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| 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 06/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Bradford Square Nursing and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 South Frankfort, KY 40601 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001</p> <p>Based on interview, record review, and review of the facility's documents and policies, the facility failed to provide a safe transfer to the appropriate level of care to meet a resident's needs to ensure a safe and orderly discharge from the facility for 1 out of 3 sampled residents (Resident (R) 197).</p> <p>Record review revealed R197 was discharged from the facility to a homeless shelter on 05/01/2023. The resident's diagnoses included type 2 diabetes with ketoacidosis (a serious complication of diabetes when too many ketones build up to dangerous levels in the body) and unspecified lack of normal physiologic development in childhood. The resident had a representative/guardian who was not notified of the discharge details and was only informed of the discharge when the resident called her, on 05/09/2023, from the homeless shelter.</p> <p>Further, record review revealed the resident was discharged from the facility without the facility providing education on medications, the necessary diabetic equipment or supplies, a discharge plan, or a discharge summary.</p> <p>According to R197's guardian, the guardian placed R197 in a hotel on 05/09/2023 and took R197, on 05/10/2023, to an acute care facility where the resident was admitted with suspected seizures due to diabetic ketoacidosis.</p> <p>The facility's failure to have an effective system in place to ensure residents were provided a safe transfer to the appropriate level of care to meet a resident's needs to ensure a safe and orderly discharge from the facility is likely to cause serious injury, impairment, or death if immediate action is not taken.</p> <p>Immediate Jeopardy (IJ) was identified on 06/27/2024 at 42 CFR 483.15 Preparation for Safe/Orderly Transfer/Discharge (F624) at the highest Scope and Severity (S/S) of a J. The Immediate Jeopardy was determined to exist on 05/01/2023. The facility was notified of Immediate Jeopardy on 06/27/2024 with an IJ Template.</p> <p>An acceptable Immediate Jeopardy Removal Plan was received by the State Survey Agency (SSA), which alleged removal of the Immediate Jeopardy on 05/31/2024. The SSA validated the Immediate Jeopardy was removed and substantial compliance was achieved for F624 on 05/31/2024, prior to exit on 06/27/2024.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of the acceptable IJ Removal Plan revealed the facility implemented the following:</p> <p>1. Starting on 05/17/2024 and concluding on 05/20/2024, the Administrator (ADM) completed an audit of all residents discharged in the previous 30 days to verify that a post-discharge plan and summary, which includes receiving education about required care, home health eligibility, current medication list with meds and instructions, available community support services, and appropriate notice to the resident and/or resident representative (if deemed incompetent) of the planned discharge. Any areas identified as a concern were addressed upon discovery.</p> <p>2. On 05/13/2024 and 05/20/2024, the Regional Nurse Consultant (RNC) reeducated the management team to include the Director of Nursing (DON), Infection Preventionist/Staff Development (IPSD), Administrative Nurse (AN), Wound Care Nurse (WCN), Business Office Manager (BOM), Activity Director (ACT), Housekeeping Manager (HM), Scheduler, Central Supply/Medical Records (CS/MR), Dietary Director (DD), ADM, Director of Maintenance (DOM), Human Resources (HR), Weekend Nurse Supervisor (WNS) that when there is a discharge anticipated (except for unplanned hospital discharges), the Interdisciplinary Team (IDT) would develop a discharge plan containing a minimum of the care required for the resident and how services determined as needed prior to discharge could be obtained and will review the resident's chart and verify that a discharge summary and post-discharge plan are provided to the resident or representative (if the resident is deemed mentally incompetent).</p> <p>Starting on 05/20/2024 and concluding on 05/30/2024, the IPSD, DON, WCN, AN, ADM, BOM, Licensed Nurse (LN) and/or RNC re-educated all licensed nurses that when a resident has a planned discharge, the resident or representative (if resident is deemed mentally incompetent) must be notified of the pending discharge and receive a copy of the discharge summary, discharge plan, and education regarding needed care post-discharge. A post-test with a passing grade of 100% was required. Staff, including Agency, not available during this time frame was provided with re-education including post-test by the HR, IPSD, AN, DON, WCN, ADM, and/or LN. Prior to working new hires, including Agency, will be provided the education and a post-test with a passing grade of 100% prior to working by the HR, IPSD, AN, DON, HR, ADM, WCN, and/or LN. No licensed nurses worked after 05/30/2024 without first being educated and passing the post-test.</p> <p>3. Starting on 05/21/2024, the ADM, Admissions and Marketing Director (AD), and/or DON will conduct an audit of all residents with an anticipated discharge not to hospital to verify that the resident or representative (if deemed mentally incompetent) received notification of the pending discharge, and a copy of their discharge summary, discharge plan, and education regarding care needed and how to obtain services required. Any areas identified as a concern will be corrected upon discovery. This audit was completed daily times two weeks.</p> <p>On 05/22/2024, the facility held an Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee Meeting with the QAPI Committee where the ADM presented the plan and the Medical Director reviewed the plan and made no further suggestions. The DON, the Medical Director and RNC, among others, were present during the meeting. The audits were reviewed by the RNC and/or DON daily for two weeks, then Monday through Friday (M-F) times two weeks, then three times a week times two weeks, then weekly time four weeks, then monthly times three months to verify compliance. The audit process and results were being verified and reviewed by the IDT Team and regional team.</p> <p>The findings include:</p> <p>(continued on next page)</p> | | |

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| <p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of the facility's policy titled, Discharge Summary and Plan H5MAPL0208, dated 08/01/2013, revealed the purpose of the policy was to provide the resident with a discharge summary and post-discharge plan. Further review revealed when the facility anticipated a resident's discharge, a discharge summary and post-discharge plan would be developed which would assist the resident to adjust to their new living environment. Per the policy, the discharge summary would include a summary of the resident's stay in the facility. The post-discharge plan would be developed by the care planning/interdisciplinary team with the assistance of the resident or resident representative and would contain at a minimum a description of the resident or resident representative preference for care and a description of how the resident or resident representative would access services.</p> <p>Further review of the policy, dated 08/01/2013, revealed a description of care coordination and continuity of care identified resident needs after discharge. Per the policy, the social services department was responsible for reviewing the plan with the resident or resident representative before the discharge. A copy of the discharge summary would be given to the resident or the resident representative at the time of discharge.</p> <p>Review of the facility's policy titled, Notice of Resident Rights and Responsibilities, revised 03/2017, revealed the purpose of the policy was to provide the resident or resident representative of his or her rights as a resident. Per the policy, should a resident be judged incompetent or identified as lacking decision-making capacity, the resident representative shall act on behalf of the resident.</p> <p>Review of the facility's document Resident Rights, undated and given to residents upon admission, revealed in the case of a resident who was declared incompetent, the right of the resident was delegated to and exercised by the resident representative appointed under the state law to act on the resident's behalf.</p> <p>Review of R197's document Notice of Your Rights and Protections as a Nursing Home Resident, dated 11/12/2022, revealed the facility must notify the legal representative if the nursing home decided to transfer or discharge the resident from the nursing home. The document was signed by a representative of the facility and R197's mother/guardian.</p> <p>Review of R197's Face Sheet revealed the facility admitted the resident on 11/12/2022 with diagnoses to include unspecified lack of expected normal physiologic development in childhood, type 2 diabetes with ketoacidosis, and cerebral vascular accident with seizure disorder.</p> <p>Review of R197's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 02/18/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact.</p> <p>Review of R197's Discharge Plan Documentation - V 2, dated 05/01/2023 and completed by social services, revealed R197 was discharged on [DATE] at 10:10 AM to a homeless shelter with a street address, although no city or state was noted. The mother/guardian was listed as the Family/Resident Representative, however it did not indicate a time and date if she was notified.</p> <p>(continued on next page)</p> | | |

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| <p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of R197's Discharge Transition Plan, undated, revealed the document was not signed or dated by a facility representative, the resident, or the R197's legal guardian. Per the plan, the facility would discharge the resident to a homeless shelter in a wheelchair-accessible van provided by medical transportation. The author of the document did not identify the name of the homeless shelter and the plan documented that the resident is responsible for self and makes own decisions.</p> <p>Further review revealed the Discharge Medication List under the medication management section was blank, with no additional instructions on how or what medications to take. Additionally, the facility documented they did not identify the need for diabetic equipment or supplies after discharge. It was recommended that the resident take the list to a primary care provider (PCP) follow up appointment and instructed the resident to follow up with a PCP after discharge and make an appointment with a specialist within six months or sooner for migraines. A summary of R197's stay showed her last blood glucose was 399 mg/dL. According to the Centers for Disease Control and Prevention (CDC), the normal blood glucose range was 1) before a meal: 80 to 130 mg/dL; 2-hours after the start of a meal: less than 180 mg/dL.</p> <p>Review of R197's Comprehensive Care Plan (CCP), last reviewed on 11/25/2022, revealed the resident was care planned with a focus as having the potential for discharge, but required an apartment or group home for placement. The goals included having an ongoing discharge plan, initiated on 11/16/2022, that provided for a safe and effective discharge. Interventions included 1) identify, discuss and document resident/patient desires and concerns/barriers regarding discharge; 2) inform interdisciplinary team (IDT) members and physician/mid-level practitioner of resident's desires; 3) evaluate discharge planning needs taking into consideration care plans, resident goals, cognitive skills, functional mobility, and need for assistive devices; and 4) make referrals to community-based agencies, providers, and services communicating the resident's needs and barriers to care.</p> <p>Review of R197's Physician Orders Summary, dated 04/25/2023, revealed an order dated 05/01/2023 for the resident to be discharged home with a 30-day supply of medications. No documentation was noted in R197's electronic medical record (EMR) or provided by the facility documenting the resident received her medication as ordered.</p> <p>During a telephone interview with a Certified Social Worker (CSW) for Case Management (CM) at a state-wide healthcare system, on 04/25/2024 at 3:23 PM, he stated he made the report to Kentucky's Division of Health and Family Services due to concerns over R197's discharge from the facility. According to the CSW CM, R197 spent almost a year at the state-wide healthcare system due to diabetic ketoacidosis (DKA) (a severe complication of uncontrolled diabetes). R197 was discharged from the state-wide healthcare system to the facility for medical management of her type 1 diabetes (an autoimmune disease that destroys the insulin-producing cells in the pancreas). However, the CSW CM stated R197 and her mother/guardian reported that the facility discharged R197 to a homeless shelter without notifying the mother/guardian of the anticipated discharge and providing a discharge plan or discharge summary.</p> <p>(continued on next page)</p> | | |

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| <p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>In further interview with the CSW CM on 04/25/2026 at 3:23 PM, he stated R197 was a vulnerable adult who had been diagnosed with developmental delays and had a history of cerebral vascular accidents and seizures. In addition, he stated R197 had type 1 diabetes and needed insulin to manage her condition, but her developmental delays and other medical issues prevented her from handling it independently. He stated R197 spent nearly a year at the state-wide healthcare system as an inpatient due to those problems, and the CSW CM stated a court order prohibited R197 from residing with her mother/legal guardian because her mother had custody of R197's minor children.</p> <p>In further interview with the CSW CM on 04/25/2024 at 3:23 PM, he stated he had further concern about the facility discharging R197 to a homeless shelter without informing or seeking permission from her legal guardian. He stated the mother/guardian only found out about the discharge when the resident called her several days after arriving at the homeless shelter. The CSW CM stated the mother/guardian then took R197 to a hotel where she stayed for two days before picking her up. He stated, at the time of pickup from the hotel, R197 had not been taking her insulin and did not have any medication. He stated R197 became severely ill while staying at the homeless shelter, which eventually led to the mother/guardian taking her to the state-wide healthcare system, where she was admitted to the hospital and diagnosed with DKA.</p> <p>During an interview with the R197's mother/guardian on 04/26/2024 at 10:41 AM, she stated the facility did not inform her about her daughter's discharge from the facility to a homeless shelter. She stated her daughter was non-compliant and was not able to manage her own care due to developmental delays and a history of cerebral vascular accidents and seizures. Additionally, the mother/guardian stated the facility did not provide the medication ordered by the physician to be sent home with the resident at discharge. Per the mother/guardian, the resident was not able to live at her residence as she had custody of R197's minor children, and there was a court order that R197 was not allowed to be with the children. She stated on 05/09/2023, R197 called her from the homeless shelter and told her she had been discharged from the facility. According to the mother/guardian, she picked R197 up from the shelter and checked her into a hotel. She stated on 05/10/2023, R197 called her and stated she was not feeling well, so she picked up R197 and took her to the state-wide healthcare system, where R197 was admitted with suspected seizures due to DKA.</p> <p>During an interview with the Advanced Practice Registered Nurse (APRN) on 04/26/2024 at 2:00 PM, she stated she did not remember the particulars of why R197 was discharged to a homeless shelter. She stated the legal guardian should be notified of any changes in condition, be a part of the discharge plan, and the facility should notify them of an anticipated discharge.</p> <p>During an interview with the DON on 04/26/2024 at 1:05 PM, she stated if a resident had a guardian the guardian should be notified of the discharge and be part of the discharge planning process. She stated she was not employed at the facility at the time of R197's discharge so she could not speak to the specific details. She stated, however, that sending a vulnerable adult resident with complex medical needs to a homeless shelter without notification or follow up care would not be a safe discharge.</p> <p>During an interview with the Administrator on 04/27/2024 at 5:01 PM, he stated staff should follow the proper discharge process and complete documentation to ensure a safe discharge.</p> | | |