

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

PRINTED: 10/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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<p>F 000 INITIAL COMMENTS</p> <p>A Standard Re-Certification Survey was initiated on 09/16/14 and concluded on 09/18/14 with deficiencies cited at the highest Scope and Severity (S/S) of an "F".</p> <p>F 160 SS=B 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</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 convey funds upon the death of a resident within a thirty (30) day timeframe for two (2) of the five (5) sampled deceased financial reviews.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled "Resident Funds", revised 09/01/13, revealed upon death of a resident, disbursement of monies should be done in accordance with state regulations. Further review revealed, refunds should be made to the family or responsible party. Continued review revealed refunds for discharged residents should be done within thirty (30) days.</p> <p>Review of Unsampled Resident A's medical record, revealed the resident expired on</p>	<p>F 000</p> <p style="text-align: center;">RECEIVED OCT 11 2014</p> <p>F 160 F160</p> <p>1. Resident A- \$1510.99 was refunded to the resident's estate on 09/1/14 by Business Office Manager. 10/25/14</p> <p>Resident B-\$223.23 refunded on 08/26/14 by Business Office Manager.</p> <p>2. Audit of residents that were discharged financial files was completed by Business Office Manager and Administrator on 09/23/14 to determine if funds were returned timely, any residents identified had funds returned to their estate/responsible party.</p> <p>3. The Business Office Manager was reeducated by the Administrator on 09/23/14 regarding the resident's funds policy that refunds must be made within 30 days of date of discharge. A post- test was given to determine competency.</p> <p>4. The Business Office Manager and/or Administrator will complete an audit of all discharged residents financial files to determine that funds have been refunded within 30 days as per policy weekly x 8 weeks and then monthly x 4. Any concerns will be addressed at the time identified. A summary of findings will be submitted to the Performance</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dawn Cunningham</i>	TITLE Administrator	(X6) DATE 10/16/14
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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 160	<p>Continued From page 1</p> <p>07/27/14. Further review of the medical record, revealed the financial reimbursement was dated 09/01/14.</p> <p>Review of Unsampled Resident B's medical record, revealed the resident expired on 04/01/14. Further review of the medical record, revealed the financial reimbursement was dated 08/26/14.</p> <p>Interview with the Business Manager, on 09/18/14 at 3:30 PM, revealed the refunds were late being processed and not done timely. Further interview revealed refunds should be sent within thirty (30) days of a resident's death.</p> <p>Interview with the Administrator, on 09/18/14 at 4:04 PM, revealed refunds should be disbursed within a thirty (30) day time frame, per the regulations.</p>	F 160	<p>Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor by the Business Office Manager or Administrator monthly for review and further recommendation.</p> <p>5. Completion date of 10/25/14.</p>	
F 164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p>	F 164	<p>F164</p> <p>1. Privacy curtain tracks ordered on 10/10/14 will be installed in 200 Hall Shower room and community bathroom, 100 hall shower room and community bathroom by the Maintenance Director by 10/24/14. Track was installed by the Maintenance Director/designee to include entire toilet and/or shower area to avoid exposure.</p> <p>2. Audit completed by Administrator and Director of Nursing on 09/22/14 revealed no further privacy or dignity issues.</p>	10/25/14

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F 164	<p>Continued From page 2</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy and review of the facility's resident rights, it was determined the facility failed to maintain each resident's personal privacy during bathing and or toileting. The facility failed to ensure curtains were in the community shower room. Additionally, the facility failed to ensure the curtains in the community toilet area were adequate for individual toileting privacy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Patient's Bill of Rights and Responsibilities", revised 08/04/14, revealed the facility had established the Patient's Bill of rights and Responsibilities in accordance with state and federal regulations.</p> <p>Review of the facility's resident rights titled, "Resident Rights for the State of Kentucky", section 216.515 Rights of residents--Duties of facilities--Actions, undated, revealed residents should be assured of at least visual privacy in</p>	F 164	<p>3. Staff reeducated by Administrator, Director of Nursing and Assistant Director of Nursing regarding Residents Rights, Privacy during care and need to use privacy curtains by 10/24/14. A post-test will be given to determine competency.</p> <p>4. Administrator/Director of Nursing, Unit Managers and Maintenance Director will complete audit of residents shower and community baths daily times 2 weeks then 3 times per week times 2 weeks then weekly times 4 weeks, bi-weekly times 4 weeks and monthly times 4 months. . A summary of findings will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor for further review and recommendations.</p> <p>5. Completion date of 10/25/14.</p>	

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F 164	Continued From page 3 multibed rooms and in tub, shower, and toilet rooms. Observation during initial tour of the 200 hall, on 09/16/14 at 11:35 AM, revealed the community shower room on the 200 hall to have no lock on the door. Further observation revealed no privacy curtains or privacy stalls for the shower or toilet. Continued observation on the 200 hall revealed, the community toilet room to have no lock on the door. Further observation revealed the community toilet room to have two (2) toilets with one privacy curtain around both toilets with no separation for privacy. Observation during initial tour of the 100 hall, on 09/16/14 at 12:58 PM, revealed the community shower room to have no lock on the door. Further observation revealed the community shower room to have no privacy curtains or stalls for the shower or toilet area. Further observation of the 100 hall, revealed the community toilet room to have no lock on the door. Further observation revealed a privacy curtain around and separating the two toilet areas with the first curtain not operational at the track. Observation of the 100 hall, on 09/17/14 at 9:45 AM, revealed a resident in the first stall of the community toilet area with the door open and the privacy curtain open. The resident's head and upper body were visible from the hall. Further observation revealed Certified Nursing Assistants (CNA) #2 and #3 assisting a resident in the second stall. Continued observation revealed CNA #1 entered the community toilet room to deliver supplies to CNA #2 and #3 and left without closing the privacy curtain or the toilet room door for the resident in the first stall.	F 164			

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F 164

Continued From page 4

Interview with CNA #1, on 09/17/14 at 10:05 AM, revealed the resident in the first stall was able to independently toilet his/her self. Further interview revealed CNA #1 should have closed the door to the toilet area or closed the privacy curtain to provide privacy to the resident.

Interview with CNA #2, on 09/17/14 at 10:20 AM, revealed she was assisting another resident in the second toilet stall when an independent resident came into the toilet area. Further interview revealed the privacy curtain should have been closed to provide privacy to the resident.

Interview with CNA #3, on 09/17/14 at 10:30 AM, revealed she was assisting another resident in the second toilet stall when an independent resident came into the toilet area. Further interview revealed staff did not provide privacy to the resident in the first stall.

Interview with House Keeper #1, on 09/17/14 at 11:06 AM, revealed the privacy curtains should have already been repaired. Further interview revealed she would repair the track so the curtain would close all the way.

Observation of the 100 hall, on 09/17/14 at 11:45 AM, after the curtain track had been repaired, revealed a resident entering the community toilet area. Further observation revealed the resident passing by the first toilet enroute to the second toilet, brushing against the privacy curtain of the first toilet, inadvertently opening the privacy curtain to expose the toilet.

Interview with the Director of Nursing, on 09/18/14 at 2:10 PM, revealed the process for the

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F 252 Continued From page 6
(14) resident bathrooms, and an exhaust fan cover that was off and on the toilet lid in one (1) of fourteen (14) fourteen resident bathrooms.

The findings include:

Review of the facility's policy titled, "Routine Maintenance", revised on 06/01/07, revealed requests for routine maintenance on the physical plant, fixtures, and equipment would require a work order and work orders would be responded to on a timely basis.

Observations on initial tour, on 09/16/14 at 11:45 AM, revealed room 409 had tiles in the bathroom cracked, broken and missing. Observation in the bathroom for rooms 307/308 had water dripping from the sink faucet with a white substance build up and the bathroom for room 305 had a wet substance at the base of the toilet with the tiles around the toilet to be discolored and cracking additionally, there was a strong odor of urine. Observation of the bathroom for 308 revealed a cracked and ill fitting toilet tank cover, and the bathroom for 309 had an exhaust fan cover off and lying on the toilet tank lid. The shower room in the 100 hall had cracked tiles on the shower wall.

Interview with a State Registered Nursing Assistant (SRNA) #5, on 09/18/14 at 2:10 PM, revealed the process for needed maintenance repairs would be to fill out a maintenance request slip and place the slip in the maintenance mailbox so maintenance was aware of the needed repair. Further interview revealed cracked tiles in the shower room and/or floors should have been reported to Maintenance as it could cause a hazard for residents.

F 252 identified concerns and issues including missing tiles, toilet lid covers and base, exhaust fans, were addressed appropriately during audit on 09/23/14 with corrective action if indicated.

3. Staff reeducated regarding work order request per Administrator, Maintenance Director, Director of Nursing and Assistant Director of Nursing by 10/24/14. Maintenance Director reeducated regarding home like environment by Administrator on 09/18/14. A post-test was given to determine competency.

4. Administrator, Director of Nursing, Assistant Director of Nursing, Admissions Director, Social Services Director, Activities, MDS Nurse, Medical Records or Unit Manager will complete an audit of center to determine a safe, clean, comfortable, homelike environment daily times 2 weeks then 3 times per week times 2 weeks then weekly times 4 weeks, bi weekly times 4 weeks and monthly times 4. Any concerns will be addressed via a work order. A summary of findings will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor for further review and recommendations.

5. Completion date of 10/25/14.

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F 252	Continued From page 7 Interview with SRNA #6, on 09/18/14 at 2:45 PM, revealed a maintenance repair form should have been completed for cracked tiles in the shower room and/or floors as it could have been a safety risk for residents. Interview with a Licensed Practical Nurse (LPN) #1, on 09/18/14 at 4:54 PM, revealed staff should have been aware of the process for completing work orders. Maintenance issues in need of immediate repair should have been reported to the Maintenance Supervisor immediately. Further interview revealed work orders should have been completed for broken tiles, leaking faucets, leaking toilets, and a missing exhaust fan cover in the resident bathrooms. Interview with the Maintenance Supervisor, on 09/18/14 at 3:30 PM, revealed the process for repairs in the facility was for staff to verbally tell him or complete a work order to report maintenance issues and place them in the designated area in the nursing station which he checked them every morning. Further interview revealed he was not aware of these maintenance issues in the residents' bathrooms or the 100 hall shower room and staff should have completed a work order on broken tiles on the 100 hall shower wall, cracked tiles on the floors of resident bathroom, leaking sink faucets with a white substance build up on the faucet, a wet substance at the base of a toilet in a resident bathroom, a cracked and ill fitting toilet lid in a resident bathroom, and a missing exhaust fan cover in a resident's bathroom, so he would have been aware of the needed repairs in the residents' bathrooms and shower room. Further interview revealed the cracked shower tiles in the	F 252			

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F 252 Continued From page 8
100 hall shower room could be a safety issue for the residents. Continued interview revealed upon hire staff received a half hour of training on the importance of reporting broken items or any safety hazards to Maintenance.

Interview with the Director of Nursing (DON), on 09/18/14 at 5:35 PM, revealed the process for maintenance issues in need of repair would be for the staff to complete a work order for the maintenance staff to alert them of the need for repairs and then the maintenance staff would prioritize those work orders in the order of what was most important. Further interview revealed her expectations would have been for staff to have completed a work order to maintenance for broken tiles in the resident bathrooms, broken tiles in the shower room, leaking faucets with a white substance build up, a leaking toilet, missing exhaust fan covers, and broken ill fitting toilet lids so those issues could have been repaired.

Interview with the Administrator, on 09/18/14 5:14 PM, revealed her expectation would be for work orders to have been completed to notify maintenance of needed repairs in resident bathrooms and throughout the facility.

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

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

F 252

F 323 F323
1. Director of Nursing removed razor from 307/308 bathroom on 09/16/14.
2. Facility rounds completed by the Director of Nursing completed rounds on residents bathrooms for razors not secured on 09/17/14 and any concerns identified were addressed immediately to ensure environment is as free of hazards as possible.

10/25/14

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F 323 Continued From page 9

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure The residents environment remained as free from accident hazards as possible. During the environment tour on 09/16/14, observation was made of razor to be in the bathroom that connected rooms 307 and 308.

The findings include:

Interview with the Administrator revealed she did not have a policy on "razors", but it was her expectation that disposable razors would not be left in resident's rooms and/or bathrooms.

The facility reported they have eight (8) residents with a Brief Interview Mental Status (BIMS) of less than eight (8) who were mobile.

Observation of Environmental Tour, on 09/16/14 at 5:50 PM, revealed a razor was stored on the top shelf, in the residents shared bathroom 307/308.

Interview with Certified Nursing Assistant (CNA) #1, on 09/16/14 at 11:20 AM, revealed razors should not be left out in resident's rooms/bathrooms. She reported the razors should be placed in the sharps container when residents were finished with the razor. She reported this was important for the safety of the residents.

Interview with Certified Nursing Assistant (CNA) #7, on 09/16/14 at 11:36 AM, revealed razors should not be left in resident's rooms. She stated

F 323 3. Staff reeducated per Administrator, Director of Nursing and Assistant Director of Nursing by 10/24/14 regarding incident/accident policy to ensure that the resident environment remains as free of accident hazards as possible. A post-test will be given to determine competency.

4. Audits to be completed by Administrator, Director of Nursing, Assistant Director of Nursing, Admissions Director, Social Services Director, Activities, MDS Nurse, Medical Records and/or Unit Manager to ensure environment remains as free of accident hazards as possible daily across all shifts times 2 weeks then 3 times per week times 2 weeks then weekly times 4 weeks, bi weekly times 4 weeks and monthly times 4. Any concerns will be addressed via a work order. A summary of findings will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor for further review and recommendations.

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F 323	Continued From page 10 razors were sharp and could potentially harm a resident who could wander into a resident's room. Interview with Certified Nursing Assistant (CNA) #8, on 09/18/14 at 1:50 PM, revealed razors should not be left in resident's rooms because another resident could possibly pick it up and cut themselves on accident. Interview with Licensed Practical Nurse (LPN) #1, on 09/18/14 at 4:54 PM, revealed disposable razors should not be left in residents rooms. She reported the razors should be kept in the supply room behind locked doors. LPN #1 stated this was important because the facility has confused residents and those with mental health issues who may get a hold of the razors. She stated it would be for the safety of the residents to lock the razors up. Interview with the Administrator, on 09/18/14 at 5:14 PM, revealed razors should not be kept in residents rooms. She reported this was for the safety of the resident, as well as, other residents.	F 323			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 1. All items not covered or dated appropriately observed in walk-in refrigerator were removed and discarded by Registered Dietician on 09/16/14. Dietary Aide #1 reeducated by Registered Dietician on 09/16/14 regarding taking proper food temp techniques, Dietary Aid #3 reeducated 09/16/14 per Registered Dietician regarding hand washing and use of gloves. Dietary Aide #4 reeducated per Registered Dietician regarding cross contamination and carrying items against	10/25/14	

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F 371 Continued From page 11
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policies, it was determined the facility failed to ensure foods were stored, prepared, distributed and serviced under sanitary conditions. Observations of foods stored in the kitchen revealed undated/unlabeled food items, uncovered food items, and expired food items. Continued observation revealed infection control issues related to air vents with brown particulate observed, staff handwashing, staff handling of clean plates, and thermometer sanitation between food items.

The findings include:

1. Review of the facility's policy titled: "4.7 Food Handling", revised date 04/01/14, revealed foods were stored, prepared and served in a safe and sanitary environment to prevent bacterial contamination. The policy revealed unused portions of foods that were prepared and not placed into service were covered, labeled and dated with a "use by" dates and served by the used by date. The policy included cold foods that remains under refrigeration during service can be covered, labeled, dated with "use by" dates and served by "use by" date. Policy review also revealed ready-to-eat foods, temperature controlled food prepared and held at forty (40) degrees Farenheit must be used or discarded at a maximum of seven (7) days.

Observation of the walk-in-refrigerator, on 09/16/14 at 10:50 AM, revealed a tray containing milk glasses un-covered on the shelf, a blue bowl container on the shelf covered with no label of the item or date, a container of Arrezzo Grated

F 371 her body 09/17/14. Post-test was given to determine competency.

Maintenance Director and Housekeeping Supervisor cleaned vents in kitchen area 09/19/14.

2. Audit completed per Administrator, Maintenance Director and Housekeeping Supervisor on 09/22/14 to ensure kitchen vents were free from brown substances and particles. Audit completed by Registered Dietician 09/16/14 for appropriate food storage to include but not limited to dating and covering food items. No further areas of concern identified.

3. The Maintenance Director, Housekeeping Supervisor and dietary staff reeducated per Administrator, Dietary Chef Supervisor and Registered Dietician to the policy and procedures of hand washing techniques cross contamination, proper food temperature techniques and vent cleaning by 10/24/14. A post- test will be given to determine competency.

4. Audits to ensure vents are clean and food stored and dated appropriately will be completed daily across dietary shifts for 2 weeks then 3 times per week times 2 week, then weekly times 4 weeks, bi weekly times 4 weeks and monthly times 4 by Administrator, Registered Dietician and/or Dietary Chef Supervisor to determine compliance. Any maintenance

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F 371	<p>Continued From page 12</p> <p>Parmigiano cheese which was not closed/covered on the shelf. Continued observations of the walk in refrigerator, on 09/16/14 at 5:09 PM, revealed a pan covered with tin foil and labeled "Apple Sauce" and dated 09/04/14.</p> <p>Continued observation of the kitchen, on 09/16/14 at 11:10 AM, revealed a cooler refrigerator containing glasses of milk uncovered and a metal Frigidaire refrigerator with glasses of red liquid.</p> <p>Interview with Dietary Aide (DA) #2, on 09/16/14 at 10:58 AM and 11:10 AM, revealed the milk glasses and juices should have been covered. Further interview revealed items could drop into the glasses and cause contamination.</p> <p>Interview with the Registered Dietician, on 09/16/14 at 5:34 PM, revealed the apple sauce was only good for seven (7) days and if kept longer there was the potential for spoilage.</p> <p>Interview with Cook/DA#1, on 09/17/14 at 2:35 PM, revealed all items in the coolers were to be covered because when they were taken out of the cooler and put onto the service line dust or other dirt from the ceiling may have fallen into the glasses which could result in contamination.</p> <p>Interview with Genesis Food Service Director/Hired Dietary Manager, on 09/17/14 at 2:40 PM, revealed the Parmigiano cheese container should not have been open in the refrigerator because other items could get into the cheese. He stated all glasses in the refrigerators/coolers should be covered to prevent exposure to dust, or anything else that was floating in the air. He further stated it was a</p>	F 371	<p>concerns will be addressed via a work order.</p> <p>Audit regarding hand washing techniques, proper food temperature techniques and cross contaminations will be completed by Dietary Chef Supervisor, Registered Dietician or Administrator daily times 2 weeks across dietary shifts then 3 times per week times 2 weeks then weekly times 4 weeks, bi weekly times 4 weeks and monthly times 4 to determine compliance. A summary of findings will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor e for further review and recommendations.</p> <p>5. Completion date of 10/25/14.</p>		

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F 371	<p>Continued From page 13</p> <p>contamination problem that had potential to cause the resident sickness. Further interview revealed food items should be labeled and dated.</p> <p>2. Review of the facility's policy titled: "4.6 Hand Washing", revised date 12/14/14, revealed hand washing was performed to minimize the spread of disease. The policy revealed handwashing was performed after contacting any soiled utensils, before touching any clean utensils, plates, cups, or pans, and when moving from one task to another. Further review revealed the use of disposable gloves did not replace proper handwashing.</p> <p>Observation, on 09/16/14 at 5:05 PM, revealed DA #3 moved from station to station in the kitchen area without washing hands/changing gloves. Continued observation at 5:34 PM, revealed DA #3 went out of the kitchen area, returned with a tray which had cups on it, take the tray to the dirty side of kitchen wash area. DA #3 then returned to the kitchen area removed gloves, placed them in garbage can, and put on a clean pair of gloves without washing hands.</p> <p>Interview with DA #3, on 9/17/14 at 2:35 PM, revealed she was trained to wash hands and put on gloves when she moved to another station and wash her hands after she had left and came back to the kitchen. She stated, by not washing hands, there was the concern of passing germs to residents. She further stated she was kind of nervous last evening.</p> <p>Continued interview with Genesis Food Service Director/Hired Dietary Manager, on 09/17/14 at 2:40 PM, revealed all staff were to wash hands when they changed tasks in the kitchen and</p>	F 371		

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F 371	<p>Continued From page 15</p> <p>Department Sanitation", effective date 10/12/08, revealed the food and nutrition services department was maintained in a clean/sanitary manner to ensure food and beverages were stored, prepared, and served in a clean/sanitary environment. Further policy review revealed cleaning schedules were followed and cleaning procedures were utilized.</p> <p>Observation and interview with DA #4, on 09/17/14 at 2:34 PM, revealed the DA #4 carried a stack of clean plates from the clean wash area to the plate warmer and had some of the plates resting against her apron. Interview with DA she had the plates against her body and they had touched her apron. She stated the Apron could be dirty and could result in cross contamination of the clean plates.</p> <p>Interview with Genesis Food Service Director/Hired Dietary Manager, on 09/17/14 at 2:38 PM, revealed the plates had touched the Dietary Aide's Apron and had to worry about cross contamination. He stated the plates should have been carried on a clean sanitized cart.</p> <p>Observation, on 09/17/14 at 2:15 PM, revealed four (4) kitchen vents had brown substances/particles on the vents. Continued observation revealed Genesis Food Service Director/Hired Dietary Manager used a gloved finger and wiped some of the brown substance/particles off of the vent.</p> <p>Interview with the Genesis Food Service Director/Hired Dietary Manager, on 09/17/14 at 2:15 PM, revealed the vents should have been wiped down because you don't want anything coming down from the vents onto the food.</p>	F 371		

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F 371	Continued From page 16 Interviews with the Maintenance Supervisor, on 09/18/14 at 2:14 PM and the Housekeeping Manager, on 09/18/14 at 2:21 PM revealed they thought kitchen staff was responsible for cleaning the vents. The Housekeeping Manager further stated it was important to clean the vents so dust didn't accumulate and fall on the food. He stated it was an infection control issue. Interview with Cook #1, on 09/18/14 at 2:35 PM, revealed kitchen staff had not climbed ladders and cleaned the air vents. She stated the vents weren't cleaned by kitchen staff and was not sure who was responsible but knew they were not responsible. Interview with the Administrator, on 09/18/14 at 2:47 PM, revealed the kitchen vents needed to be cleaned because you don't want particles from the vent coming down when the food was prepared. The Administrator thought housekeeping cleaned the kitchen vents.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	F441 1. Soiled bedpan in bathroom for room 312 cleaned, sanitized, labeled and placed in a plastic bag, soiled urine graduates in rooms 305 and 309 cleaned, sanitized, labeled and placed in a plastic bag, plunger in bathroom for 305 removed, gloves on floor in room 303 were discarded, toothbrushes for room 308 were discarded per Director of Nursing on 09/19/14.	10/25/14

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F 441	<p>Continued From page 17</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and review of the facility's policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Observation during initial tour revealed bedpans unlabeled and unbagged, toilet plungers unbagged in resident bathrooms, and toothbrushes unlabeled and uncovered.</p> <p>The findings include:</p>	F 441	<p>2. Audit for infection control .i.e. bedpans, urinals, tooth brushes stored, appropriately completed on 09/19/14 by Director of Nursing to ensure a safe sanitary comfortable environment to prevent the development and transmission of disease and infection standards are met. No further areas of concern were identified.</p> <p>3. Staff reeducated regarding infection control policy and procedures to include storage of tooth brushes, bedpans, urinals and plungers by Director of Nursing, Assistant Director of Nursing and/or Administrator by 10/24/14. A post- test will be given to determine compliance.</p> <p>4. Infection Control audits to be completed by Director of Nursing, Assistant Director of Nursing, Administrator and/or Unit Managers daily times 2 week then 3 times per week times 2 weeks then weekly times 4 weeks, bi weekly times 4 weeks and monthly times 4 to determine compliance. Any concerns to be addressed immediately. A summary of findings will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor for further review and recommendations.</p> <p>5. Completion date of 10/25/14.</p>

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F 441 Continued From page 18

Review of the facility's policy, titled "IC 307 Standard Precautions" revised 10/01/13, revealed the purpose was to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Further review revealed to prevent transmission of microorganisms from used equipment, the equipment should be cleaned and disinfected appropriately prior to another resident use. Further review revealed disposable equipment could be used when available and any single use items were to be disposed of promptly.

Observation during initial tour, on 09/16/14 at 10:30 AM, revealed a soiled bedpan in the bathroom of resident room 312 to be unlabeled and unbagged. Further observation revealed the bathroom for resident room 309 to contain a soiled urine graduate without an identifying label and unbagged on the floor. Continued observation revealed the bathroom for resident room 305 to contain two (2) soiled toilet plungers unbagged on the floor and a urinal without an identifying label and unbagged on the floor. Resident room 303 had soiled examination gloves lying on the floor near a trash can.

Interview with CNA #7, on 09/16/14 at 11:36 AM, revealed toothbrushes should be placed in a cover holder and labled to prevent from mixing toothbrushes up with other residents. Continued interview revealed plungers should be covered for infection control.

Interview with Certified Nursing Assistant (CNA) #4, on 09/16/14 at 11:45 AM, revealed soiled toilet plungers should be bagged for infection control. Continued interview revealed soiled

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F 441	<p>Continued From page 19</p> <p>bedpans, urinals and toothbrushes should be labeled with the residents' identifier to decrease risk of cross contamination. Further interview revealed bedpans and urinals should be bagged and toothbrushes should be covered for infection control.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 , on 09/18/14 at 4:54 PM, revealed plungers and toothbrushes should have been covered to prevent the spread of infection.</p> <p>Interview with the Director of Nursing (DON), on 09/18/14 at 2:30 PM, revealed the facility did not have a policy specific for storage of toilet plungers, urinals and or bedpans; however, it was her expectation that the items would be labeled with the resident's identifier and bagged to prevent cross contamination and for infection control purposes. The DON further reported the toothbrushes should be labeled, covered and properly stored.</p> <p>Interview with the Assistant Director of Nursing, who was also the Infection Control Nurse (ICN), on 09/14/14 at 5:07 PM, revealed the toilet plungers should be stored in a container or plastic bag due to infection control contamination concerns. Further interview revealed, bedpans should be labeled and stored in a plastic bag related to infection control and cross contamination with the risk of a resident utilizing the soiled bedpan of another resident.</p>	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	F520 A plan of action was developed and implemented by the Performance Improvement Committee to correct identified quality issues and concerns. A Performance Improvement Committee meeting was held on 10/24/2014 to	10/25/14

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F 520	<p>Continued From page 20</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review, and review of the facility's Plan of correction from the last recertification survey, completed 09/19/13, it was determined the facility's Quality Assessment and Assurance program failed to ensure the plan of correction prevented continued deficient practice at F-371. Observation of resident tray line on 09/16/14 at 5:45 PM, revealed Dietary Aide/Cook #1 sanitized the food temperature thermometer with the same alcohol prep pad between three (3) food products on the tray line. Record review of the facility's F-371</p>	F 520	<p>discuss the action plans including audit, education, and compliance monitor.</p> <p>The Nursing Home Administrator (NHA) conducted an "ad-hoc" Performance Improvement Committee meeting on 09/29/2014 to address the identified quality issues.</p> <p>The Manager of Clinical Operations (MCO) reeducated the NHA on 09/18/2014 who will then reeducate the Interdisciplinary Team (IDT) on the Performance Improvement Committee process on or before 10/24/2014.</p> <p>The governing body will ensure that the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, psychosocial well-being of each resident.</p> <p>The Performance Improvement Committee for this facility has and will continue to meet monthly and ad hoc as needed to identify issues with respect to which quality assessment and assurance activities are necessary to effectively and efficiently attain or maintain the highest practicable physical, mental, psychosocial wellbeing of each resident.</p>	
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deficiency citation, from the last recertification survey, revealed staff had sanitized the thermometer with one alcohol wipe between three (3) food products.

The findings include:

Review of the Facility's policy: OPS103 "Center Quality Improvement Process", revised date 04/01/03, revealed one purpose of Quality Improvement was to establish and maintain processes to satisfy regulatory requirements. Further policy review revealed the Quality Improvement process included the development and implementation of action plans to correct identified quality deficiencies.

Review of the Statement of Deficiency (SOD) for the standard survey completed on 09/19/13 revealed the facility was cited under F-371 for deficient practice related to the failure to properly sanitize the thermometer between three (3) food items.

Review of the facility's Plan of Correction (POD), date of completion 10/13/13, revealed the plan included re-education, September 19, 2013, on the proper way food temperatures were taken. Continued review revealed the plan included observation/audit of staff food temperature practices by the Dietary Manager monthly and the submission of findings to the Performance Review Committee.

Review of the facility's policy titled: 4.9 "Thermometer Usage", revised date 04/01/14, revealed thermometers were to be washed, rinsed, sanitized, and air dried before and after each use to prevent cross-contamination.

F 520 1. All items not covered or dated appropriately observed in walk-in refrigerator were removed and discarded by Registered Dietician on 09/16/14. Dietary Aide #1 reeducated by Registered Dietician on 09/16/14 regarding taking proper food temp techniques, Dietary Aid #3 reeducated 09/16/14 per Registered Dietician regarding hand washing and use of gloves. Dietary Aide #4 reeducated per Registered Dietician regarding cross contamination and carrying items against her body 09/17/14. Post-test was given to determine competency. Maintenance Director and Housekeeping Supervisor cleaned vents in kitchen area 09/19/14.

2. Audit completed per Administrator, Maintenance Director and Housekeeping Supervisor on 09/22/14 to ensure kitchen vents were free from brown substances and particles. Audit completed by Registered Dietician 09/16/14 for appropriate food storage to include but not limited to dating and covering food items. No further areas of concern identified.

3. The Maintenance Director, Housekeeping Supervisor and dietary staff reeducated per Administrator, Dietary Chef Supervisor and Registered Dietician to the policy and procedures of hand washing techniques cross contamination, proper food temperature techniques and vent cleaning by 10/24/14.

10/25/14

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F 520	Continued From page 22 Observation, on 09/17/14 at 5:45 PM, of food line temperatures revealed Dietary Aide/Cook #1 used the same alcohol pads to sanitize the thermometer between temperatures of three (3) food items: the Dysphagia Diet (used for residents with difficulty swallowing) tray, the Regular Diet Sausage tray, and the Mashed Potatoes tray, before a new alcohol pad was used to sanitize the thermometer. Interview, on 09/17/14 at 2:42 PM, with Dietary Aide/Cook #1 revealed verification she had not used a clean alcohol pad to sanitize the thermometer between some of the food items. She stated the concern with not using a clean alcohol pad between the food items was cross contamination. Interview, on 09/17/14 at 2:48 PM, with the Genesis Food Service Director/newly hired Dietary Manager revealed a clean alcohol pad was needed to sanitize the thermometer between food items to prevent cross contamination and food allergies. Interviews with the Administrator, on 09/18/14 at 2:47 PM and 7:00 PM, revealed they just hired a new Dietary Manager (DM), who had not yet started, but had not had a DM the last couple of months. She stated in the absence of the DM, the cook had assumed the duties and was familiar with the responsibilities of the position. However, the Administrator revealed the prior DM was familiar with the Plan of Correction and was not involved in cooking but oversaw the kitchen serving process on a daily basis. In addition, she revealed that based on the Plan of Correction audit findings they were no longer doing the same	F 520	A post- test will be given to determine competency. 4. Audits to ensure vents are clean and food stored and dated appropriately will be completed daily across dietary shifts for 2 weeks then 3 times per week times 2 week, then weekly times 4 weeks, bi weekly times 4 weeks and monthly times 4 by Administrator, Registered Dietician and/or Dietary Chef Supervisor to determine compliance. Any maintenance concerns will be addressed via a work order. Audit regarding hand washing techniques, proper food temperature techniques and cross contaminations will be completed by Dietary Chef Supervisor, Registered Dietician or Administrator daily times 2 weeks across dietary shifts then 3 times per week times 2 weeks then weekly times 4 weeks, bi weekly times 4 weeks and monthly times 4 to determine compliance. A summary of findings will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor e for further review and recommendations. 5. Completion date of 10/25/14.		

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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 520	Continued From page 23 monthly audit which included monitoring of thermometer sanitation. The Administrator stated in the absence of the DM, the Dietician performed random audits in the kitchen and the audit tool being utilized had no thermometer sanitation observation check off.	F 520			

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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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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 007/14/76 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected SMOKE COMPARTMENTS: Five (5) smoke compartments. COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (Wet SYSTEM) EMERGENCY POWER: Type II Diesel Generator. A life safety code survey was initiated on 09/16/14 and concluded on 09/17/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred (100) beds and the census was ninety-five (95) the day of the survey. Deficiencies were cited with the highest	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bradford Square 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." Bradford Square	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James Cunningham TITLE: Administrator (X6) DATE: 10/17/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000 K 018 SS=D	Continued From page 1 deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors were clear of obstructions to their closing, according to National Fire Protection Association (NFPA). The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty (20) residents, staff and visitors The findings included:	K 000 K 018	<u>K018</u> 1. Room 103 bed was rearranged by maintenance and housekeeping director to allow door to close freely, room 114 fall mat was rearranged to allow door to close freely, rooms 112, 113 and 106 privacy curtains are placed in a position that allows door to close freely on 09/17/14. 2. Maintenance Director completed an audit of Center on 09/17/14 to ensure all doors closed freely without obstructions. No further areas of concern were identified. No further areas of concern were identified. 3. Maintenance Director/Administrator/Director of Nursing or Assistant Director of Nursing will reeducate staff that there is no impediment to the closing of doors by 10/24/14. A post- test will be given to determine competency. 4. Maintenance Director or Administrator will complete an audit of doors to ensure doors close without impediment daily times 1 week then 3 times a week for 4 weeks, weekly for 4 weeks and monthly times 4 months with corrective action upon discovery to determine compliance. A summary of findings will be submitted by the Maintenance Director to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business	10/25/14

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K 018	Continued From page 2 Observation on 09/17/14 at 8:48 AM, with the Maintenance Director, revealed the door of resident room 103 would not close due to a resident's bed blocking the area. Interview, with the Maintenance Director, revealed he was not aware of the requirements regarding corridor doors in the Life Safety Code. Further observation revealed the following: At 8:51 AM, Door for resident room 114 would not close and latch due to being blocked by fall mat. At 8:53 AM, Door for Resident rooms 113, 112, and 106 would not close due to being blocked by privacy curtains. The findings were acknowledged by the Administrator during the exit conference. Reference: NFPA (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA-80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments	K 018	Office Manager and Dietary Chef Supervisor monthly for further review and recommendations. 5. Date of completion will be 10/25/14.

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K 018	Continued From page 3 protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018		
K-029 SS=D	NFPA-101-LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty four (24) residents, staff and visitors. The findings included: Observation on 09/17/14 at 8:21 AM, revealed the door for the gas fuel-fired furnace room in Therapy was not equipped with a self-closer.	K-029	K029 1. A self-closure was placed on the gas-fired fuel furnace room door in the Therapy Dept. by maintenance director on 10/09/14. Sprinkler escutcheon rings were tightened to ensure no penetrations were visible 09/17/14 by the maintenance director. Penetrations in the walls and ceiling of furnace room in therapy were sealed on 10/21/14 by the Maintenance Director. 2. Audit of center completed by Maintenance Director on 9/17/14 revealed no further concerns. Maintenance Director determined proper requirements were met regarding maintaining hazardous areas according to NFPA standards. 3. Maintenance Director was reeducated on life safety code standards regarding penetrations and reeducated regarding doors that require self-closures to meet NFPA standards per the Regional Property Manager on 09/17/14. 4. Maintenance Director will monitor ceilings for penetrations including following any installation of wiring or equipment in ceilings and doors throughout the center for required self-	10/25/14

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K 029	Continued From page 4 Further observation revealed multiply penetrations in the walls and ceiling of the room. The observations were confirmed with the Maintenance Director. Interview, revealed he was not aware the door needed to be equipped with a self-closer and the penetrations in the walls and ceiling sealed.	K 029	closures monthly times 6 months to determine ceilings have no penetrations and doors meet NFPA standards. A summary of findings will be submitted by the maintenance director to the Performance Improvement Committee of consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor monthly for further review and recommendations. 5. Date of completion 10/25/14.
	<p>Observation on 09/17/14 at 8:25 AM, revealed in the 300 Hall storage and Soiled Utility room the sprinkler escutcheon rings were loose and allowed penetrations of the ceiling. The observation were confirmed by the Maintenance Director. Interview, revealed he was unaware the sprinkler escutcheon rings were loose.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms</p>		

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K 029	<p>Continued From page 5</p> <p>(6) Trash collection rooms</p> <p>(7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</p> <p>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions:</p>	K 029		

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K 029 Continued From page 6
a. It shall be made on either side of the smoke partitions.
b. It shall be made by an approved device that is designed for the specific purpose.

K 029

K 052 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 052 K052

A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

1. A sensitivity test was performed on all smoke detectors 9/17/14 by fire safety vendor, Fesco.

2. A sensitivity test was performed on all smoke detectors 9/17/14 by fire safety vendor Fesco to ensure NFPA standards were met. No concerns identified, standards met.

3. Maintenance Director reeducated on a fire alarm system required for life safety, installed, tested and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72 by Regional Property Manager on 09/17/14. A post- test will be given to determine competency.

4. Further tracking to be maintained per TELS monthly by Maintenance Director to ensure NFPA 70 and NFPA 72 standards are met. A summary of findings will be submitted by the maintenance director to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor monthly for further review and recommendations.

5. Completion date of 10/25/14.

This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were not inspected according to National Fire Protection association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, one hundred (100) residents, staff and visitors.

The findings included:

Record review on 09/17/14 at 10:55 AM of the fire alarm inspection reports, revealed sensitivity

10/25/14

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K 052	Continued From page 7 testing for smoke detectors connected to the fire alarm had not been performed within the last two (2) years. The finding was confirmed by the Maintenance Director. Interview, revealed the facility had recently changed vendors for fire alarm testing and maintenance and the new vender was going to perform sensitivity testing during the next scheduled testing.	K 052		
	The findings were acknowledged by the Administrator during the exit conference.			
	Reference: NFPA 72 (1999 edition)			
	7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the			

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K 052	Continued From page 8 control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.	K 052			
K 144 SS#F	Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review, observation and interview it was determined the facility failed to ensure the emergency generator was inspected	K 144 K144	1. Generator tested under load for 30 minutes on 09/22/14 by Maintenance Director. 2. The center has no additional generator. 3. Maintenance director reeducated regarding NFPA 99 requirements to perform load test 30 minutes per month ongoing per regional property manager 09/22/14. A post- test will be given to determine competency. 4. Further tracking to be maintained per TELS monthly by Maintenance Director to ensure NFPA 99 standards are met. A summary of findings will be submitted by	10/25/14	

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K 144	Continued From page 9 according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, one hundred (100) residents, staff and visitors. The findings included: Review of the inspection and maintenance records for the facility's emergency generator on 09/17/14 at 9:52 AM, revealed the facility did not have any documented proof that the emergency generator had been tested under load from 01/14 to 07/14. The findings were confirmed with the Maintenance Director. Interview revealed, the generator starts each week but the Maintenance Director is unaware if the generator is running under load during the weekly starting. The Maintenance Director was not aware of the procedures to take to place the emergency generator under load and stated the last time it was placed under load was when the Regional Maintenance Director inspected it on 08/31/14. Observation at the emergency generator annunciator panel revealed the emergency generator was not under load. The findings were acknowledged by the Administrator during the exit conference. Reference: NFPA 110 (1999 Edition) 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be		K 144	the maintenance director to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager and Dietary Chef Supervisor monthly for further review and recommendations. 5. Completion date of 10/25/14.	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2014
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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K 144	Continued From page 10 recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.2.1 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. 6-4.3 Load tests of generator sets shall include complete cold starts.	K 144		

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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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K 144	<p>Continued From page 11</p> <p>6-4.4 Time delays shall be set as follows:</p> <p>(a) Time delay on start: 1 second minimum</p> <p>Exception: Gas turbine cycle: 0.5 second minimum.</p> <p>(b) Time delay on transfer to emergency: no minimum required.</p> <p>(c) Time delay on restoration to normal: 5 minutes minimum</p> <p>(see A-4-2.4.7)</p> <p>(d) Time delay on shutdown: 5 minutes minimum</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>6-4.6* EPSS circuit breakers for Level 1 system usage, including main and feed breakers between the EPS and the transfer switch load terminals, shall be exercised annually with the EPS in the off position.</p> <p>Exception: Medium- and high-voltage circuit breakers for Level 1 system usage shall be exercised every 6 months and tested under simulated overload conditions every 2 years.</p> <p>6-4.7 The routine maintenance and operational testing program shall be overseen by a properly instructed individual.</p>	K 144		