15, an order to administer Norco (combination pain medication containing a narcotic and acetaminophen (Tylenol) 7.5/325 milligrams (mg), one (1) tablet, three (3) times a day (TID) at 9:00 AM, 1:00 PM and 5:00 PM; and on 01/28/15, an order to administer Naproxen (pain medication) 500 mg two (2) times daily (BID) for back pain.</p> <p>Review of a Nurse's Note, dated 02/04/15 at 6:00 PM, (one (1) hour after the scheduled pain medication was administered) revealed Resident #1 was crying and stating over and over, "My back hurts". Further documentation revealed Resident #1 was informed his/her pain medication had been administered and it needed time to take effect. The nurse documented Resident #1 was asked if she would like to lie down in bed and Registered Nurse (RN) #1 stated to the resident, "Sitting in the wheel chair for long periods of time would make your back hurt". The resident stated he/she did not want to go to bed and then began repeating "My leg hurts, my back is killing me, I didn't sleep good last night". The resident was again reminded about when his/her pain meds were given, and was satisfied for a while; however, he/she began crying and whimpering again. The resident was then observed cursing to his/her baby doll in hallway over and over. There was no documented evidence the facility assessed Resident #1's level of pain, provided comfort measures such as positioning, music and massage, or administered Biofreeze topically to back as needed for back pain.</p> <p>Review of a facility's "Pain Analysis", dated 02/06/15, revealed Resident #1's pain was</p>	F 309	<p>[7] During orientation, newly hired Nursing Assistants will be educated by the Resident Care Coordinator/Staff Development Coordinator on non-verbal signs/symptoms pain and non-pharmacological interventions.</p> <p>[8] Newly admitted/re-admitted residents will have a Pain Analysis completed every week times four weeks by the Unit Manager, Assistant Director of Nursing, Resident Care Coordinator/Staff Development Coordinator, or floor nurse to assess the resident's for pain.</p> <p>[9] Licensed nurses will document on the Pain Management Log any non-pharmacological interventions implemented by the licensed nurse or nurse aide when a resident is experiencing pain. The Pain Management Logs will be reviewed during the Abbreviated Quality Assurance meeting Monday-Friday by the Director of Nursing, Assistant Director of Nursing, Unit Manager and Staff Development Coordinator for any follow up that is needed.</p> <p>[10] The Unit Manager, Assistant Director of Nursing, Director of Nursing, and the Staff Development Coordinator will audit the pain care plans to ensure they are in place in front of the residents' Mars and with the residents' NADS every week times four weeks; every other week times four</p>	05/15/15	

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F 309	<p>Continued From page 14</p> <p>assessed with an intensity of nine (9) out of ten (10) on the Numeric Pain scale and was described as throbbing and aching constant in frequency and duration with decreased in sleep and no appetite. Further review revealed the resident had decreased socialization and episodes of crying. Review of the February 2015 Medication Administration Record (MAR) revealed the resident received the scheduled pain medication as ordered by the physician; however, further review of the pain analysis revealed there was no documented evidence the physician was notified of Resident #1's constant state of pain per the facility's policy and procedure.</p> <p>Review of Nurse's Notes, dated 02/06/15 at 1:00 PM, 02/07/15 at 5:00 PM, 02/08/15 at 1:00 PM, and 02/09/15 at 10:15 AM, revealed Resident #1 was noted to be crying and complaining of back pain. Further review of the Nurse's Note revealed no documented evidence the facility assessed Resident #1's level of pain and the effectiveness of the pain medication, or provided comfort measures such as positioning, music and massage, and administered Biofreeze topically to the resident's back as needed for pain.</p> <p>Interview with the MDS Coordinator, RN #2 on 04/08/15 at 8:35 AM, revealed she completed a Significant Change MDS assessment on Resident #1 related to his/her decline. She stated Resident #1 had increased back pain and just started to go down hill. She stated, "it was so sad to see him/her crumble". She revealed she completed the ancillary pain assessment on Resident #1 but did not notify the physician because she expected the resident's nurse to notify the physician.</p>	F 309	<p>weeks; and monthly times three months. [11] The Pain Management Logs will be placed with each resident's Narcotic Sign out sheets for easier access when documenting a resident experiencing pain. The narcotic book from each nursing station will be brought to the Abbreviated Quality Assurance Meeting Monday-Friday for review by the Director of Nursing, Assistant Director of Nursing, Unit Manager, and Staff Development Coordinator to ensure pain medications administered had follow up for effectiveness and documentation made on the Pain Management Log and any pain not being controlled effectively had physician notification. Every resident who was administered an as need pain medication will be reviewed during the next Abbreviated Quality Assurance meeting.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u> [1] The Assistant Director of Nursing, Resident Care Coordinator, or the Unit Manager will be responsible for making sure the pain care plans are in place in front of each resident's Medication Administration Record and with each resident's Nurse Aide Data Sheet with the non-pharmacological interventions</p>	05/15/15	

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F 309	<p>Continued From page 15</p> <p>Review of a Nurse's Note, dated 02/10/15 at 3:15 PM, and on 02/11/15 at 11:00 AM and 6:00 PM revealed Resident #1 began to refuse care and refused to get out of bed to socialize. Resident #1 was noted to have behaviors of scratching and rubbing his/her legs which caused bleeding; grinding his/her teeth, crying, and pulling his/her own hair out. The physician was notified and discontinued the Seroquel 25 mg and Depakote sprinkles; and added Haldol 0.5 mg, and Geodon 20 mg daily. In addition, an order was received to send resident to the hospital, however the resident refused.</p> <p>Review of a facility's "Pain Analysis", dated 02/13/15, revealed Resident #1 was assessed by the facility to have pain on the Numeric Pain Scale of nine (9) out of ten (10) and described as throbbing and the frequency and duration was constant and behaviors of rocking back and forth. Review of a Physician's Order, dated 02/13/15, revealed an order was obtained for Norco 10/325 every six (6) hours as needed.</p> <p>Interview with Wound Care Nurse, Licensed Practical Nurse (LPN #1) on 04/02/15 at 3:25 PM, revealed Resident #1 has chronic pain due to breast cancer. She further stated Resident #1's pain had gotten worse and she became less active. She stated she was not usually Resident #1's primary nurse but she did see her when she did her wound care treatments. LPN #1 stated she did complete the facility's "Pain Analysis" on 02/13/15 and stated this was done due to the increase in Resident #1's pain medication. LPN #1 stated Resident #1 was not able to comprehend the numerical value of a number related to rating the level of his/her pain. She further stated Resident #1 would look away if</p>	F 309	<p>highlighted. The Director of Nursing, Assistant Director of Nursing, Unit Manager, and Staff Development Coordinator will be responsible for making sure non-pharmacological interventions that are used when a resident is experiencing pain is documented on the Pain Management log. The Assistant Director of Nursing, Resident Care Coordinator, or the Unit Manager will be responsible for making sure the pain assessments are completed according to the schedule. The Resident Care Coordinator/Staff Development Coordinator will be responsible for making sure the monthly education and post-testing is completed for Licensed Nurses and Nursing Assistants, and the newly hired Licensed Nurses and Nursing Assistants receive education during orientation. The Director of Nursing, Assistant Director of Nursing, Unit Manager, and Staff Development Coordinator are responsible for auditing the Pain Management Logs to ensure follow up by the Licensed nurse for the effectiveness of the pain medication is being documented on the Pain Management Log and the physician is being notified of any pain not being effectively controlled. The Director of Nursing will bring the results of the audits to the Monthly Quality Assurance Committee. The Director of Nursing will bring the results to the Monthly Quality Assurance Committee</p>	05/15/15

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F 309	<p>Continued From page 18</p> <p>asked to rate his/her pain on the Faces Pain Scale. She stated Resident #1 would state it hurts real bad and that meant a nine (9) or a (ten) 10.</p> <p>Review of a Nurse's Notes, dated 02/14/15 at 6:40 PM, 02/15/15 at 12:00 noon and 6:30 PM, and on 02/18/15 at 9:00 AM revealed Resident #1 refused to get out of bed and curled up in a fetal position with the bed covers pulled up to his/her chin and refused to allow wound care stating "No, it hurts"; was up in his/her wheelchair crying and gnashing his/her teeth, scratching at self and smearing blood along the hallway and the hand rails; began to scream and use profanity and loosing hair due to pulling it out. Further review revealed there was no documented evidence of continued monitoring to ensure the effectiveness of pain medication was monitored and the degree of pain relief. In addition, there was no documented evidence comfort measures were provided such as music or massage, as per plan of care.</p> <p>Review of a Physician's Order, dated 02/18/15, revealed a new order for a Computed Tomography (CT) scan (x-ray test that produces cross sectional images of the body using x-rays and a computer) of lumbar (lower back region) spine. Review of the CT Scan Report, dated 02/19/15, revealed Resident #1 had a L-1 burst fracture (traumatic spinal injury in which a vertebra breaks from a high-energy axial load such as a car accident or fall from a great height) with significant subluxation (when one or more of the bones of spine move out of position and create pressure on or irritate spinal nerves).</p>	F 309	[consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Resident Care Coordinator, Unit Manager, MDS Coordinator, Plant Services Director, Activities Director, Medical Records Director, Social Services Director, Admissions Coordinator] for review and development of action plans monthly times six months.	05/15/15	

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F 309	Continued From page 17 Review of a Physician's Order, dated 02/20/15, revealed new orders for a Neurosurgeon Consult and an order for a Fentanyl patch (adhesive patch containing an Opiod pain relieving agent) 25 micrograms (mcg) topically, and change every seventy-two (72) hours for severe back pain. Further review revealed a Physician's Order was received to transport Resident #1 to Jennie Stewart Medical Center on 0/20/15. Interview with Registered Nurse (RN) #1, on 04/08/15 at 11:50 AM revealed she documented the Nurse's Notes on 02/05/15, 02/06/15, 02/07/15, and 02/08/15. RN #1 stated Resident #1 had uncontrolled pain. RN #1 revealed she did not apply the Biofreeze as ordered because the resident stated it did not help. She stated Resident #1 received a scheduled pain medication; however, it got to where it would not hold the resident over until time for the next dose was due. She stated she had provided back massages and repositioning which did relieve pain sometimes. She stated she was unsure if the resident had uncontrolled pain or increase in behaviors. Interview with Floor Nurse, LPN #2, on 04/06/15 at 8:30 AM, revealed Resident #1's pain had worsened since he/she was admitted to the facility. She further stated she would offer to reposition Resident #1, however did not recall offering music or massage to the him/her. She further stated Resident #1 received scheduled pain medication and she would only document an assessment if the medication administered was an as needed medication and if it was scheduled she would just sign it out on the MAR.	F 309			

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NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240
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F 309	<p>Continued From page 18</p> <p>Interview with Floor Nurse, LPN #3, on 04/16/15 at 11:20 AM, revealed Resident #1 had frequent complaints with back pain and had issues with back pain since admission. She stated the back pain got worse in February this year. She stated she would administered the scheduled pain medication and offer to reposition Resident #1 and prop him/her up with pillows.</p> <p>Interview with the Director of Nursing (DON), on 04/08/15 at 5:25 PM, revealed she expected the staff to follow the care plan. She further stated she expected the staff to complete the facility's Pain Analysis form or the Pain Analysis for for the Non-Communicative Resident when a Resident experienced a change in his/her pain level.</p> <p>Interview with the Licensed Counseling Psychologist, on 04/08/15 at 9:34 AM, revealed she received a referral for Resident #1 for a Psychiatric Consultation due to Resident #1's increased behaviors. She stated Resident #1 was having increased pain and that could have been the cause of the increased behaviors. She further stated she had seen Resident #1 in the past and stated she had been more outgoing before; however, now she felt the resident was more withdrawn.</p> <p>Interview with the Advance Practice Nurse Practitioner, on 04/08/15 at 9:48 AM, revealed facility staff reported to her on occasions that Resident #1 continued to have pain. She stated she was hesitant to continue to increase the pain medication and stated she thought it could possibly be related to psychiatric issues. She stated she felt that it was important to identify the underlying cause of the continued pain and not</p>	F 309		
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F 309	Continued From page 19 just increase the medication. She further stated she was not aware Resident #1's pain was severe and uncontrolled and stated she should have been notified. She stated she expected the staff to continue to monitor for the effectiveness of the pain medication and to have provided comfort measures per the Comprehensive Care Plan. Interview with the Physician, on 04/08/15 at 2:23 PM, revealed he was made aware of Resident #1's increased pain; however, he stated he could not recall the exact dates and times. He further stated he had changed the pain medication in the past; however he stated he wanted to identify the underlying cause of the continued pain.	F 309		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed	F 353	F 353 (a) SUFFICIENT 24-HR NURSING STAFF COVERAGE PER CARE PLANS <u>Corrective Measures for Resident(s) Identified In The Deficiency.</u> [1] Social Services Director interviewed the residents on the 300 hall with a BIMS of 7 or greater on 04/15/15 to see if the residents had any issues with call lights being answered. [2] Number of staff working on the 300 hall on the night shift was increased.	

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F 353	<p>Continued From page 20 nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to provide sufficient nursing staff to provide nursing and related services to residents residing on the 300 Unit to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by the resident's assessments and individual plans of care for two (2) of six (6) sampled residents (Residents #5 and #6) and four (4) Unsampeld Residents (Resident A, D, F, and G). Interviews with family members, facility staff and alert/oriented residents revealed the facility was "short-staffed" at times and there were times on the night shift when residents had to wait for extended periods of time for staff to respond to call lights, and to provide incontinence care/toileting for residents.</p> <p>The findings include: Interview with the Administrator, on 04/08/15 at 11:50 AM, revealed the facility did not have a specific staffing guidelines policy. She stated there were budgeted hours according to the census that determines how many staffing hours were to be used during a twenty-four (24) hour period. She further stated the number of staff used was adjusted as needed according to census change and resident acuity.</p>	F 353	<p><u>How Other Residents Who May Have Been Affected By This Practice Were Identified</u> [1] On 04/27/15-04/30/15, the Social Services Director interviewed all residents with a Bims of seven or greater regarding staff answering call lights in a timely manner. The results were brought to the Abbreviated Quality Assurance meeting for review and action plan development if needed on 05/01/15.</p> <p><u>Measures Implemented or Systems Altered To Prevent Re-Occurrence.</u> [1] Residents on the 300 hall with a BIMS of 7 or greater will be interviewed by the Social Services Director every week times four weeks regarding call lights being answered timely. [2] The Regional Human Resources Director has ads on Careerbuilders for nurse openings and nurse aide openings with sign on bonuses being offered. [3] Nurse staff on the 300 hall has been increased on the night shift. [4] Nurse aide certification classes are being offered for non-certified nursing assistant candidates. [5] Recruitment and retention meetings will be held monthly with the Administrator, Director of Nursing, Assistant Director of Nursing, Resident</p>	05/15/15
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F 353	<p>Continued From page 21</p> <p>Observations during tour of the 300 Hallway on 04/06/15 at 10:00 PM, revealed upon entering through the lobby entrance there was a call light audibly sounding. Further observation revealed there was no staff visible in the hallway or at the nurses station. Observator of 200 hallway from the 300 hallway revealed a nurse in the hallway giving medications at the medication cart.</p> <p>Review of the facility's daily sign in sheet, dated 04/06/15, revealed on the 300 Hallway on 1st shift they had scheduled 1 (one) Licensed Practical Nurse (LPN) scheduled to work 7 AM-7 PM, and one (1) State Registered Nursing Assistant (SRNA) scheduled to work 6 AM-6 PM. Further review of the schedule revealed, the 3rd shift schedule had one LPN scheduled to work 7 PM-7 AM, and one SRNA scheduled to work 6 PM-6 AM. The Census Acuity for this hall was twelve (12).</p> <p>Interview with LPN #1, on 04/06/15 at 10:45 PM, revealed this was a normal schedule and there had been no call in's on the 300 Unit. LPN #1 stated she was responsible for the 300 Unit and half of the 200 Unit and the LPN on the 100 unit, was responsible for her unit and the other half of the 200 Unit. She further stated the other two units normally had two (2) SRNAs scheduled to work and the 300 Unit only has one (1) SRNA. LPN # 1 stated there were currently (12) twelve residents on the unit at this time. She further revealed that of the twelve (12) residents, four (2) require total care, and three (2) had a documented behavior problem.</p> <p>1. Record review revealed the facility admitted Resident #5 on 04/04/14 with diagnoses which included Dementia, Anxiety, and Parkinson's</p>	F 353	<p>Care Coordinator, Unit Manager, Staffing Coordinator, Human Resources Director, and front-line staff attending to determine interventions to recruit new staff and/or increase retention rates of staff.</p> <p>[6] The Staff Development Coordinator will oversee staffing and coverage for any call-ins in the nursing department with the assistance of the Unit Manager and Assistant Director of Nursing.</p> <p>[7] An on call schedule was developed by the Director of Nursing on 05/06/15 for the Staff Development Coordinator, Unit Manager, and Assistant Director of Nursing to take weekend call and help to cover any call ins that occur over the weekend. Monday-Friday the Staff Development Coordinator, Unit Manager, and Assistant Director of Nursing will work together to cover any call ins that occur in the nursing department.</p> <p><u>Monitoring Measures To Maintain On-going Compliance</u></p> <p>[1] The Staff Development Coordinator, Unit Manager, and Assistant Director of Nursing are responsible for finding coverage for any call ins that occur in the nursing department including taking call on the weekends. The Director of Nursing, Social Services Director, Unit Manager, Assistant Director of Nursing,</p>	05/15/15

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F 353	<p>Continued From page 22</p> <p>Disease. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/02/15, revealed the facility assessed Resident #5's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of four (4), indicating the resident was not interviewable. The resident required extensive assistance of two (2) for bed mobility, toileting and personal hygiene.</p> <p>Review of the Nurse Aide Data Sheet, effective 03/29/15 with an end date of 06/04/15, revealed the resident was assessed to require physical assist of two (2) for bed mobility, bed pan and incontinent care; and, use of the mechanical lift for transferring.</p> <p>Interview with Resident #5's spouse, on 04/06/15 at 10:05 PM, revealed on 04/05/15, after 6:00 PM they did not have a SRNA working on the 300 Hallway. The resident's spouse stated Resident #5 had to lay in bowel movement for over an hour before someone came from the hall to answer the call light. Resident #5's Spouse stated he/she felt the residents were in need "last night" and he/she hated to see the nurse working by herself. Further interview revealed that he/she visits at night because he/she was afraid the resident would not be taken care of as he/she should be. He/She stated he/she also hired sitters to come in part time to help with the resident's care.</p> <p>2. Record review revealed the facility admitted Resident #6 on 03/11/15 with diagnoses which included Occupational Therapy Rehab, and Above the Knee Amputation. Review of the Admission MDS assessment, dated 03/28/15, revealed the facility assessed Resident #6's cognitive status at cognitively intact with a BIMS score of fifteen (15), indicating the resident was</p>	F 353	<p>Resident Care Coordinator are responsible for the follow up interviews with residents regarding call lights being answered timely. The Administrator or Director of Nursing is responsible for conducting the Recruitment and Retention meeting each month. The Director of Nursing will bring the results of the follow up resident interventions and the results of the Recruitment and Retention meeting to the Monthly Quality Assurance Meeting [consisting of: Administrator, Director of Nursing, Assistant Director of Nursing, Resident Care Coordinator, Unit Manager, MDS Coordinator, Plant Services Director, Activities Director, Medical Records Director, Social Services Director, Admissions Coordinator] for review and development of action plans monthly times six months.</p>	05/15/15
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F 353	<p>Continued From page 23</p> <p>Interviewable. The resident required total assistance of one for transferring, toileting and incontinent care.</p> <p>Interview with Resident #6, on 04/07/15 at 2:00 PM, revealed on Sunday night (04/05/15) he/she had to wait to be put on the commode chair. The resident stated at around 5:00 PM, he/she turned on the call light for assistance, and at 7:00 PM someone answered and told the resident he/she would have to use the bed pan. Resident #6 revealed he/she did not want to use the bed pan and was told by the State Registered Nurse Assistant (SRNA) that he/she would have to wait until she could find some help to transfer him/her to the commode chair.</p> <p>Interview with Unit Supervisor #1, on 04/07/15 at 12:45 PM, revealed LPN # 2 called her at home on 04/05/15 to let her know that the SRNA scheduled to work from 6:00 PM- 6:00 AM shift for the 300 Hallway did not show up. The Supervisor stated she called several people and no one would come in to work so the SRNA on the 200 Hallway helped LPN #1 as much as she could until 10:00 PM. The Unit Supervisor stated she was aware Resident #6 got upset about waiting to use the bedside commode chair but at the time the resident was care planned for a "Hoyer" (brand of mechanical lift) lift to transfer and the SRNA couldn't do it without assistance.</p> <p>Interview with LPN #2, on 04/07/15 at 9:30 AM, revealed there were currently (14) fourteen residents on the 300 Hall. She stated that out of the fourteen (14) residents, four (4) required total care and three (3) had a documented behavior problem. She stated she was busy trying to do her job and it was hard to always have time to</p>	F 353		05/15/15
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F 353	<p>Continued From page 24 help the SRNA when she needed it.</p> <p>Interview with LPN #1, on 04/07/15 at 5:00 PM, revealed when she arrived at work on the night of 04/05/15 at 7:00 PM, she was told the SRNA for the 300 Hall did not show up for work at 6:00 PM, and they were trying to replace her. LPN #1 stated she contacted the Unit Manager and she was trying to find someone to come in to work. LPN #1 stated she and the Unit Manager were unable to find anyone to work so she had to do her job and the SRNA's job on the 300 Hall until 10:00 PM that night. LPN #1 stated, "We did not have a SRNA on the floor from 6:00 PM to 10:00 PM that night." Further interview revealed she did not get to the 300 Hall until 8:30 or 9:00 PM that night because she was passing pills on the 200 Hallway. She further stated the medications on the 300 Hall were late and she didn't get them all passed until around 11:00 PM. She stated she had asked before about getting more help and was told staffing was scheduled according to the census, and that half the time SRNAs can't get their job done at night.</p> <p>Interview with SRNA #3, on 04/08/15 at 2:30 PM, revealed she was scheduled to work the 2:00 PM to 10:00 PM shift on the 200 Hall the night of 04/05/15, and she had been helping the SRNA on the 300 Hallway during the supper meal. SRNA #3 stated she was not aware that no one had came in at 6:00 PM on the 300 Hall; but she had noticed a lot of call lights were on down the 300 Hall at around 7:00 PM or 8:00 PM. She stated she was told by the nurse that someone had called off so she started answering lights trying to help. SRNA #3 stated one resident needed help but she was afraid to lift him/her without help because the resident was a two person transfer</p>	F 353		

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F 353	<p>Continued From page 25</p> <p>so she offered the bed pan but they refused. SRNA #3 stated she had to wait until the nurse could assist her at around 8:00 or 9:00 PM.</p> <p>Interview with Unsampled Resident F (whom the facility identified as having a BIMS' score of 14 which indicated the resident was interviewable), on 04/06/15 at 10:00 AM, revealed "They don't answer the call lights at night and they don't have enough staff to help us go to the bathroom." The resident stated he/she would have accidents in his/her pants and the bed because they couldn't get there fast enough.</p> <p>Interview with Unsampled Resident D (whom the facility identified as having a BIMS' score of 14 which indicated the resident was interviewable), on 04/06/15 at 10:15 AM, revealed the nursing staff needed help on the 300 Hall and they took too long to answer the call lights. The resident stated there was no specific shift stating, "They all take so long to get to you." The resident stated on Sunday (04/05/15) night it was 11:00 PM before he/she got his/her 9:00 PM medication and there was no SRNA on the hall until 10:00 PM that night. The resident stated the LPN was giving the medication and getting the vital signs at the same time. The resident stated, "The nurse said the aid that was scheduled did not show up, and if he/she wasn't able to toilet his/herself and give his/her own bath the he/she would be in trouble".</p> <p>Interview with Unsampled Resident G (whom the facility identified as having a BIMS' score of 14 which indicated the resident was interviewable), on 04/06/15 at 10:30 AM, revealed there was not enough staff working at night and the staff took too long to get to the residents. The resident stated when he/she was first admitted there were times</p>	F 353			

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F 353	<p>Continued From page 26</p> <p>when he/she had incontinent episodes due to staff not answering the call light in time.</p> <p>Interview with Unsampled Resident A (whom the facility identified with a BIMS' score of 15 which indicated the resident was Interviewable, on 04/07/15 at 2:10 PM, revealed that sometimes there was only one SRNA working on the hall and the residents would have to wait over an hour for someone to answer the call lights. The resident stated by the time the staff would get to him/her, he/she would have had a bowel movement and urinated on him/herself. The resident further stated it happened about three (3) or four (4) times last month and it had been discussed in Resident Council but it didn't do any good.</p> <p>Interview with SRNA #1, on 04/06/15 at 10:45 PM, revealed that most nights she worked by herself and she had a hard time taking care of everyone. SRNA #1 stated the nurse would help her if she needed help, but sometimes residents had to wait.</p> <p>Interview with SRNA #2, on 04/06/15 at 9:30 AM, revealed there were days that she could not get her work completed. SRNA #2 stated the staffing was supposed to increase when the census increased but it didn't usually happen. SRNA #1 stated that yesterday (04/05/15) she was able to get everything done except pass ice water. She stated her scheduled shift to work was 6 AM to 6 PM.</p> <p>Interview with Staffing Coordinator, on 04/07/15 at 11:50 AM, revealed that on Sunday night 04/05/15 there was not a SRNA assigned to the 300 Hall from 6:00 PM until 10:00 PM due to a call out of the scheduled SRNA, and they were</p>	F 353		

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F 353	<p>Continued From page 27</p> <p>unable to find a replacement. She stated the SRNA scheduled to work the 200 Hall was required to help the LPN answer lights as well as cover her assigned 200 Hall assignment. She stated the facility had a total of four (4) SRNAs working in the entire building. The Staffing Coordinator revealed the normal process was if someone called out she was required to find a replacement for that person, and if she was unable to cover them she was required to come in and work in their place. She stated she was out of town that weekend.</p> <p>Interview with Activity Director, on 04/07/15 at 10:30 AM, revealed the residents had complained to him about the time it takes the SRNAs to answer the call lights and take them to the bathroom. He stated he reports any complaint to the Administrator for investigation.</p> <p>Review of the Resident Council Minutes, dated 12/2014 and 01/14/15, revealed residents complained about the time it was taking call lights to be answered and SRNAs not passing ice water. Interview with the Activity Director, on 04/07/15 at 10:30 AM, revealed they did an investigation on the 12/2014 complaints but was unable to find any documentation that the investigation had been completed.</p> <p>Interview with the Administrator and the Resident Care Coordinator, on 04/07/15 at 12:00 PM, revealed they were unaware of the situation that occurred related to the staffing on Sunday 04/05/15. They stated they expected the Unit Manager to come to the facility and work if he/she was unable to find a replacement.</p> <p>Interview with the Administrator, on 04/05/15 at</p>	F 353		
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NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DR. HOPKINSVILLE, KY 42240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 353	Continued From page 28 12:30 PM, revealed she was unaware of any complaints voiced during the resident council meeting and was unable to find any written grievances pertaining to staffing and not passing ice water. She stated she did not think it was acceptable for the residents to have incontinent episodes due to staff being unable to answer the call lights timely.	F 353			
F 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and review of the Director of Nursing (DON) job description, it was determined the facility failed to ensure the DON did not serve as a Charge Nurse. The findings include:	F 354	F 354 483.30 (b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON <u>Corrective Measures for Resident(s) Identified In the Deficiency.</u> No residents were identified in the deficiency. <u>How Other Residents Who May Have Been Affected By This Practice Were</u>	05/15/15	

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F 354	Continued From page 29 Review of the Director of Nurse's job description, last revised 06/28/13, revealed the DON was responsible for organizing, developing, and directing those activities related to nursing service in accordance with established objectives and standards. Interview with the DON, on 04/07/15 at 3:45 PM, revealed she was the Unit Manager for the 200 and half of the 300 hall. She stated it was difficult keeping up with both the DON's responsibilities as well as the Unit Manager's responsibilities. Interview with the Administrator, on 04/08/15 at 5:45 PM, revealed she was aware the DON was also the Unit Manager. She further stated she had only been the Administrator at that facility for a few months and that was the way it was when she started. She stated she did not know that it was a problem the way they had it set up.	F 354	<u>Identified</u> No residents affected by this practice. <u>Measures Implemented or Systems Altered To Prevent Re-Occurrence.</u> [1] An interim Director of Nursing was put in place at the facility on April 16, 2015. [2] Ad placed on Careerbuilders for Director of Nursing position by the Regional Human Resources Director.	
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.	F 411	<u>Monitoring Measures to Maintain On-going Compliance</u> [1] The Administrator or interim Director Director of Nursing will bring the results of the recruitment process to the Monthly Quality Assurance Meeting [consisting of: Administrator, Director of Nursing, Assistant Director of Nursing, Resident Care Coordinator, Unit Manager, MDS Coordinator, Plant Services Director, Activities Director, Medical Records Director, Social Services Director, Admission Coordinator] for review and development of action plans monthly until a Director of Nursing is employed. F 411 483.55(a)	05/15/15

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F 411	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure each resident was afforded the opportunity to have routine dental services for one (1) of three (3) sampled residents (Resident #1). The findings include: Review of the facility's policy and procedures titled, "Dental Services", not dated, revealed its policy was to make dental services available to residents requiring such services. Further review revealed dental services were made available to all residents requiring routine and emergency dental care. In addition, the facility would assist the resident in making appointments and arranging transportation. Record review revealed the facility admitted Resident #1 on 09/17/14 with diagnoses which included Intellectual Disability, Breast Cancer, Scoliosis and Anxiety. Review of a Significant Change Minimum Data Set (MDS) assessment, dated 02/09/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) indicating the resident was not interviewable. Further review revealed the facility had assessed the resident's oral/dental status as broken or loose fitting denture. Observation of Resident #1 on 04/06/15 at 7:45 AM, revealed the resident was resting in bed.	F 411	ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS <u>Corrective Measures for Resident(s) Identified In The Deficiency.</u> [1] Resident was discharged from the facility on 04/07/15 per the original discharge plan. <u>How Other Resident's Who May Have Been Affected By This Practice Were Identified.</u> [1] On 04/14/15 and 04/16/15, 100% of the residents had an oral assessment completed by the Unit Manager and the Assistant Director of Nursing with no acute dental issues being observed. <u>Measures Implemented Or Systems Altered To Prevent Re-Occurrence.</u> [1] Residents will continue to have weekly oral assessments performed by the floor nurses along with their weekly skin assessment and documented on the Weekly Skin Observation form. [2] Licensed Nurses were educated on	05/15/15
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F 411	<p>Continued From page 31</p> <p>Further observation revealed Resident #1's teeth appeared discolored with a yellow, brown, and green substance noted. Record review revealed no documented evidence Resident #1 was offered or provided routine dental care from a dentist.</p> <p>Interview with the Resident's Legal Guardian, on 04/08/15 at 4:45 PM, revealed she wanted Resident #1 to receive dental services while a resident at the facility. She stated Resident #1's dental /oral status had declined since admission to the facility, as the resident's teeth had increased discoloration.</p> <p>Interview with the MDS Coordinator, Registered Nurse (RN) #2 on 04/08/15 at 8:35 AM, revealed she completed the Significant Change MDS assessment on 02/09/14, and stated the oral/dental status section was coded incorrectly. She stated Resident #1 did not have dentures. Further interview revealed RN #2 revealed the resident's dental health was in poor condition. She stated Resident #1's teeth were discolored and some teeth appeared to be missing. Additionally, she stated it would not have been a bad idea for Resident #1 to have been referred for a dental evaluation and stated, "I think everyone should see a dentist". In addition, she stated she thought the resident's nurse would obtain the referral for the dental services.</p> <p>Interview with the Social Service Director (SSD), on 04/08/15 at 10:25 AM, revealed the facility had a dental program for all residents to receive routine dental care. She further stated the resident needed a referral for the dental services from the physician. The SSD stated she was responsible for arranging the dental</p>	F 411	<p>performing oral assessments and notifying MD of any issues by the Resident Care Coordinator. Education began on 04/09/15 and was completed on 04/29/15.</p> <p>[3] Nursing Assistants were educated by the Resident Care Coordinator/Staff Development Coordinator on performing of oral care. Education began on 04/09/15 and was completed on 04/29/15.</p> <p>[4] Nursing assistants were educated by the Resident Care Coordinator/Staff Development Coordinator on reporting oral issues to the Licensed Nurses. Education began on 04/09/15 and was completed on 04/29/15.</p> <p>[5] Licensed Nurses educated by the Resident Care Coordinator/Staff Development Coordinator that dental services are available with an MD order. Education began on 04/09/15 and completed on 04/29/15.</p> <p><u>Monitoring Measures To Maintain On-going Compliance.</u></p> <p>[1] The Unit Manager, Resident Care Coordinator, and the Assistant Director of Nursing will be responsible for monitoring of the weekly oral assessments. The Director of Nursing</p> <p>will be responsible for bringing the results to the Monthly Quality</p>	05/15/15

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F 411	<p>Continued From page 32</p> <p>appointments; however, she had not received a referral to arrange an appointment for Resident #1. She stated it would be the Nurse's responsibility to obtain the referral from the physician.</p> <p>Interview with the Director of Nursing (DON) on 04/08/15 at 5:40 PM, revealed she would expect the nurse to assess each resident's oral/dental status and obtain a Physician's Order for a dental exam.</p> <p>Interview with the facility's Medical Director/Resident #1's Physician, on 04/08/15 at 2:23 PM, revealed he would have referred Resident #1 for dental services if he had noted any complaints of any dental problems; however, he did not usually refer residents for routine screenings.</p>	F 411	<p>Assurance meeting [consisting of Administrator, Director of Nursing, Assistant Director of Nursing, Resident Care Coordinator, Unit Manager, MDS Coordinator, Plant Services Director, Activities Director, Medical Records Director, Social Services Director, Admissions Coordinator] for review and development of action plans monthly times six months.</p>	05/15/ 5
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