| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185076 | A. Building<br>B. Wing | 09/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Bradford Heights Nursing & Rehabilitation | 950 Highpoint Drive<br>Hopkinsville, KY 42240 |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>47798<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure each resident had the right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments, and plan of care and the resident had a right to make choices about aspects of his or her life in the facility that were significant to the resident for 1 of 30 sampled residents (Resident #6 (R6)).<br><br>The findings include:<br><br>Review of the facility's policy titled, Resident Self Determination and Participation, dated 02/22/2024, revealed the facility was to promote and facilitate a resident's right to self-determination through support of the resident's choice. Further review revealed a resident had the right to make choices about aspects of his or her life that were significant to the resident.<br><br>Review of R6's Face Sheet for revealed the facility admitted the resident on 05/06/2016, with diagnoses that included chronic obstructive pulmonary disease (COPD), anxiety disorder, and morbid obesity (severe), due to excess calories.<br><br>Review of R6's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 08/02/2024, revealed the facility assessed R6 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This score indicated the resident was cognitively intact.<br><br>Review of R6's comprehensive care plan revealed the facility care planned the resident for Activities of Daily Living (ADL), dated 11/21/2022. Continued review of the ADL care plan revealed the interventions included when bathing or showering R6 was to have a maximum assist of two staff twice weekly and as necessary.<br><br>Review of the facility's bath/shower schedule documentation revealed from 05/26/2024 through 09/16/2024, R6 received partial to full bedbaths. The shower record noted R6 was to receive showers on day shift; however, over the past four months the resident only received a bed bath/partial bed bath five times on night shift. Further review revealed no documented evidence R6 received a shower during that timeframe.<br><br>(continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with R6 on 09/17/2024 at 6:00 AM, he stated he would like to take a shower, but he did not think he could fit on the shower bed any longer due to his size. R6 stated he would like to be taken into the shower, have his hair washed, and just let the water run over him. He stated he had voiced his concern about bathing to the new girl (Administrator). R6 stated he had been told he could not have showers because he could no longer fit on the shower bed/table. He further stated it had been a long time since he had been able to take a shower and that made him feel sad.<br><br>During an interview with Certified Nursing Assistant (CNA) 8 on 09/19/2024 at 10:30 AM, she stated she thought R6 received his baths on the night shift. She stated she had provided care of R6 and he refused his bedbaths often, and told her he had already washed up. CNA8 stated she did not think R6 would fit on the shower bed. She stated she did not think there was any other option for R6 in order for him to be able to take a shower.<br><br>During an interview with the Assistant Director of Nursing (ADON) on 09/20/2024 at 3:00 PM, she stated residents were given a choice if they wanted a shower or a bed bath. She stated she did not know who was responsible for assessing residents to know their bathing/showering preferences. The ADON stated R6 preferred to have a bed bath. She further stated the facility had bariatric shower equipment that could be utilized for morbidly obese residents.<br><br>During an interview with the Director of Nursing (DON) on 09/19/2024 at 3:29 PM, she stated R6 was scheduled for baths or showers twice a week. The DON stated R6 had received showers previously using the shower bed; however, he had gained weight and no longer fit on the bed. She stated she thought R6 preferred bed baths and was unaware R6 wanted to take a shower. The DON stated residents should be given a choice and staff should give the resident their preference, a bath or shower.<br><br>During an interview with the Administrator on 09/20/2024 at 3:00 PM, she stated the facility did not have a set way to assess a resident's preferences, to include their bathing preference. The Administrator stated she thought R6 wanted a bed bath. She stated the facility had a bariatric shower chair that was available to give R6 a shower if he chose to have one. The Administrator stated staff should just ask the resident whether they wanted a bath or shower and just do what they preferred. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370<br><br>Based on observation, interview, record review and review of facility polity, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment for 2 of 30 sampled residents (Resident (R)23 and R99).<br><br>1. The facility admitted R99 on 04/28/2022, and on 05/04/2024 assessed R99 as being at risk for developing pressure injuries. However the facility failed to develop a care plan for at risk for impaired skin integrity or risk for developing pressure injuries. On 05/11/2024, R99 developed a suspected deep tissue injury (SDTI) to the right heel.<br><br>2. The facility admitted R23 with diagnoses of schizophrenia, bipolar disorder, depression, and anxiety. However, the facility failed to develop and implement a care plan to address R23's psychiatric diagnoses.<br><br>The findings include:<br><br>Review of the facility's policy titled, Comprehensive Care Plans, revised 02/2024, revealed it was the facility's policy to develop and implement a comprehensive person-centered care plan for each resident to meet the resident's medical, physical, mental, and psychosocial needs. Continued review revealed the care plan process was to include an assessment of the resident's strengths and needs and was to incorporate the resident's personal and cultural preferences in developing the goals of care. Additionally, all Care Area Assessments (CAAs) triggered by the Minimum Data Set (MDS) Assessment were to be considered in the development of the care plan. Further review revealed the facility's rationale for deciding whether to proceed with care planning was to be documented in the residents' clinical records.<br><br>1. Review of the facility's policy titled, Pressure Injury, Prevention, and Management, revised on 08/30/2022 revealed interventions were to be based on specific factors identified in a resident's risk assessment, skin assessment, and any pressure injury assessment. Further review revealed evidence-based interventions for prevention were to be implemented for all residents assessed as at risk or who had a pressure injury present. Additionally, policy review revealed interventions were to be documented on the resident's care plan and communicated to all relevant staff.<br><br>Review of R99's electronic health record (EHR) Admission Record revealed the facility admitted the resident on 04/28/2022, with diagnoses that included: altered mental status, opioid dependence with withdrawal, and Alzheimer's Disease with late onset.<br><br>Review of R99's Admission MDS assessment dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 00 of 15, which indicated R99 was severely cognitively impaired. Review of the MDS Section M revealed the facility assessed R99 as at risk for developing pressure ulcers/injuries and not to have unhealed pressure ulcers on admission.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Admission MDS Care Area Assessment (CAA) worksheet for pressure ulcer injury dated 05/04/2022, revealed R99 was at risk for and had potential for pressure ulcer/injury. Continued review revealed the risk factors included: decreased mobility, incontinence, altered mental status, and Alzheimer's Disease. Per review, for the question, Care plan considerations would be addressed on the care plan, the facility answered Yes. However, review of R99's EHR revealed no documented evidence the facility developed and implemented a care plan for R99's assessed risk for developing pressure ulcers. Review of R99's care plan revealed a skin integrity care plan was not developed until 05/11/2024, after the resident developed an in-house pressure injury to the right heel.<br><br>Review of the Comprehensive Care Plan initiated on 05/11/2022, for R99 revealed a focus problem noting the resident had an actual impairment to skin integrity related to fragile skin and weakness. Continued review revealed interventions which included: a pressure reducing mattress to R99's bed, dated 05/11/2024; encouraging good nutrition and hydration in order to promote healthy skin, dated 05/11/2022; pressure reducing mattress to bed, dated 05/11/2022; and wound care as ordered, dated 06/29/2022.<br><br>Review of the facility's initial wound evaluation dated 05/13/2022, revealed R99 had a facility acquired pressure ulcer, Suspected Deep Tissue Injury (SDTI) with an onset date of 05/11/2022 to the right heel. Per review, the SDTI area measured 4.04 centimeters (cm) x 3.09 cm. Continued review revealed skin prep was ordered, and pressure reduction and offloading were recommended. In addition, recommendations were also noted for ensuring R99's compliance with the turning protocol; using a wedge or foam cushion for offloading (pressure); and elevating the resident's legs regularly.<br><br>Review of the Progress Note documented by the wound care provider dated 05/13/2022, revealed, R99 had a facility acquired right heel deep tissue injury. (DTI). Continued review of the Note revealed there was a large deep tissue injury to R99's right heel. Further review revealed it appeared the resident rested her heels over the edge of her wheelchair which was likely to cause the injury. In addition, the wound care provider recommended skin prep to the DTI every shift and to continue with the protective booties.<br><br>interview on 09/18/2024 at 1:18 PM, MDS Nurse 1 stated she and MDS Nurse 2 were responsible for completing the residents' comprehensive care plans. She stated the baseline care plans were initiated by the admitting nurse. MDS Nurse 1 stated she would expect the care plan to have been initiated if a resident had a problem or was at risk for having a problem. She stated the care plan should be developed/revised with interventions as needed.<br><br>In interview on 09/20/2024 at 10:40 AM, the Unit Manager (UM) stated the admitting nurse was responsible for the developing residents' baseline care plans on admission. The UM stated the MDS Nurse was responsible for updating the care plan. She stated she expected all residents to have a skin integrity care plan.<br><br>In interview on 09/20/2024 at 10:46 AM, MDS Nurse 2 stated she was responsible for residents' care plans. She stated if she was made aware of a new concern for a resident she updated their care plan.<br><br>In interview on 09/20/2024 at 3:00 PM, the Assistant Director of Nursing (ADON) stated R99 should have had a baseline care plan developed on admission that addressed the resident's skin integrity.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview on 09/20/2024 at 5:47 PM, the Director of Nursing (DON) stated she recalled R99 developed a SDTI shortly after admission. She stated R99 had been followed by the wound care clinic after developing the SDTI. The DON stated she was unable to recall any interventions in place for R99 prior to developing the SDTI area. She stated a care plan had been developed for R99 after the SDTI area was discovered. The DON stated she expected care plans to be developed and implemented for all residents. She stated the admitting nurse was responsible for developing residents' baseline care plan and she expected those to be completed on admission. Per the DON heel boots were added as an intervention for R99; however, she was not sure if any other interventions had been initiated. According to the DON, heel boots should have been on the Certified Nursing Assistants (CNA) care guide and on the resident's care plan. She further stated she was not familiar with the MDS Assessment process, but R99 should have had a care plan for skin integrity.<br><br>In interview on 9/20/2024 at 7:00 PM, the Administrator stated she was not familiar with R99, but the MDS Nurse was responsible for developing residents' care plans. The Administrator stated residents' baseline care plans should be completed within 48 hours of admission. The Administrator stated she would expect the care plan to be developed as required. She stated all residents had interventions in place such as turning and repositioning.<br><br>2. Review of R23's EHR Admission Record revealed the facility admitted the resident on 10/26/2022, with diagnoses of anxiety, depression, bipolar disorder unspecified, and schizophrenia unspecified.<br><br>Review of R23's History and Physical, documentation from an acute psychiatric (psych) hospital stay, dated 09/24/2022, revealed the facility admitted the resident to the acute psych hospital in February 2022.<br><br>Review of the Admission MDS assessment dated [DATE] for R23, of section A 1500, Preadmission Screening and Resident Review (PASRR) revealed no was the answer to the question, Has the resident been evaluated by Level 2 PASRR and determined to have a serious mental illness, and or mental retardation or a related condition? Review of Section I of the Admission MDS, for Active Diagnosis, the facility documented R23's primary medical condition was schizophrenia.<br><br>Review of the Quarterly MDS assessment dated [DATE] for R23, revealed the facility assessed the resident as having a BIMS score of 15 out of 15, which indicated R23 was intact cognitively.<br><br>Review of R23's Comprehensive Care Plan (CCP) dated 10/29/2022, revealed no documented evidence of care plans developed or implemented related to the resident's diagnoses of schizophrenia, bipolar disorder, depression or anxiety.<br><br>Review of the CCP focus problem, Psychotropic Drug Use dated 02/02/2023, revealed R23 had depression, insomnia, and tremor. Further review revealed the interventions included, administering medications as ordered and to evaluate, record, report effectiveness, and any adverse side effects.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the CCP focus problem, Psychotropic Drug Use dated 11/01/2022, revealed R23 was at risk for adverse consequences related to receiving psychotropic medications and to the resident's bipolar and schizophrenia diagnoses. Per review, the interventions dated 11/01/2022 included: reviewing for continued need at least quarterly; quantitively and objectively documenting R23's behavior. Continued review revealed the interventions also included consulting, reviewing, monitoring R23's behavior and response to medication, attempting to give the lowest dose possible, and attempting a gradual dose reduction if not contraindicated. Further review revealed an intervention added for staff to listen when R23 was upset and reassure the resident she was safe.<br><br>Review of the CCP focus problem, Behaviorial Symptoms dated 12/06/2022, revealed R23 resisted care such as dressing changes, incontinent care, showers, and removal of facial hair at times. Continued review revealed the interventions dated 12/06/2022, included actively involve R23 in care, express willingness to adjust regimen, administer medications as ordered, and monitor and record effectiveness and report adverse side effects. Continued review revealed the interventions also included: allowing R23 to choose options; explaining the disease process and consequences of all of the therapy, medication and care; maintaining a common environment and approach to the resident; and obtaining a psych consult or psychosocial therapy. Further review revealed when R23 began to resist care, stop and try later, do not force the resident to do a task, an intervention dated 01/01/2023. In addition, review of the care plan revealed the interventions encompassed redirecting R23 when the resident made false allegations an intervention dated 01/24/2023, and personal care to be completed with at least two staff assist.<br><br>In interview on 09/20/2024 at 10:48 AM, the Licensed Clinical Social Worker (LCSW) stated she saw R23 on a weekly basis and the resident's mood was up and down. She stated overall though R23 was doing well. The LCSW further stated she was not aware of any current episodes of behaviors that R23 was having.<br><br>In interview on 9/20/2024 at 7:00 PM, the Administrator stated she was not sure if R23 should have a care plan (for her psych diagnoses) because care plans varied from person to person. She stated she was unsure if R23 should have a care plan for psychosocial concerns; however, thought R23's diagnoses should have been on the care plan. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370<br><br>Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure interventions were in place to prevent a resident from developing a pressure injury for 1 of 30 sampled residents, (Resident (R)99).<br><br>On 05/11/2022, 13 days following admission to the facility, Resident 99 developed a facility acquired suspected deep tissue injury (SDTI) to the right heel.<br><br>The findings include:<br><br>Review of the facility's policy titled, Pressure Injury, Prevention, and Management, revised 08/30/2022, revealed, the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable . Per policy review, the facility was also committed to providing treatment and services to heal a pressure ulcer/injury, prevent infection and development of additional pressure ulcers/injuries. Continued review revealed after completing a thorough assessment/evaluation, the interdisciplinary team (IDT) was to develop a relevant care plan that included measurable goals for prevention and management of pressure injuries with appropriate interventions. Policy review revealed the interventions were to be based on specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment. Further review revealed evidence-based interventions for prevention were to be implemented for all residents assessed as at risk or who had a pressure injury present. Additionally, policy review revealed the interventions were to be documented on the resident's care plan and communicated to all relevant staff.<br><br>Review of R99's electronic health record (EHR) Admission Record revealed the facility admitted the resident on 04/28/2022 with diagnoses to include Alzheimer's Disease, altered mental status, unspecified and opioid dependence with withdrawal.<br><br>Review of the facility's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed R99 to have a Brief Interview for Mental Status (BIMS) score of 00 of 15, indicating the resident had severe cognitive impairment. Review of the MDS Section M revealed the facility assessed R99 as at risk for developing pressure ulcers/injuries and as not having unhealed pressure ulcers on admission.<br><br>Review of R99's Comprehensive Care Plan initiated on 05/11/2022, 13 days after admission, revealed the facility had developed a focus problem that noted the resident had an actual impairment to skin integrity related to fragile skin and weakness. Continued review revealed the interventions included: encouraging good nutrition and hydration in order to promote healthy skin, dated 05/11/2022; wheelchair cushion and pressure reducing mattress to the resident's bed, dated 05/11/2022; and wound care as ordered, dated 06/29/2022, which was R99's date of discharge.<br><br>Review of a daily skilled note for R99 dated 05/12/2022 at 4:25 PM, for skin integrity, revealed, No changes in skin integrity noted. Continues with deep tissue injury to right heel. Continued review revealed R99 does stomp foot and hold firmly when trying to transfer in the bed and wheelchair. Further review revealed it was noted R99 was Constantly taking socks and shoes off and manipulating footrest while trying to get up and walk.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | However, further review of R99's care plan revealed no documented evidence of interventions to address the resident constantly taking off her shoes and socks, manipulating the wheelchair footrest, and constantly trying to get up and walk.<br><br>Review of the Progress Note for R99 dated 05/13/2022 at 4:03 PM, signed by the Assistant Director of Nursing (ADON) revealed the ADON documented, new wound care orders received for wound to right heel. Daughter made aware.<br><br>Review of the Progress Note from the wound care provider dated 05/13/2022, revealed R99 had a facility acquired right heel deep tissue injury. Per review of the Note, there was a large deep tissue injury to R99's right heel. Continued review revealed it appeared the patient rested her heels over the edge of her wheelchair, likely to have caused the injury. Further review revealed the wound care provider noted, Recommend skin prep every shift and continue with protective booties.<br><br>Review of the wound care Nurse Practitioner's (NP's) initial wound evaluation documentation dated 05/13/2022, revealed R99 had a facility acquired pressure ulcer, Suspected Deep Tissue Injury (SDTI) with an onset date of 05/11/2022 to the right heel. Continued review revealed the area measured 4.04 centimeters (cm) x 3.09 cm and skin prep was ordered. Further review revealed recommendations included: pressure reduction and offloading; ensuring compliance with the turning protocol; elevating the resident's legs regularly; and use of a wedge or foam cushion for offloading (pressure).<br><br>Review of the wound consult documentation dated 05/18/2022, revealed R99 had a SDTI to the right heel, acquired in house which measured 2.36 cm x 2.23 cm. Continued review revealed Betadine was ordered to the area. Additionally review revealed recommendations that included: pressure reduction and offloading; ensuring compliance with the turning protocol; elevation of the resident's legs regularly; and using a wedge or foam cushion for offloading (pressure).<br><br>Review of the wound consult documentation dated 05/25/2022, revealed R99 had a SDTI to the right heel which measured 4.19 x 4.95 cm and Betadine was continued as the treatment.<br><br>Review of the wound consult documentation dated 06/01/2022, revealed R99 had a right heel SDTI that measured 4.69 cm x 3.84 cm, with Betadine continued as the treatment.<br><br>Review of the wound consult documentation dated 06/08/2022, revealed R99 had a SDTI to the right heel that measured 3.64 cm x 3.51 cm.<br><br>Review of the wound consult documentation dated 06/15/2022, revealed R99 had a right heel SDTI measuring 2.98 cm x 3.52 cm and was noted as improving. Further review revealed to cleanse (the SDTI) with wound cleanser and apply Betadine.<br><br>Review of the wound consult note dated 06/22/2022, revealed suspected DTI to right heel, measures 4.76 cm x 4.80 cm, area is improving. Continued review revealed For the most part the wound appears healed. The outer edges still appear dark. Further review of the note revealed Recommend skin prep instead of Betadine as it may be discoloring the skin.<br><br>Review of the progress note dated 06/27/2022 at 8:00 PM, documented by the ADON, for R99 revealed, area to back of right heel had ruptured. Further review revealed a new order to cleanse and apply comfort foam daily, and R99's daughter made aware.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the progress note dated 06/29/2022 at 3:00 PM, signed by the Director of Nursing (DON), revealed weekly observation of (R99's) pressure ulcer injury and light amount of serous drainage noted. Further review revealed the wound progress was worsening, and the Physician had been notified for need of a treatment change for the wound.<br><br>In interview with R99's Family Member (FM) on 09/19/2024 at 8:40 PM, she stated she worked as a Certified Nurse Aide and had [AGE] years of experience. She stated R99 admitted to the facility to receive therapy services and had planned to return home. The FM stated she was made aware R99 had a pressure injury to the right heel about 2 weeks after the resident was admitted there. She stated she had not been aware of any specific interventions being used prior to that for R99's right heel. Per the FM in interview, she had requested the facility to keep heel boots on R99 and that had been a challenge. She stated R99 seldom had the heel boots on when she visited and she visited daily. The FM stated she observed R99's right heel on 06/09/2022, and observed a very dark area to the right heel. She stated she visited the facility on 06/27/2022 and saw blood on R99's right heel bandage, and she informed the ADON who explained to her that the area on the resident's right heel had busted. In continued interview, the FM stated the ADON told her the area of R99's right foot was healed and all the dead skin would come off and new skin would be there. She stated she told the ADON however, R99's heel did not look right. The FM stated when she arrived to the facility on [DATE] to take R99 home and there was blood on the bandage again she asked for it to be changed before they left. She stated the nurse cleaning the area on R99's right foot said the dressing on the area had not been changed for the day. The FM further stated she went to speak to the DON and learned that the wound clinic nurse had not seen R99 as the resident was being discharged home.<br><br>In interview with the ADON on 09/20/2024 at 3:00 PM, she stated she had been the ADON for approximately two months, but had been employed at the facility for about three years. She stated she provided care for R99 and recalled the resident developed a deep tissue injury (DTI) to the right heel. The ADON stated when R99 was moved to her hall the resident already had the DTI and had heel boots. Per the ADON's interview, R99 also had a heel elevator (a foam protector that wrapped around the ankle area to elevate the heel off of the bed) and a regular (not specialized) pressure reducing wheel chair cushion implemented. She stated she could not speak to any other interventions R99 had while a resident. Per the ADON in interview, she recalled the wound on R99's right heel had been a DTI, which became a blistered area. She stated she had been working on 06/27/2022 when the blister on R99's right heel ruptured. The ADON further stated the area had been leaking bloody drainage, and she informed the Nurse Practitioner (NP) and applied a foam dressing to the area.<br><br>During interview with the DON on 09/20/2024 at 5:47 PM, she stated she recalled R99 developed a SDTI shortly after admission to the facility. She stated R99 had been followed by the wound care clinic. The DON stated she was unable to recall any interventions in place prior to R99 developing the SDTI area. The DON stated a care plan had been developed after the area was discovered. The DON further stated heel boots were added but she was not sure if any other interventions had been initiated.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185076 | A. Building<br>B. Wing | 09/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bradford Heights Nursing & Rehabilitation | 950 Highpoint Drive<br>Hopkinsville, KY 42240 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview with the Administrator on 9/20/2024 at 7:00 PM, she stated she had been the Administrator since 02/2024 and this was her first job as Administrator since graduating last May. She stated she was not familiar with R99, but the MDS Nurse was responsible for residents' care plans. Per the Administrator's interview, she was not familiar with the MDS process or the care area assessments that indicated R99 had been at risk for skin impairment on admission or that a care plan was to be initiated. She stated she expected a resident's care plan to be developed as required. The Administrator stated all residents had interventions in place such as turn and repositioning. She further stated she was not sure, when asked how the direct care givers knew what interventions to provide for a resident. |