

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

PRINTED: 05/01/2014  
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  04/17/2014
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  A Recertification/Abbreviated Survey (#KY21568) was conducted on 04/15/14 through 04/17/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "F". #KY21568 was unsubstantiated with no deficiencies cited.	F 000			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS  Based on the comprehensive assessment of a resident, the facility must ensure that --  (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and  (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure one (1) of	F 322	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.  F322 483.25(g)(2) NG TREATMENT/SERVICES-RESTORE EATING SKILLS  1. Resident #10 tube feeding formula and tube feeding tubing was immediately discarded upon discovery of outdated enteral feeding and feeding set and replaced with a new feeding and feeding set by the charge nurse. Resident #10 was assessed for any gastrointestinal distress and infection per nurse, signs or symptoms of distress or infection was noted.  2. A complete list of who all residents whom receive enteral feedings was obtained per DON. All enteral feedings and feeding sets were checked by unit manager to ensure they had not expired. All enteral tube feedings and feeding sets had been changed within the past 24 hours per facility protocol.  3. Re-education by DON and Staff Development Coordinator was initiated on 4/15/14 with all licensed nurses regarding changing out enteral feedings and feeding sets within 24 hours. This education was completed on the date of 4/21/14 with all licensed nurses being educated prior to their next shift		

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

TITLE

(X6) DATE

*Sammy Workman*

*Administrator*

*5/9/14*

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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F 322	<p>Continued From page 1</p> <p>sixteen (16) sampled residents (Resident #10) who was fed by a gastrostomy tube (g-tube) received the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, and metabolic abnormalities. The facility failed to change out Resident #10's enteral feeding and feeding set for one-hundred and one (101) hours after the enteral feeding was initiated.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Enteral Feeding", revised 04/02/13, revealed the facility's policy is residents are not fed by tubes unless the resident's clinical condition demonstrates that the feeding was medically necessary. Residents who receive such services will receive the appropriate treatment and intervention to prevent avoidable complications.</p> <p>Review of the "Abbott Nutrition, Abbott Laboratories Manufacture's Guidelines for "Vital 1.2 cal" enteral feeding" revealed the product should not hang for greater than forty-eight (48) hours after initial connection when clean technique and only one new feeding set are used. Otherwise, hang no longer than twenty-four (24) hours.</p> <p>Review of Covidien Kangaroo "Epump Safety Screw Spike Set" manufacture's guidelines revealed due to risk of bacterial contamination and overall system accuracy, feeding set can not be used for a period greater that twenty-four (24) hours.</p> <p>1. Record review revealed the facility readmitted Resident #10 on 01/09/14, with diagnoses which</p>	F 322	<p>4. DON or unit manager will complete a 100% audit on all residents receiving a tube feeding to ensure feeding and tubing have been changed within the past 24 hours. The audits will take place 5 days a week x2 weeks, then weekly x4, then monthly x3. The findings of these onservations/audits will be reported to the Director of Nursing and the Quality Assessment and Assurance Committee for review at the monthly meeting and recommendations if indicated.</p> <p>5/2/14</p>

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F 322	<p>Continued From page 2</p> <p>included Alzheimer's, Dementia, and Gastrostomy Tube (g-tube).</p> <p>Review of the April 2014 monthly Physician orders revealed an order for "Vital 1.2 cal" tube feeding at forty (40) milliliters per hour (ml/hr) continuously and an order to change Enteral Feeding set every forty-eight (48) hours and as needed. Further review of the physician's orders revealed on 04/13/14 at 3:30 PM, an order was received to withhold the enteral feeding until 04/14/14 at 3:30 PM due to vomiting.</p> <p>Review of the April 2014 Medication Administration Record (MAR) revealed Vital 1.2 cal" tube feeding at forty (40) milliliters per hour (ml/hr) continuously and to withhold the enteral feeding on 04/13/14 at 3:30 PM until 04/14/14 at 3:30 PM. The box to restart the feeding on 04/14/14 at 3:30 PM was initialed by Licensed Practical Nurse (LPN) #2. Additionally, there was an order to change Enteral Feeding set every forty-eight (48) hours and as needed but the boxes on the MAR next to this order were blank.</p> <p>Observation of Resident #10's tube feeding, on 04/15/14 at 10:13 AM, revealed the tube feeding was infusing Vital 1.2 cal at forty (40) milliliters(ml)/hour (hr). The Enteral Feeding and Enteral Feeding set were dated 04/11/14 at 5:00 AM which indicated the Enteral Feeding and Enteral Feeding set had been hanging for one-hundred and one (101) hours.</p> <p>Interview with LPN #2, on 04/15/14 at 12:13 PM, revealed on 04/13/14 at 3:30 PM, Resident #10's tube feeding was placed on standby per physician's order related to the resident having vomiting. She stated she resumed the feeding</p>	F 322			

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F 322	<p>Continued From page 3</p> <p>via g-tube on 04/14/14 at 3:00 PM; however, she stated the Enteral feeding and feeding set were not changed prior to restarting the feeding on 04/14/14. She revealed the facility practice was for the enteral feeding and enteral feeding set to be changed every twenty-four (24) hours. She stated by not changing out the feeding and feeding set she placed the resident at risk for infections and becoming sick.</p> <p>Observation of Resident #10 tube feeding and interview with the Unit Manager, on 04/15/14 at 12:04 PM, Resident #10's enteral feeding bottle of Vital 1.2 cal being infused at 40 ml/hr. was not labeled with the resident's name; however, it was dated 4/11/14 at 5:00 AM. The Unit Manager stated this was unacceptable and nursing education was needed by staff of the policy and procedure for enteral feeding. She revealed when the tube feeding was hung by the staff, the staff should document the resident's name and date/time it was initiated on the feeding. She stated all enteral feeding and feeding sets should be changed every twenty-four (24) hours and as needed. She revealed if the enteral feeding was placed on hold for more than twenty-four (24) hours, she would expect the staff to change out both the feeding and feeding set before resuming feedings. She stated this failure could cause a resident to be at risk for infection and cause the resident to get sick.</p> <p>Interview with the Director of Nursing (DON), on 04/17/14 at 1:47 PM, revealed had been made aware of the findings of the tube feeding set not being changed every 24 hours and that the nurse had restarted the tube feeding on Resident #10 after an extended hold time. She stated her expectation of the staff was that both the feeding</p>	F 322	

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F 322  F 371 SS=F	<p>Continued From page 4</p> <p>bottle and the tube feeding set should have been changed prior to restarting feeding. She revealed these failures placed the resident at risk for infection.</p> <p>483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of the facility's Handwashing Policy, it was determined the facility failed to ensure food was stored and served under sanitary conditions. Review of the Census and Condition, dated 04/15/14, revealed the facility census was seventy-eight (78) residents with three (3) residents receiving tube feeding.</p> <p>The findings include:</p> <p>Review of the "Hand Washing Policy", dated 12/01/11, revealed hands should be washed after touching un-sanitized equipment, work surfaces, or wash cloths.</p> <p>Observation, on 04/15/14 at 11:40 AM, revealed Cook #1 donned gloves prior to serving trays</p>	F 322  F 371	<p>F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</p> <p>1. The cook was instructed on proper handwashing techniques and observation by the Dietary Manager revealed that staff were changing gloves and washing hands appropriately including during tray line service. The bread crumbs were discarded immediately by the Dietary Manager.</p> <p>2. All cooks were instructed on proper handwashing techniques and observation by the Dietary Manager revealed that staff were changing gloves and washing hands appropriately including during tray line service. The bread crumbs were discarded immediately by the Dietary Manager.</p> <p>3. All dietary staff were re-educated by the Dietary Service Manager on 4/18/14 on proper handwashing including washing hands after touching un-sanitized equipment, work surfaces, and wash clothes. Dietary managed reeducated staff on 4/18/14 on proper storage technique for dry food storage items.</p> <p>4. The dietary manger will monitor handwashing during tray line service 5x week for 1 weeks, 3x week for 3 weeks, then weekly for 2 months. Results will be shared with Administrator and reviewed monthly by Quality Assurance Committee with revisions made as needed. 5/2/14</p>

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F 371	<p>Continued From page 5</p> <p>from the tray line. During the observation, the cook was observed to leave the tray line to obtain a knife. She returned, using the knife to cut up ham on two resident trays; however, she did not change gloves or wash her hands. She was observed to touch plates, bowls, utensils, and the surface in front of the steam table food compartments while wearing the same gloves. Further observation revealed Cook #1 used her gloved hand to pick up cornbread, placing a piece on sixteen (16) resident trays.</p> <p>Observation of the dry storage area, on 04/15/14 at 9:00 AM, revealed (1) bag of breadcrumbs stored in a clear trash bag with multiple holes noted in the bag. The breadcrumbs had spilled out onto the box where the bag was located. The bag had no date to indicate when it had been opened.</p> <p>Interview with the Dietary Manager, on 04/15/14 at 9:10 AM and 04/16/14 at 1:20 PM and 3:30 PM, revealed Cook #1 should only handle food items with clean gloves. She revealed staff should ensure they seal and date food items when opened. The breadcrumbs should have been sealed in a bag with no holes. She further revealed there was no specific policy related to dry storage items.</p> <p>Interview with the Administrator, on 04/17/14 at 2:00 PM, revealed she expected dry storage items to be dated when opened and placed in a sealed container to avoid spillage. She revealed staff were supposed to wash their hands and don new gloves before handling food items.</p>	F 371			

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K 000	Continued From page 1 Fire).	K 000	<b>Plan of Correction Disclaimer</b> The Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because of State and Federal requirement.	
K 025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred (100) beds and at the time of the survey, the census was seventy-eight (78).</p> <p>The findings include:</p> <p>Observation, on 04/16/14 at 1:45 PM with the Environmental Director, revealed the smoke</p>	K 025	<p>K 025 NFPA 101 LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> <li>1. No residents were identified in this deficiency</li> <li>2. Residents in 2 of the 7 smoke compartments had the potential to be affected</li> <li>3. The Environmental Director was re-educated on verifying the kitchen service windows would close upon activation of the fire alarm per NFPA 101 Life Safety Code by the NHA on 4/18/14. The kitchen service window drop down fire doors were tied into every alarm zone on 5/2/14 by Pennyryle Fire Safety. On 5/2/14 the Environmental Director verified that the drop down fire doors were working correctly at the tripping of each zone's fire alarm.</li> <li>4. The Environmental Director will conduct a monthly audit of the kitchen service windows weekly for 1 month, then monthly for 2 months to validate ongoing compliance that the windows operate correctly. The results of the audits will be reported to the Administrator and the Quality Assessment and Assurance Committee on a monthly basis.</li> </ol>	5/2/14

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K 025	<p>Continued From page 2</p> <p>partition at the kitchen was penetrated by two service windows. The service windows were equipped with drop down fire rated doors. The drop down doors did not function upon activation of the fire alarm.</p> <p>Interview, on 04/16/14 at 1:46 PM with the Environmental Director, revealed he was unaware the doors did not close properly upon the activation of the fire alarm. Further interview revealed upon talking to the fire alarm company only the fire pull stations close to the kitchen activated the doors</p> <p>The census of seventy-eight (78) was verified by the Administrator on 04/16/14. The findings were acknowledged by the Administrator and verified by the Environmental Director at the exit interview on 04/16/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> </ol>	K 025		
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K 025	Continued From page 3 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.  8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025			