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MAY 19 2010
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEREA HEALTH CARE CENTER	601 RICHMOND ROAD, P.O. BOX 27 BEREA, KY 40403

(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 standard health survey was conducted on March 29-April 5, 2010. Deficient practice was identified with the highest scope and severity at a "G" level, with an opportunity to correct.	F 000	Berea Health Care Center does not believe and does not admit that any deficiencies existed before, during or after the survey. Berea Health Care Center reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings or administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds. Nor is it meant to establish any standard of care, contractual obligation or position. Berea Health Care Center reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potential applicable peer review, quality assurance or self critical examination privileges which Berea Health Care Center does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Berea Health Care Center offers its responses, credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 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. 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. 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. 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. This REQUIREMENT is not met as evidenced by:	F 164	**F 164** It is and was on the days of survey the policy of Berea Health Care Center to provide the resident the right	

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

Admn. 5-19-10

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 164	Continued From page 1 Based on observation and interview, the facility failed to ensure privacy for one (1) of nineteen (19) sampled residents was provided during administration of medical treatment. Resident #4 had physician's orders for wound care to be provided daily to the resident's left lower extremity. However, during the wound care provided on March 30, 2010, facility staff failed to provide privacy for resident #4. The findings include: Resident #4 was observed on March 29, 2010, at 2:55 p.m., to be sitting in a wheelchair and not interviewable. The resident's left lower extremity was noted to have a dressing applied with an orthotic device covering the dressing. During the treatment observation conducted on March 30, 2010, at 10:00 a.m., resident #4 was observed sitting in a wheelchair in the resident's room. Another resident was observed to be lying on the other bed in the room. The nurse was observed to remove the equipment/supplies from the treatment cart and carry them to the resident's room. The nurse removed the soiled dressing from the resident's lower leg/ankle and applied a clean dressing to the wound. However, the nurse left the resident's door open and did not pull the privacy curtain between resident #4 and the resident's roommate during the treatment. The facility nurse stated in an interview conducted on March 30, 2010, at 11:15 a.m., that privacy should have been provided for resident #4 during wound care. The nurse stated the resident's door should have been closed and the privacy curtain pulled. According to the nurse, he/she realized privacy had not been provided after the treatment	F 164	Continued From page 1 to personal privacy and confidentiality of his or her personal and clinical records. It is and was on the days of survey the policy of Berea Health Care Center that personal privacy includes accommodations, medical treatment, written and telephone communication, 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. 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. It is and was on the days of survey the policy of Berea Health Care Center that 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. It is and was on the day of survey the policy of Berea Health Care Center to 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.	

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F 164	Continued From page 2 had been initiated, but was not sure if it was appropriate to stop the treatment and to provide privacy for the resident.	F 164	Continued From page 2 1. Resident #4's charge nurse was inserviced and counseled on April 8, 2010 to the resident's right to privacy when medical treatments are being administered. 2. All nurses were inserviced by the Director of Nursing on April 16, 2010 on the residents' right to privacy when medical treatments are being administered. 3. The Director of Nursing will on a weekly basis monitor nurses to ensure privacy is being provided when administering medical treatments. She will continue this practice for the next three months. 4. As part of the Quality Assurance Program, the Administrator and Clinical Team Leader will monitor on a monthly basis for the next three months to ensure that nurses are providing privacy when administering medical treatments. 5. April 16, 2010 **F 221** It is and was on the days of survey, the policy of Berea Health Care Center that the resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free from physical restraints not required to treat medical symptoms for eight (8) of nineteen (19) sampled residents (residents #1, #6, #7, #9, #10, #12, #13, and #17). The findings include: 1. Resident #9 was admitted to the facility on October 23, 2002, and had diagnoses including Alzheimer's Disease, Aphasia, Macular Degeneration, and Osteoporosis. Observations of resident #9 on March 29, 2010, at 3:00 p.m., and on March 30, 2010, at 9:45 a.m. and 11:10 a.m., revealed the resident was lying quietly in bed with a Posey vest restraint applied, and padded full side rails raised bilaterally. Observations of resident #9 on March 29, 2010, at 3:50 p.m. and 4:35 p.m., and on March 30, 2010, at 5:55 p.m., revealed the resident was in a reclining, high-back wheelchair with a lap tray in place. Observations of resident #9 revealed the	F 221		

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F 221	Continued From page 3 resident to be cognitively impaired and unable to communicate. A review of resident #9's quarterly Minimum Data Set (MDS) assessment dated March 3, 2010, revealed the resident was severely cognitively impaired, rarely/never understood/understands, and was a totally dependent two-plus person physical assist with bed mobility/transfers. Resident #9 was assessed to use full rails on all open sides of the bed, a trunk restraint, and a chair that prevented rising daily. Review of resident #9's physician's orders dated February 2010 revealed padded side rails were to be raised bilaterally for repositioning and bed mobility, a lap tray utilized when up in a wheelchair for positioning to improve safety and quality of life, and Posey vest when in bed due to being unaware of danger and personal safety. A review of a Side Rail Assessment form for resident #9 dated March 2, 2010, revealed the resident had cognitive deficits related to End Stage Alzheimer's Disease, visual deficits related to glaucoma and macular degeneration, and problems with balance/trunk control (leaning). The assessment indicated resident #9 was unable to get in/out of bed, had no history of falls, and did not use the side rail for positioning/support. Additionally, the side rail assessment indicated there was evidence the resident had a desire to get out of bed, and there was a possibility the resident would climb over the side rails. Further review of the side rail assessment for resident #9 revealed the assessment required all Alternatives/Interventions attempted in the past to be indicated (checked from a list of possibilities), including the date	F 221	Continued From page 3 1. A Physical Restraint Elimination Assessment was completed on Resident #9 on April 5, 2010 indicating that the resident was a candidate for restraint reduction. Reduction was implemented and will be reassessed in 30 days to determine if another reduction or elimination would be indicated. A Physical Restraint Elimination Assessment was completed on Resident #10 on April 12, 2010 indicating that the resident was a candidate for restraint reduction. Reduction was implemented and will be reassessed on a quarterly basis to determine if another reduction or elimination would be indicated. A Physical Restraint Elimination Assessment was completed on Resident #12 on April 8, 2010 indicating that the resident was a candidate for reduction but due to a recent fall and using the least restrictive device, the Restraint Team elected to not do a reduction at this time and to reassess in 30 days. A Physical Restraint Elimination Assessment was completed on Resident #13 on April 8, 2010 indicating that the resident was a candidate for reduction. Reduction was implemented and will be reassessed on a quarterly basis to determine if elimination is	

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F 221	Continued From page 4 initiated. The assessment for resident #9 revealed no other alternatives/interventions had been attempted, including frequent monitoring or a low bed. The side rail assessment revealed a recommendation for bilateral side rails, but failed to include a rationale for the recommendation. A review of a Physical Restraint Assessment form dated March 11, 2010, for resident #9 revealed the resident had current orders for a Posey vest in bed due to being unaware of danger and personal safety. The assessment indicated resident #9 had experienced no recent falls/self-injury, and required the recommendations of the restraint team, and justification for the restraint be included in the assessment. However, the assessment stated, "Continue plan of care." The assessment indicated that the restraint team had decided the recommendation was the least restrictive restraint for resident #9, but failed to indicate any previous devices that had been attempted or less restrictive devices considered for resident #9, leaving the form blank in that area. The assessment did not address resident #9's bilateral side rails, and indicated the reclining wheelchair and lap tray were devices needed for alignment, proper body position, or to prevent contractures. There was no medical symptom identified on the assessment or in resident #9's medical record that restraints were being used to treat. An interview was conducted on March 29, 2010, at 3:20 p.m., with the Certified Nurse Aide (CNA) caring for resident #9. The CNA stated the Posey vest restraint was always applied and side rails raised bilaterally when resident #9 was in bed. The CNA stated resident #9 had attempted to	F 221	Continued From page 4 indicated. A Physical Restraint Elimination Assessment was completed on resident #7 on April 8, 2010 and indicated that the resident was a candidate for elimination. The restraint was eliminated on the date of the assessment. A Physical Restraint Elimination Assessment was completed on Resident #1 indicating that the resident was a poor candidate for restraint reduction. Current physician restraint orders will be continued and the resident will be reassessed on a quarterly basis to determine if reduction is indicated. Resident #17 expired on January 15, 2010; therefore the Restraint Team was unable to complete a Physical Restraint Elimination Assessment. A Physical Restraint Elimination Assessment was completed on Resident #6 on April 7, 2010 indicating that the resident was a poor candidate for restraint reduction. Current physician restraint orders will be continued and the resident will be reassessed on a quarterly basis to determine if reduction is indicated. 2. A Pre-Restraint Assessment will be completed on all residents for which a	

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F 221	Continued From page 5 climb out of bed over the side rails previously (could not provide dates). The CNA stated resident #9 required total care, was turned and repositioned every two hours, and made no attempts to assist in repositioning utilizing the side rails. An interview was conducted on March 29, 2010, at 3:50 p.m., with the Unit Manager (UM) for resident #9. The UM stated resident #9 had experienced falls in the past, but that had been "several years" ago. The UM explained resident #9 had attempted to climb out of bed in the past, stating, "I've found [the resident] with his/her feet over the rail." According to the UM, resident #9 utilized the vest restraint, bilateral side rails, and lap tray due to the resident's history of falls. An interview was conducted on March 30, 2010, at 3:10 p.m., with the Administrator, Director of Nursing (DON), and MDS Coordinator. The Administrator stated resident #9's Posey vest, side rails, and lap tray were utilized to prevent falls for the resident. However, the Administrator confirmed that resident #9 had experienced no falls since January 2008. The Administrator stated bilateral side rails were used for resident #9 to provide a "boundary" for the resident while in bed, and the rails were padded due to resident #9 getting "up against the rails." The Administrator explained the medical symptom the side rails were treating for resident #9 was "to keep [the resident] in bed." The Administrator, DON, and MDS Coordinator were unable to explain how keeping the resident in bed had been determined to be a medical symptom. The Administrator stated the Posey vest restraint utilized when resident #9 was in bed was to prevent the resident from leaning while sitting up	F 221	Continued From page 5 physical restraint/device may be indicated. Part of the Pre-Restraint Assessment will include ensuring the presence of medical symptoms indicating the necessity of a restraint device. All residents that currently have physical restraints will be reviewed on a weekly basis during the facility's Quality of Care Meeting to ensure that the residents have been assessed on an ongoing basis for the least restrictive restraining device. 3. Restraint usage will be reviewed on an ongoing basis weekly at the facility's Quality of Care Meeting. The Director of Nursing, MDS Coordinator, Administrator, Unit Nurse Managers and Therapists will all be in attendance at these meetings. 4. As part of the facility's Quality Assurance program, restraints will be reviewed monthly until such time as they are below 75 percentile on the facility's Quality Indicator Report. The Administrator, Director of Nursing and Clinical Team Leader will also periodically audit Restraint Assessments to ensure timely and accurate completion of assessments. 5. April 12, 2010	

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F 221	Continued From page 6 in bed, and to prevent the resident from "scooting to the foot of the bed and coming out at the bottom." The Administrator, DON, and MDS Coordinator could not provide a medical symptom displayed by resident #9 that the Posey vest was treating. A review of resident #9's medical record revealed the resident had utilized padded bilateral side rails since June 7, 2007, the lap tray when up in wheelchair since March 5, 2008, and the Posey vest while in bed since September 8, 2008. However, a review of the resident's medical record and interview with the Administrator, DON, MDS Coordinator, and OT (Occupational Therapist) on March 31, 2010, at 1:45 p.m., revealed no attempts had been made by the facility to reduce/eliminate the restraints for resident #9. Additionally, the DON was unable to explain why resident #9 continued to be restrained to prevent /reduce falls, when the resident had not experienced a fall since January 2008, stating, "I can't tell you that, it has been that way since I've been DON." 2. Resident #10 was admitted to the facility on September 30, 2002, with diagnoses including Dementia, Osteoarthritis, Depression, and a history of bilateral Hip Fractures. Observations of resident #10 on March 29, 2010, at 3:10 p.m. and 5:20 p.m., and on March 30, 2010, at 10:00 a.m. and 3:30 p.m., revealed the resident was up in a wheelchair with a lap tray in place. Observations of resident #10 on March 30, 2010, at 2:25 p.m. and 3:30 p.m., revealed the resident was lying in bed with a Posey belt around the resident's mid-section and secured to the bed. Full padded side rails were raised bilaterally. The	F 221		

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F 221	Continued From page 7 side rails were noted to be completely padded with a blue vinyl device, with "windows" cut out on each upper side approximately twelve by nine inches. Observations of resident #10 revealed the resident was alert with cognitive impairment. Resident #10 was observed numerous times to be mumbling to self, however, made no attempts to answer questions or communicate. Review of the medical record for resident #10 revealed the most recent quarterly Minimum Data Set (MDS) assessment dated February 25, 2010, revealed the resident had been assessed to be severely cognitively impaired, rarely/never understood/understands, has no behavioral symptoms, totally dependent two-plus person physical assist with bed mobility/transfers. Resident #10 was assessed to use full rails on all open sides of the bed, a trunk restraint, and a chair that prevented rising daily. A review of resident #10's physician's orders dated February 2010 revealed orders for side rails up bilaterally, "padded w/view" due to thrashing in bed due to dementia with agitation, resident to have a lap tray in wheelchair for positioning, and a Posey belt in bed due to inability to comprehend danger due to Alzheimer's dementia. Review of a Side Rail Assessment form dated February 20, 2010, revealed the resident had not expressed a desire to have side rails raised, had visual deficits, unable to get in/out of bed, did not utilize the side rails for positioning, and received narcotics requiring safety precautions. Review of a Physical Restraint Assessment form dated February 17, 2010, revealed the resident	F 221		

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F 221	Continued From page 8 had orders for a Posey belt in bed due to the inability to comprehend danger due to Alzheimer's Disease. The side rails were not listed on the form and there was no medical symptom identified for the use of the restraints. The assessment indicated resident #10 had experienced no recent falls/self-injury, and required the recommendations of the restraint team and justification be included in the assessment. However, the assessment only stated, "Continue plan of care." The assessment indicated the restraint team had decided the recommendation was the least restrictive restraint for resident #10, but failed to indicate any previous devices that had been attempted or less restrictive devices to be tried for resident #10, leaving the form blank in that area. The assessment addressed the padded bilateral side rails "w/view" as other devices needed for alignment, proper body position, or to prevent contractures. The resident's lap tray when in the wheelchair was addressed as other suggestions or modifications to environment. There was no medical symptom identified on the assessment or in resident #10's medical record that the restraints were treating. Interviews were conducted on March 30, 2010, at 3:35 p.m., with two CNAs that were caring for resident #10. The CNAs stated resident #10 had the Posey belt applied in bed due to "sitting up in bed." The CNAs stated the resident utilized the Posey belt at all times while in bed. The CNAs revealed resident #10 was usually calm in bed. The CNAs explained resident #10 required total care, was turned and repositioned every two hours, and made no attempts to assist with repositioning self in bed.	F 221		

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F 221	Continued From page 9 An interview was conducted with the UM for resident #10 on March 31, 2010, at 3:45 p.m. The UM stated resident #10 utilized the Posey vest restraint in bed due to "raising up and sitting up" while in bed. Additionally, the UM stated resident #10 had full padded side rails raised bilaterally because the resident would "move around in bed," and if the side rails were raised it would keep the resident in bed, and prevent a fall to the floor. Further interview with the UM revealed resident #10 had no history of falls in the facility to his/her knowledge. A review of resident #10's medical record, and an interview with the Administrator, DON, MDS Coordinator, and OT on March 31, 2010, at 1:45 p.m., confirmed resident #10 had no history of falls in the facility. The DON stated resident #10 utilized the Posey vest in bed due to "sitting up in bed," and the full padded side rails were to keep resident #10 from falling out of bed, despite the fact the resident had no history of falls in the facility. The Administrator, DON, MDS Coordinator, and OT were able to provide a medical symptom the restraints were treating. A review of resident #10's medical record revealed the resident had utilized the padded bilateral side rails and lap tray in wheelchair since September 28, 2006, and the Posey belt in bed since December 4, 2006. However, a review of the resident's medical record and interview with the Administrator, DON, MDS Coordinator, and OT on March 31, 2010, at 1:45 p.m., revealed no attempts had been made by the facility to reduce/eliminate the restraints for resident #10. 3. Resident #12 was admitted to the facility on March 20, 2007, and had diagnoses including	F 221		

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F 221	Continued From page 10 Alzheimer's Disease, Osteoporosis, Chronic Lower Back Pain, and Anxiety. An observation of resident #12 on April 1, 2010, at 12:00 p.m., revealed the resident was up in a wheelchair with a lap buddy in place, and did not respond when spoken to by the surveyor. A review of nurse's notes for resident #12 dated March 2, 2010, at 11:00 a.m., revealed resident #12 "has been standing up in chair and walking x 2 today without assistance. Resident wanting to walk. Resident has not tried to walk or stand up per self in a long time." The entry further stated the resident's daughter was notified, and the nurse would "raise wheelchair in front, and place pressure sensor alarm" in chair. A review of physician's orders dated March 2, 2010, at 11:15 a.m., revealed an order was obtained to place the pressure sensor alarm to the resident's wheelchair. The concurrent nurse's note dated March 2, 2010, at 3:40 p.m., and a review of physician's orders dated March 2, 2010, at 3:00 p.m., revealed an order for "Lap buddy to be used while up in wheelchair due to attempts to stand per self." An interview was conducted on April 1, 2010, at 10:15 a.m., with the nurse that cared for resident #12 on March 2, 2010. The nurse stated that resident #12 had a dosage increase of Remeron (anti-depressant medication) on February 24, 2010, and attributed the medication change to the resident's change in behavior stating, "All of a sudden [he/she] decided [he/she] could walk." The nurse added that attempting to stand/ambulate was unusual behavior for resident #12, and had since resolved. The nurse stated the episode had only lasted a "few days."	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

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F 221	Continued From page 11 A review of a resident Accident/Incident Report dated March 3, 2010, revealed that resident #12 sustained a fall on March 3, 2010, at 3:45 p.m. A review of a physician's order note dated March 3, 2010, (no time) made by the Advanced Registered Nurse Practitioner (ARNP) revealed resident #12 had been seen and examined as a result of the fall, that the resident had removed the lap buddy per self, stood up, and fallen forward. A review of nurse's notes dated March 4, 2010, at 6:00 p.m., revealed the resident had been placed in a smaller wheelchair to enable the lap buddy to "stay in place better." Additionally, the entry stated "resident got upset with lap buddy and tried to remove, but was unable." A review of a Pre-Restraining Assessment form for resident #12 dated March 2, 2010, revealed the form addressed physical, mental, emotional, environmental, and social considerations, and had been completed by the nurse who had been caring for resident #12 on March 2, 2010. The form also contained an area entitled Referrals/Recommendations, which required the Interdisciplinary Team's (IDT's) date of evaluation and recommendations to be documented. However, the IDT's portion was left blank, and the recommendation for the lap buddy was made by the nurse who had completed the previous portions of the form. A review of a Physical Restraint Assessment form for resident #12 dated March 11, 2010, revealed the resident was utilizing a lap buddy while up in a wheelchair due to attempts to stand per self. The assessment form required the recommendations of the restraint team and justification be included in the assessment, however, that portion of the	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 221	Continued From page 12 assessment was left blank. The assessment indicated the restraint team had decided the recommendation was the least restrictive restraint for resident #12, but failed to indicate any previous devices attempted, or less restrictive devices to be tried for resident #12, leaving the form blank in that area. There was no medical symptom identified on the assessment or in resident #10's medical record that the restraint was treating. A review of an Acknowledgement of Restraint Intervention consent form for resident #12 was reviewed. The form had the intervention of a lap buddy to be used while up in a wheelchair listed, along with ten possible complications related to the use of the restraint. Further review of the consent form revealed resident #12's Responsible Party (RP) had signed the consent form, however, the date signed was March 28, 2010, 26 days after the restraint had been implemented, despite documentation in resident #12's nurse's notes that resident #12's daughter was in the facility on March 3, 2010. An interview was conducted on April 1, 2010, at 2:30 p.m., with the RP of resident #12. The RP stated he/she was notified on March 2, 2010, that resident #12 had sustained a fall, and a restraint had been ordered for the resident in an effort to prevent further falls. The RP stated he/she was actually not given a choice regarding initiation of the restraint, but was not opposed to applying the restraint if it would prevent further falls for resident #12. The RP added that the risk/benefits had not been explained to him/her on March 2, 2010. Additionally, the RP stated he/she had not been asked to sign the restraint consent form until March 28, 2010, although the RP stated	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 221	Continued From page 13 he/she was in the facility several times weekly to visit resident #12. An interview was conducted on April 1, 2010, at 3:10 p.m., with the DON. The DON stated the nurse who obtained the consent signature was responsible for explaining the possible risks of restraint application to the resident/RP. The DON stated the lap buddy had been applied on March 2, 2010, due to the resident's sudden acute episodes of standing up and attempting to ambulate independently. Although the DON thought resident #12 no longer made attempts to stand up unassisted, the facility had made no attempts to reduce/eliminate the restraint for resident #12. The DON was unable to provide a medical symptom the restraint was treating. 4. A review of the medical record revealed resident #13 was admitted to the facility on April 18, 2008, with diagnoses of Alzheimer's Disease, Senile Dementia with mood/behavior disturbances, Anxiety, Hypertension, Atrial Fibrillation, and Degenerative Joint Disease. A review of the physician's orders revealed an order on February 24, 2010, for a lap buddy to be utilized for resident #13 when the resident was in a wheelchair, due to being cognitively unable to comprehend dangers of being up unattended secondary to Alzheimer's disease. Resident #13 was observed on April 1, 2010, at 10:50 a.m. and at 12:00 p.m. The resident was lying on the bed holding a doll. The resident's eyes were closed and no restraints were in use. A review of the significant change MDS assessment conducted on December 21, 2009, revealed resident #13 was assessed to have	F 221		

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F 221	Continued From page 14 short/long-term memory loss, to have severely impaired decision-making skills, and to require extensive assistance of two staff persons for bed mobility and transfers. The resident was assessed to be nonambulatory and to have sustained falls during the past 30 days. The resident was assessed to require no restraint devices during the assessment period. A review of the quarterly assessment conducted on March 17, 2010, revealed resident #7 had sustained falls in the past 30 days and in the past 31 to 180 days and required a chair to prevent rising daily. Further record review revealed resident #13 sustained falls on December 19, 2009, on December 21, 2009, and on January 16, 2010. The facility implemented an intervention to place Dycem in the resident's wheelchair after the January 16, 2010 fall. On February 24, 2010, resident #13 again sustained a fall when the resident attempted to stand unassisted from the wheelchair, and a lap buddy was implemented to be used when the resident was up in the wheelchair. There was no evidence the facility had attempted other fall interventions or a less restrictive device for the resident prior to the initiation of a restraint. A pre-restraining assessment was conducted by facility staff and revealed resident #13's physical/mental considerations for the restraint included: disorientation falls/leans forward, unsteady gait, loss of balance, history of falls, and wheelchair mobility. The emotional, environmental, and social considerations for the restraint included: wet/soiled clothing, misinterprets words, does not understand what is being said, and cannot comprehend surroundings. The assessment contained a	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 221	Continued From page 15	F 221		

section for the IDT team to document an evaluation to include alternatives to restraints. However, this section had not been completed. In addition, the assessment had not been signed or dated by staff.

An interview was conducted on March 31, 2010, at 1:45 p.m., with the Administrator and the restraint team. The Administrator stated if a resident had experienced two or more falls, was having trouble with balance, or the nurse suspected a restraint was needed for the safety of a resident, the nurse caring for the resident completed a "Pre-restraining Assessment Form." However, the restraint team members and the Administrator stated no formalized individualized interdisciplinary team meeting was conducted to discuss the risk/benefits, safety concerns for the resident, or to determine the specific medical symptom that warranted the use of the restraint prior to initiating the restraint.

5. A review of the closed record revealed resident #17 was admitted to the facility on February 18, 2003, with diagnoses of Parkinson's Disease, Diabetes Mellitus, Congestive Heart Failure, and End Stage Alzheimer's Disease. According to the medical record, resident #17 expired at the facility on January 15, 2010, due to advanced Parkinson's Disease and End Stage Alzheimer's.

Further review of the medical record revealed a physician's order was obtained on May 7, 2007, for a Posey belt to be applied when resident #17 was in a wheelchair due to the resident being cognitively unable to comprehend danger, due to confusion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

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F 221	Continued From page 16	F 221		

A review of the annual MDS assessment conducted on September 2, 2009, revealed resident #17 was assessed to have short/long-term memory deficits, moderately impaired decision-making abilities, to require extensive assistance of two staff persons for bed mobility and transfers, and to be nonambulatory. The assessment further identified resident #17 to have sustained no falls and to require a trunk restraint daily. A quarterly assessment conducted on December 1, 2009, revealed resident #13 had sustained a fall in the past 30 days and continued to require the use of a trunk restraint.

Review of the resident's medical record revealed resident #17 did not sustain falls from October 16, 2008 to November 6, 2009. On November 6, 2009 and November 11, 2009, resident #17 was lowered to the floor by facility staff when the resident attempted to stand without assistance.

An interview conducted with the Unit Coordinator (UC) on April 1, 2010, at 5:05 p.m., revealed resident #17 continued to be up in a wheelchair until approximately two weeks prior to the resident's death. The UC stated the lap belt continued to be used for the resident at that time. The UC explained resident #17 would lean forward and topple the wheelchair. The UC stated a personal alarm was used to alert staff when the resident was in bed, however, was not used when the Posey belt restraint was applied.

An interview conducted with the Administrator and the restraint team on March 31, 2010, at 1:45 p.m., revealed the facility could not provide evidence regarding assessments to evaluate for restraint reduction/elimination for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 221	Continued From page 17 6. A review of the medical record revealed resident #7 was admitted to the facility on February 3, 2009, with diagnoses of Dementia, Rhabdomyolysis, Anxiety, Alzheimer's Disease, and Hypertension. A review of the admission nurse's notes dated February 3, 2009, at 3:00 p.m., revealed resident #7 was at risk for falls due to falls sustained at home. On February 3, 2009, at 3:30 p.m., a physician's order was obtained to use a lap buddy to decrease the risk of injury related to unsupervised transfers. Further review of the nurse's notes revealed resident #7 removed the lap buddy on February 6, 2009, at 12:30 p.m., at 1:00 p.m., and at 1:30 p.m., and a lap tray was implemented. The nurse's notes continued on February 20, 2009, at 2:00 p.m., resident #7 removed the lap tray and was observed by a nurse aide. The lap tray was then changed to a Posey belt to be used when the resident was in a wheelchair. Resident #7 was observed in the facility dining room on March 29, 2010, at 6:00 p.m., during the evening meal and on March 30, 2010, at 12:15 p.m., during the noon meal. The resident was sitting in a wheelchair at the dining table with a Posey belt in place. The resident was observed to consume both meals while wearing the restraint. On March 29, 2010, at 3:05 p.m., resident #7 was observed propelling self in the hallway in a wheelchair with a Posey belt in place. Resident #7 was also observed on March 30, 2010, at 2:15 p.m., to be in a wheelchair with a Posey belt in place while attending a group activity in the resident lounge area. Resident #7 stated, at the time, the Posey belt was used to keep the resident from bumping into things.	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 221	Continued From page 18 A review of the annual comprehensive assessment (MDS) completed on January 13, 2010, revealed resident #7 was assessed to have short/long-term memory deficits, moderate impairment with decision-making skills, to require extensive assistance of two staff persons for transfers, bed mobility, and ambulation. The assessment further identified resident #7 to have sustained falls in the past 31 to 180 days and to utilize a trunk restraint daily. A review of the Restraint RAPs revealed resident #7 required a soft Posey belt due to a history of falls and was cognitively unaware of dangers of self-transfers. The RAP further noted facility staff would ensure the least restrictive device would be used for the resident. A review of the accident/incident report dated September 5, 2009, revealed resident #7 sustained a fall without injury when the resident attempted to self-transfer from the resident's bed. According to the fall risk assessment, resident #7 had sustained no further falls since September 2009. A quarterly restraint assessment was conducted by the OT and MDS Coordinators on January 13, 2010. The assessment noted recommendations were to continue utilizing the lap belt for resident #7 when the resident was in the wheelchair. No justification was provided for the continued use of the lap belt. The assessment further identified the restraint team had decided this device was the least restrictive for the resident. In addition, the assessment noted the current physician's order was dated March 3, 2009, and directed the Posey belt be used when the resident was in the wheelchair due to being cognitively unable to	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

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F 221	Continued From page 19 comprehend danger of being up unattended due to Alzheimer's. An interview conducted with the restraint committee on March 31, 2010, at 2:50 p.m., revealed the restraint team was responsible to evaluate the resident at least quarterly to determine the effectiveness of restraints and consider a less restrictive device for the resident. The restraint committee stated there was no documentation that restraint reduction had been attempted for resident #7 since the lap belt was implemented in March 2009. The restraint committee further stated the facility had not evaluated resident #7 to allow for restraint-free periods during supervised daily activities. There was no evidence the facility had evaluated/considered the medical symptom or the risks/benefits of the Posey belt, and no evidence the facility had evaluated the resident to determine if a less restrictive device could be utilized for resident #7. 7. Resident #1 was admitted to the facility on February 2, 2009, with diagnoses of Alzheimer's Disease, Dementia, Depression, Anxiety, Paranoia and Psychosis, Degenerative Joint Disease, Diabetes Mellitus, Hypertension, and Osteoporosis. Observation of resident #1 at 3:00 p.m. on March 29, 2010, revealed the resident was sitting in a wheelchair with a waist belt, and a personal alarm in place. Observation of resident #1's room revealed the resident had a low bed with the right side of the bed placed against the wall, and the left side of the bed had two half side rails raised with a soft bed bolster pillow between the two half	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEREA HEALTH CARE CENTER	601 RICHMOND ROAD, P O BOX 40 BEREA, KY 40403

(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 221	Continued From page 20 rails. A review of resident #1's most recent significant change Minimum Data Set (MDS) assessment dated January 3, 2010, revealed the resident was severely cognitively impaired, sometimes understood/understands, and was a totally dependent two-plus person physical assist with bed mobility/transfers. Resident #1 was assessed to use full bed rails on all open sides of the bed, and a trunk restraint. A review of resident #1's physician's orders dated February 2010 revealed two half side rails were to be up on the left side of the bed with a soft bolster pillow between the rails to define bed parameters. There was a physician's order for the resident to utilize a low bed due to Alzheimer's Disease with a mat on the floor beside the bed due to a Right Hip Fracture. A review of the Physical Restraint Assessment form for resident #1 dated March 11, 2010, revealed the resident had current orders for an early warning self-release seat belt to wheelchair due to a diagnosis of Dementia. The assessment indicated resident #1 sustained a recent fall, and required the recommendations of the restraint team and justification to be included in the assessment. However, that area on the form was left blank. In addition, the assessment identified that the restraint team had decided this device was the least restrictive for the resident; however, the less restrictive measures area of the form was left blank. An interview was conducted with the Unit Manager (UM) at 3:30 p.m. on March 31, 2010. The UM stated the lap belt could be considered a	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 221	Continued From page 21	F 221		

physical restraint because the resident cannot always release the lap belt on command. The UM stated resident #1 might, on occasion, release the lap belt accidentally.

An interview conducted with the Administrator and the restraint team at 1:45 p.m. on March 31, 2010, revealed the facility could not provide evidence regarding assessments to evaluate for restraint reduction/elimination for the resident, nor could the facility provide a medical symptom for the use of the physical restraint for resident #1.

8. Resident #6 was admitted to the facility on February 7, 2008, with diagnoses that included Paranoia and Psychosis, Depression, Anxiety, History of Delusions, Cerebrovascular Accident, Diabetes Mellitus, Alzheimer's Disease with Dementia, and Hypertension.

Observation of resident #6 at 3:05 p.m. on March 29, 2010, revealed the resident was sitting in the doorway to the room in a wheelchair with a Posey belt in place and tied to the frame of the wheelchair. Observation of the resident's room revealed the resident had a low bed with two half side rails on the left side of the bed. In addition, a mat was on the floor beside the bed, and the resident had a bed alarm in place.

A review of an annual MDS assessment dated January 12, 2010, revealed the resident's cognition was moderately impaired, had difficulty understanding speech related to Hearing Loss, and needed extensive assistance of two-plus persons with bed mobility/transfers.

A review of resident #6's physician's orders dated February 2010 revealed two half side rails were to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 221	Continued From page 22	F 221		

be up on the left side of the bed to define bed parameters, and a low bed due to Alzheimer's Disease with a mat on the floor beside the bed.

A review of the Physical Restraint Assessment form for resident #6 dated January 13, 2010, revealed the resident had current orders for a Posey belt with ties to be used when up in wheelchair due to inability to comprehend danger of being up unattended, and diagnoses of Alzheimer's Disease and History of Falls. The restraint team recommended resident #6 have Occupational Therapy (OT) for treatment related to wheelchair seating and positioning. However, there was no justification documented for the use of the Posey belt. In addition, the assessment further identified the restraint team decided this device was the least restrictive for the resident. The less restrictive measures area of the form was left blank.

An interview conducted with the Administrator and the restraint team at 1:45 p.m. on March 31, 2010, revealed the facility could not provide evidence of assessments to evaluate for restraint reduction/elimination for resident #6, nor could the facility provide a medical symptom for the use of the physical restraint.

A review of the facility's policy/procedure Restraints-Physical, dated January 9, 2003, revealed the facility would use restraints only for medically related symptoms and only after other alternatives have been tried unsuccessfully. Additionally, the policy/procedure indicated restraints should be used only as a last resort, and the medical record must indicate the events leading up to the necessity of the restraint. The policy/procedure stated an evaluation would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEREA HEALTH CARE CENTER	601 RICHMOND ROAD, P O BOX 40 BEREA, KY 40403

(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 221	Continued From page 23	F 221		

conducted by an interdisciplinary team to assure the least restrictive device was used. The policy/procedure revealed a restraint would be re-evaluated quarterly to determine continued need, and every effort would be made to eliminate use.

An interview was conducted on March 31, 2010, at 1:45 p.m., with the Administrator, DON, MDS Coordinator, and OT. The Administrator stated the "restraint team" was comprised of the DON, MDS Coordinator, and OT. The Administrator stated if a resident had experienced two or more falls, was having trouble with balance, or the nurse suspected a restraint was needed for the safety of a resident, the nurse caring for the resident completed a "Pre-restraining Assessment Form," which included the evaluation of physical and mental considerations including mental status, ambulation, balance, medical factors affecting behavior, and emotional, environmental, and social considerations. The Administrator stated the nurse would then contact the resident's physician for the restraint order, and a copy of the form would be sent to the DON, MDS Coordinator, and OT for signature. The team explained that the floor nurse and "ultimately the physician" decided if and what type of restraint would be placed on the resident at the time the order was received. The MDS Coordinator and OT stated the assessment and physician's order would be reviewed, and if the ordered restraint did not appear to be appropriate for a resident the restraint team would discuss other options. However, the restraint team members and the Administrator added that no formalized individualized interdisciplinary team meeting was conducted to discuss the risk/benefits of the restraint, safety concerns for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

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F 221	Continued From page 24 the resident, or to determine the specific medical symptom that warranted the use of the restraint prior to initiating the restraint. Further interview with the Administrator and restraint team revealed the MDS Coordinator completed a quarterly restraint assessment form for each resident who utilized a restraint, and each team member individually signed the assessment. However, no formalized team meeting was conducted to discuss a continued need for the restraint, if a less restrictive device would be appropriate, or if a restraint reduction could be attempted. The Administrator and restraint team stated the facility failed to have a process in place to gradually reduce restraint use.	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an appropriate wheelchair to meet reasonable individual accomodation for one (1) of nineteen (19) sampled residents to enhance the resident's physical and psychosocial well being (resident #11). The findings include:	F 246	**F 246** It is and was on the days of survey the policy of Berea Health Care Center to ensure the resident the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. 1. Resident #11 was assessed on March 30, 2010 to determine an adequate wheel chair for the resident. The item was received on April 6, 2010, assembled per Maintenance and delivered to Resident #11. 2. Nursing will notify the Occupational Therapist as needs arise for special equipment for residents. The Occupational Therapist will assess the resident as soon as possible to	

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F 246	Continued From page 25 A review of the medical record revealed resident #11 was admitted to the facility on June 26, 2007, with diagnoses to include: Cerebrovascular Accident (CVA) with left side hemiplegia, and Reflex Sympathetic Dystrophy of the right leg secondary to crushing injuries to the leg. In addition, resident #11 required an Intrathecal Morphine Pump to control chronic pain related to these injuries. Resident #11's height was noted to be six feet and two inches and the resident's current weight was recorded at 233.6 pounds. The resident's ideal body weight was noted to be 171-209 pounds. Resident #11 was observed on March 29, 2010, at 11:35 a.m., to be lying in bed. A wheelchair was observed to be sitting in front of the resident's sink. On March 30, 2010, at 11:00 a.m., resident #11 was observed to be sitting in a wheelchair with the resident's legs extending outward from the wheelchair and the resident's trunk did not fit appropriately into the seat of the wheelchair. An interview conducted with resident #11 on March 29, 2010, at 11:35 a.m., revealed the wheelchair provided by the facility was too small to enable the resident to be out of bed comfortably. The resident stated the resident had used a different wheelchair prior to a hospital stay approximately two months ago. Resident #11 further stated the resident would like to be able to go downstairs to some of the facility activities, but could not tolerate being up for very long due to the wheelchair being too small and uncomfortable due the resident's size and chronic pain disorder. Interviews conducted with direct care staff (CNAs	F 246	Continued From page 25 determine proper equipment. If indicated equipment is not in stock, the Occupational Therapist will immediately order the equipment. 3. At weekly meetings, the Quality of Care Committee will discuss any special need items needed by residents to ensure that all residents have the medical equipment they need to be as functional as possible. 4. As part of the Quality Assurance Program, the Administrator, Director of Nursing and Clinical Team Leader will randomly assess resident equipment needs to ensure they have the medical equipment/devices in place to be as functional as possible. 5. April 6, 2010	

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	185384	A. BUILDING _____ B. WING _____	04/05/2010

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F 246	Continued From page 26 #1, #2, and #3) on March 30, 2010, at 10:00 a.m., and on March 31, 2010, at 4:15 p.m., revealed resident #11 frequently refused to be out of bed except for showers and physician appointments. The CNAs stated the resident refused to be out of bed due to complaints of pain, tiredness, or did not feel like being up. The CNAs stated resident #11 would often request to be transferred back to bed due to pain. An interview conducted with the Unit Coordinator (UC) on April 1, 2010, at 10:45 a.m., revealed resident #11 frequently refused to be out of bed due to complaints that the wheelchair bothered the resident's back. The UC stated resident #11 had a different wheelchair prior to the hospitalization and the resident's legs "looked like they did not fit" in the wheelchair used for resident #11. An interview conducted with the Activity Director (AD) on April 1, 2010, at 11:15 a.m., revealed in-room activities were provided for resident #11. The AD stated the resident had reported to the AD that the resident's pain levels were affected by the wheelchair. An interview conducted with the maintenance staff on March 29, 2010, at 4:00 p.m., revealed the maintenance staff had replaced resident #11's wheelchair after the resident was readmitted from the hospital approximately two months ago. The maintenance staff stated a 20-inch wheelchair was the largest wheelchair the facility had and there was no difference in the size of the wheelchair the resident had previously used. The maintenance staff stated he/she had reported to the Occupational Therapist (OT) that the resident stated the wheelchair was too small.	F 246		

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F 246	Continued From page 27 An interview conducted with the OT on March 29, 2010, at 3:30 p.m., revealed the OT stated the wheelchair the resident currently used was appropriate; however, resident #11 preferred a wheelchair with a reclined back. The OT stated resident #11 had verbalized this request to the OT approximately one month ago and that is when the OT became aware of the resident's need for a wheelchair with a back rest and leg extensions. However, the OT explained the resident had not been evaluated/fitted for this type of wheelchair since the facility had to be able to justify the use of the wheelchair.	F 246		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and medical record review, the facility failed to ensure that medically-related social service needs had been provided for one (1) of nineteen (19) sampled residents. Resident #11 had a diagnosis of depression and a chronic pain disorder and frequently refused to be out of bed except for showers and to go out of the facility for physician appointments. There was no evidence the facility had identified the medically-related social service needs of the resident and developed interventions to support the resident's individual needs. In addition, there was no evidence the facility monitored resident	F 250	**F 250** It is and was on the days of survey the policy of Berea Health Care Center to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. 1. The Social Service designee was instructed to monitor Behavior Notes made by Nursing of Resident #11 on a daily basis. Nursing will notify the Social Service designee if increased behaviors occur so he can assess the situation, intervene as needed and document outcome. The Nursing and Therapy Departments will communicate Resident #11's needs, equipment needs and concerns to the Social Service designee. The Social Service designee will follow up with Resident #11 and document outcome.	

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F 250	Continued From page 28 #11 for behavioral symptoms or that a behavioral plan had been developed for the resident. (Refer to F279.) The findings include: A review of the medical record of resident #11 revealed the resident was admitted to the facility on June 26, 2007, with diagnoses of CVA with left hemiparesis, Spasticity, Depression, Obesity, Intrathecal Morphine Pump Placement, and Reflux Sympathetic Disorder of the right leg secondary to crushing injuries of the leg. A review of the physician's orders revealed resident #11 received a scheduled narcotic analgesic several times a day for pain, in addition to the medication administered through the morphine pain pump. The physician's orders further reflected the resident received an antidepressant medication daily. Resident #11 was observed on March 29, 2010, at 11:35 a.m., and on March 30, 2010, at 9:50 a.m., to be lying in bed with the privacy curtain pulled. On March 30, 2010, at 11:00 a.m., resident #11 was observed to be sitting in a wheelchair with the resident's legs extending outward from the wheelchair and the resident's trunk did not fit appropriately into the seat of the wheelchair. An interview conducted with resident #11 on March 29, 2010, at 11:35 a.m., revealed the wheelchair provided by the facility was too small to enable the resident to be out of bed comfortably. Resident #11 stated the resident would like to be able to go downstairs to some of the facility activities, but could not tolerate being up for very long due to the wheelchair being too	F 250	Continued From page 28 2. The Director of Nursing and Nurse Unit Coordinators have reviewed all behavior logs to ensure all medically-related social service needs have been addressed and interventions are in place. The Social Service designee will make daily rounds to visit with residents, families and communicate with Nursing and Therapy staff to stay abreast of all resident needs so needs and concerns can be addressed. The Social Service designee will also review behavioral logs daily to identify any issues that may require Social Service intervention. While the Social Service designee is off duty, the Nursing staff will leave written report for the Social Service designee if needs/concerns arise that require follow-up. 3. The Assistant Administrator and Director of Nursing will periodically communicate with residents, families and Nursing staff to ensure that resident need are met and concerns are followed up. The Director of Nursing will also receive a copy of written information left for the Social Service designee so that she can monitor to ensure that all issues have been addressed. 4. As part of the Quality Assurance Program, the Administrator and Clinical	

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F 250	Continued From page 29 small and uncomfortable due the resident's obesity and chronic pain disorder. Resident #11 further stated, "I'm 55 years old and have chronic pain due to my legs being crushed by a forklift on my job." A review of the social services progress notes dated June 16, 2009 through March 9, 2010, revealed the Social Services Director (SSD) assessed resident #11 to be alert and oriented and to exhibit frequent complaints of heath issues, anger, noncompliance with medical needs, and inappropriate behaviors. The SSD noted the resident exhibited sexual overtures to staff, used call light frequently, voided/defecated in bed to get staff attention, and used inappropriate language. The SSD further noted the resident chose to remain in bed and not to participate in group activities. In addition, the SSD progress notes contained documentation of routine visits by the psychiatrist. A review of the psychiatric consultation notes dated January 28, 2010, February 19, 2010, and March 9, 2010, revealed the resident had a current diagnosis of Major Depression, recurrent, severe without psychotic features, and the psychiatrist evaluations indicated to "follow-up related to depression and insomnia." Further review of the consultation notes revealed the psychiatrist reviewed the resident's medication regimen during the facility visits and the report indicated to continue the same treatment plan for resident #11. A review of the monthly logs for mood and behavior patterns dated September 2009, October 2009, and November 2009 revealed documentation that resident #11 exhibited	F 250	Continued From page 29 and Administrative Team Leaders will audit ten percent of resident records monthly to ensure all needs are met and documented. This will be an ongoing process and will be reviewed at bi-monthly Quality Assurance Meetings. 5. April 1, 2010	

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F 250	Continued From page 30	F 250		

repetitive health and anxious complaints (non-health related) several times each month. During September 2009 resident #11 was noted to have three episodes of socially inappropriate behaviors consisting of food complaints, health concerns, ringing call light constantly, and telling dirty jokes. There was no documentation related to resisting/refusal of care. During October 2009, resident #11 was noted to have one episode of socially inappropriate behavior (food complaints) and 14 episodes of resistance to care (taking medications, ADLs, eating, and assistance). During November 2009, staff documented the resident to have frequent episodes of unpleasant mood in the morning, repetitive health/non-health related complaints, and 14 episodes of verbally abusive behavior. The mood/behavior log for December 2009 contained no documentation of mood/behavior problems. During January 2010, resident #11 was noted to have 12 episodes of repetitive non-health related complaints and no episodes of behaviors. The mood/behavior log for February 2010 contained documentation that the resident had two episodes of health related complaints, one episode of insomnia and non-related health complaints, and four episodes of socially inappropriate behaviors with one episode of verbally abusive behavior. During March 2010, resident #11 was noted to have one non-health related complaint, three episodes of verbally abusive behaviors, and 22 episodes of socially inappropriate behaviors.

A review of the facility's policy/procedure (no date) revealed behaviors were required to be documented by any discipline who observed the resident's behavior. The policy further directed that the SSD and Nursing were responsible to review the resident's patterns for concerns in

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F 250	Continued From page 31 behaviors having the potential to, or that are, affecting the resident's overall psychosocial status and care delivery. An interview conducted with the Unit Coordinator (UC) on April 1, 2010, at 10:45 a.m., revealed resident mood/behavior indicators were documented on the mood/behavior form by the licensed nurses only. The UC stated the UC occasionally reviewed the mood/behavior logs. The UC stated resident #11's behaviors of resisting/refusal of care should have been documented more consistently. The UC stated the UC did not identify that the behaviors had not been documented appropriately for resident #11. The UC stated the staff becomes immune to the residents' behaviors. Interview with the social worker on March 29, 2010, at 4:15 p.m., revealed the SSD was aware the resident frequently refused to be out of bed. The SSD stated facility staff encouraged resident #11 to be out of bed more. The SSD stated the resident's refusal was due to the resident's attention-seeking behaviors. The SSD noted the SSD reviewed the behavior monitoring logs quarterly, but did not identify that the resident's behaviors were not being documented consistently. The SSD further stated the SSD did not always attend the interdisciplinary care plan meetings for the residents and was not able to recall any specific behavioral interventions for the resident. The SSD noted the resident's chronic pain disorder had never been considered a factor for the resident's refusal to be out of bed.	F 250		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically	F 272	**F 272** It is and was on the days of survey, the policy of Berea Health Care Center to conduct initially and periodically a comprehensive	

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F 272	Continued From page 32 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to conduct thorough assessments utilizing the Resident Assessment Instrument (RAI) process for four (4) of (19) sampled residents (residents #1, #7, #9, and #10) who utilized physical restraints. (Refer to F221.)	F 272	Continued From page 32 assessment of each resident's functional capacity. Berea Health Care Center does make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment does include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. 1. A Physical Restraint Elimination Assessment was completed on	

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F 272	Continued From page 33 The findings include: 1. Resident #9 was admitted to the facility on October 23, 2002, and had diagnoses including Alzheimer's Disease, Aphasia, Macular Degeneration, and Osteoporosis. Observations of resident #9 on March 29 and 30, 2010, and a review of physician's orders for resident #9 dated February 2010, revealed the resident utilized a Posey vest restraint (since September 8, 2008) and padded full side rails raised bilaterally (since June 7, 2007) while in bed, and a reclining high-back wheelchair with a lap tray when up in a chair (since March 5, 2008). A review of resident #9's most recent comprehensive assessment dated June 10, 2009, revealed the resident was severely cognitively impaired, rarely/never understood/understands, and was a totally dependent two-plus person physical assist with bed mobility/transfers, had periods of restlessness, and was resistive to care at times. Resident #9 was assessed to use full rails on all open sides of the bed, a trunk restraint, and a chair that prevented rising daily. A review of the Resident Assessment Protocol (RAP) summary for physical restraints dated June 9, 2009, stated to "see falls RAP." A review of the falls RAP dated June 9, 2009, revealed resident #9 triggered for a falls RAP due to utilization of a restraint. The RAP revealed side rails were raised bilaterally for repositioning and bed mobility, and the resident "will grab on to them and pull." However, a review of the side rail assessment forms completed quarterly from March 10, 2009 through March 2, 2010, revealed	F 272	Continued From page 33 Resident #9 on April 5, 2010 indicating that the resident was a candidate for restraint reduction. Reduction was implemented and will be reassessed in 30 days to determine if another reduction or elimination would be indicated. The RAI process was followed and update on Resident #9 as of April 5, 2010. A Physical Restraint Elimination Assessment was completed on Resident #10 on April 12, 2010 indicating that the resident was a candidate for restraint reduction. Reduction was implemented and will be reassessed on a quarterly basis to determine if another reduction or elimination would be indicated. The RAI process was followed and up to date on Resident #10 as of April 12, 2010. A Physical Restraint Elimination Assessment was completed on resident #7 on April 8, 2010 and indicated that the resident was a candidate for elimination. The restraint was eliminated on the date of the assessment. The RAI process was followed and the elimination was reflected on the assessment for Resident #7 on April 8, 2010. A Physical Restraint Elimination Assessment was completed on resident #1 on April 7, 2010 indicating that the	

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F 272	Continued From page 34 resident #9 did not use the side rails for positioning or support. Additionally, interviews on March 29, 2010, with the CNA and UM caring for resident #9 revealed the resident did not use the side rails to assist with bed mobility. The RAPs further stated resident #9's lap tray on the wheelchair was for "positioning to improve safety and quality of life," and the Posey vest in bed was "secondary to Alzheimer's." However, The RAP failed to identify a specific medical symptom being treated with the use of restraints, how the restraints would have treated the medical symptom, how the restraint would protect the resident's safety, and how the restraint assisted the resident in maintaining his/her highest practicable level of physical and psychosocial well-being. A review of resident #9's comprehensive care plan dated March 3, 2010, revealed the facility would "assess as needed and quarterly to ensure least restrictive device is being utilized." However a review of Physical Restraint Assessment forms dated December 9, 2009 and March 11, 2010, revealed no less restrictive devices had been considered or implemented for resident #9. Although the facility completed a Physical Restraint Assessment form for resident #9 on a quarterly basis, there was no evidence the facility considered resident #9's individualized needs, problems, conditions, or risk factors. 2. Resident #10 was admitted to the facility on September 30, 2002, with diagnoses including Dementia, Osteoarthritis, Depression, and a history of bilateral Hip Fractures. Observations of resident #10 on March 29 and 30, 2010, and a review of physician's orders for	F 272	Continued from page 34 resident was a poor candidate for restraint reduction. Current physician restraint orders will be continued and the resident will be reassessed on a quarterly basis to determine if reduction is indicated. The RAI process was followed on Resident #1 and also reflects that Resident #1 is a poor candidate for a reduction as of April 7, 2010. RAPs have also been reviewed on Residents #1, 7, 9 and 10 to ensure they are reflective of current assessments. 2. A Physicial Restraint Elimination Assessment has been completed on all other residents with a physical restraint. The RAI process was followed also and all changes were reflected on this. 3. The MDS Coordinator will review the RAI when there is a new or changed restraint order to ensure that the process has been followed and is correct. 4. As part of the facility's Quality Assurance Program, RAIs will be audited by the Administrator, Director of Nursing and Clinical Team Leader to ensure that the correct process is being followed and is reflective of the resident's current assessment and plan of care. These audits will be done on a monthly basis for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

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BEREA HEALTH CARE CENTER	601 RICHMOND ROAD, P O BOX 40 BEREA, KY 40403

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F 272	Continued From page 35 resident #10 dated February 2010, revealed the resident was to have side rails up bilaterally "padded w/view," a lap tray while up in wheelchair (both since September 28, 2006), and a Posey belt in bed (since December 4, 2006). A review of resident #10's most recent comprehensive MDS assessment dated September 8, 2009, revealed the resident had been assessed to be severely cognitively impaired, rarely/never understood/understands, and a totally dependent two-plus person physical assist with bed mobility/transfers. Resident #10 was assessed to use full rails on all open sides of the bed, a trunk restraint, and a chair that prevented rising daily. A review of the Resident Assessment Protocol (RAP) summary for physical restraints dated September 1, 2009, for resident #10 was conducted. The RAP revealed resident #10 had been assessed to be a high risk for falls, utilized a lap tray in wheelchair for upper body positioning, padded side rails "with view" bilaterally, and a Posey belt while in bed due to thrashing and inability to comprehend danger. The RAP indicated resident #10 used the side rails to "pull against in bed," and the resident was "unable to rise from chair without the use of the lap tray, lap tray for positioning." However, a review of side rail assessment forms completed quarterly from August 31, 2009 through February 22, 2010, revealed resident #10 did not use the side rails for positioning or support. Additionally, interviews on March 30, 2010, with CNAs and the UM caring for resident #10 revealed the resident did not use the side rails to assist with bed mobility, and made no	F 272	Continued From page 35 5. April 12, 2010	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 36 effort to assist with transfers. An interview with the Administrator, DON, and MDS Coordinator on March 31, 2010, revealed the staff was unable to describe/demonstrate how resident #10 could have utilized the lap tray on the wheelchair to rise from the chair, as documented in the RAPs. A review of resident #10's medical record and interviews with the Administrator, DON, MDS Coordinator, and OT on March 31, 2010, at 1:45 p.m., revealed the facility failed to identify a specific medical symptom that required the use of the restraints for resident #10, how the restraints would have treated the medical symptom, and how the restraints would protect the resident's safety and assist the resident in maintaining his/her highest practicable level of physical and psychosocial well-being. Although the facility completed a Physical Restraint Assessment form for resident #10 on a quarterly basis, there was no evidence the facility considered resident #9's individualized needs, problems, conditions, or risk factors. 3. A review of the medical record revealed resident #7 was admitted to the facility on February 3, 2009, with diagnoses of Dementia, Rhabdomyolysis, Anxiety, Alzheimer's, and Hypertension. Resident #7 was observed in the facility dining room on March 29, 2010, at 6:00 p.m., during the evening meal and on March 30, 2010, at 12:15 p.m., during the noon meal. The resident was sitting in a wheelchair at the dining table with a Posey belt in place. On March 29, 2010, at 3:05 p.m., resident #7 was observed propelling self in	F 272		

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F 272	Continued From page 37	F 272		

the hallway in a wheelchair with a Posey belt in place, and on March 30, 2010, at 2:15 p.m., resident #7 attended activities with the Posey belt in place.

A review of the annual comprehensive assessment (MDS) completed on January 13, 2010, revealed resident #7 was assessed to have short/long-term memory deficits, moderately impaired decision-making skills, and to require extensive assistance of two staff persons for transfers, bed mobility, and ambulation. The assessment further identified resident #7 utilized a trunk restraint daily.

A review of the Resident Assessment Protocols (RAPs) to address restraints revealed resident #7 required a soft Posey belt due to a history of falls and was cognitively unaware of dangers of self-transfers. The RAP further noted facility staff would ensure the least restrictive device would be used for the resident. However, there was no evidence the facility had evaluated/identified a specific medical symptom that the restraint would treat, or considered risks/benefits of the Posey belt. In addition, there was no evidence the facility had evaluated the resident to determine if a less restrictive device could be utilized for resident #7.

4. Resident #1 was admitted to the facility on February 2, 2009, with diagnoses of Alzheimer's Disease, Dementia, Anxiety, Paranoia and Psychosis, Degenerative Joint Disease, and Osteoporosis.

Resident #1 was observed at 3:05 p.m. on March 29, 2010, sitting in a wheelchair with a waist belt, and an alarm in place, and had a low bed with the

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F 272	Continued From page 38	F 272		

right side placed against the wall. The left side of the bed had two half side rails with a soft bed bolster placed between the rails.

A review of a significant change Minimum Data Set (MDS) comprehensive assessment completed on January 3, 2010, revealed resident #1 was assessed to have short/long-term memory deficits, severely impaired decision-making skills, and required extensive assistance of two staff persons for transfers/bed mobility. The assessment further identified resident #1 to utilize a trunk restraint daily.

A review of the Resident Assessment Protocols (RAPs) dated January 4, 2010, revealed the resident utilized a self-release seat belt which resident #1 was unable to release on command. However, the RAP did not identify a specific medical symptom that the restraint would treat or how the restraint would benefit the resident. In addition, the RAP did not include the risk factors of the restraint use, i.e. safety, decline in activities of daily living, etc.

An interview conducted with the Administrator and the restraint team at 1:45 p.m. on March 31, 2010, revealed the facility could not provide evidence regarding assessments to evaluate for restraint reduction/elimination for resident #1.

An interview conducted on March 31, 2010, at 1:45 p.m., with the Administrator and the restraint team, consisting of the DON, MDS Coordinator, and OT, revealed the MDS Coordinator completed a quarterly restraint assessment form for each resident who utilized a restraint and each team member individually signs the assessment. However, no formalized team meeting was

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F 272	Continued From page 39 conducted to discuss if the resident had a continued need for the restraint, if a less restrictive device would be appropriate, or if a restraint reduction could be attempted. An interview conducted with MDS Coordinators #1 and #2 on April 1, 2010, at 1:45 p.m., revealed MDS Coordinator #1 was aware of the four criteria required to be included in the RAP summary. MDS Coordinator #2 stated he/she was not familiar with the four criteria. MDS Coordinator #1 stated he/she thought the criteria had been addressed for the restraint RAPs. The MDS 2.0 User's Manual, under section 4.3, states: "Staff assess the resident in the areas that have been triggered and are guided by the RAPs and other assessment information, including items not automatically triggered, as needed, to determine the nature of the problem and understand the causes specific to the resident." The MDS 2.0 manual continued that the RAP assessment documentation should generally describe: the nature of the condition; complications and risk factors that affect the staff's decision to proceed to care planning; factors that must be considered in developing individualized care plan interventions; and the need for referrals or further evaluation by appropriate health professionals. In addition, the MDS 2.0 manual stated that based on the review of the assessment information, the interdisciplinary team would decide whether or not the triggered condition affected the resident's functional status or well-being and warranted a care plan intervention.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	**F 279** It is and was on the days of survey, the policy of Berea Health Care Center to use the result of the	

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F 279	Continued From page 40 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to develop a comprehensive care plan for one (1) of nineteen (19) sampled residents to address behavioral symptoms. Observation and interviews revealed resident #11 displayed behavioral symptoms of resistance/refusal of care, verbally abusive behaviors, and socially inappropriate behaviors. However, the facility failed to identify these behavioral symptoms during the completion of the comprehensive assessment and a comprehensive care plan was not developed to provide behavioral interventions or program for resident #11.	F 279	Continued From page 40 assessment to develop, review and revise the resident's comprehensive plan of care. It is and was on the days of survey, the policy of Berea Health Care Center to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. It is and was on the days of survey the policy of Berea Health Care Center that the care plan describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). 1. All of Resident #11's behaviors were careplanned with goals and interventions in place on April 5, 2010. 2. All residents' care plans have been audited to ensure that the care plan is reflective of the resident's current care needs.	

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F 279	Continued From page 41 The findings include: Resident #11 was observed on March 29, 2010, at 11:35 a.m., and on March 30, 2010, at 9:50 a.m., to be lying in bed with the privacy curtain pulled. On March 30, 2010, a CNA was noted to be in the resident's room attempting to get the resident out of bed for a shower. The resident was refusing to get out of bed and spoke in a loud/angry tone to the CNA. An interview conducted with resident #11 on March 29, 2010, at 11:35 a.m., revealed the wheelchair provided by the facility was too small to enable the resident to be out of bed comfortably. Resident #11 revealed he/she did not refuse to get out of bed due to choosing to stay in bed, but due to being uncomfortable and unable to tolerate being up in the wheelchair. An interview conducted with CNA #3 on March 30, 2010, at 10:00 a.m., and with CNAs #2 and #3 on March 31, 2010, at 4:15 p.m., revealed resident #11 frequently refused to get out of bed except for showers or physician's appointments outside the facility. The CNAs stated they were responsible to report any behavioral symptoms to the nurse and the nurse documented the behaviors. The CNAs also reported encouraging resident #11 to get out of bed, but would report refusals to the nurse. A review of the annual MDS assessment conducted on June 15, 2009, revealed resident #11 was assessed to exhibit persistent anger with self/others and repetitive health and non-health related complaints. The assessment noted the resident had displayed no behaviors. A review of the quarterly assessment dated September 14,	F 279	Continued From page 41 3. The nursing staff were inserviced on April 16, 2010 on the importance of checking the care plan when specific behavior is exhibited to ensure all behaviors are care planned and have goals and interventions in place. The Director of Nursing and Unit Coordinators will audit behavior records weekly to ensure all behaviors that are exhibited are careplanned and have goals and interventions in place. 4. As part of the ongoing Quality Assurance Program, the Administrator and Clinical Team Leader will audit behavior records monthly for the next three months to ensure that all behaviors are careplanned and have goals and interventions in place. 5. April 16, 2010	

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F 279	Continued From page 42 2009, revealed resident #11 continued to exhibit persistent anger with self/others, unpleasant mood in the morning, repetitive health and non-health related complaints, and socially inappropriate/disruptive behaviors. The quarterly assessments dated December 8, 2009 and March 4, 2010, revealed the resident displayed repetitive health and non-health related complaints and no behaviors were displayed. A review of the Resident Assessment Protocols (RAPs) revealed behaviors had not been assessed. A review of resident #11's care plan revealed the facility identified resident #11 exhibited mood problems related to persistent anger, repetitive health complaints, repetitive anxious complaints; seeks attention/reassurance due to a diagnosis of Depression and Anxiety. The care plan interventions included to give medications as ordered, provide a psychiatric evaluation as ordered, attempt to eliminate stressors, encourage to participate in activities/social events, and to monitor for an increase/decrease in behaviors and to document. Further review of the care plan revealed no evidence the facility had developed a care plan that addressed resident #11's behavioral symptoms and no evidence the facility had implemented behavioral interventions to improve/eliminate the resident's behaviors. Interview with the social worker on March 29, 2010, at 4:15 p.m., revealed the SSD was aware the resident frequently refused to be out of bed. The SSD stated the resident's refusal was due to the resident's attention-seeking behaviors. The SSD further stated he/she did not attend the care plan meetings unless the resident or the	F 279		

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F 279	Continued From page 43 resident's family was present. The SSD stated the nurses had a quarterly meeting and developed the resident's care plan. The SSD could not recall any specific behavioral interventions for the resident and was not aware the resident did not have a care plan to address behaviors. An interview with the MDS Coordinators on April 1, 2010, at 1:45 p.m., revealed the MDS Coordinators reviewed the mood/behavior logs when the residents' MDS assessment was due for completion. The MDS Coordinators stated they were aware of resident #11's behavioral symptoms, but did not identify that the behaviors were not consistently documented for the resident and as a result, no care plan had been developed to address the behaviors.	F 279		
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	**F 280** It is and was on the days of survey the policy of Berea Health Care Center to have a comprehensive care plan developed within seven days after the completion of the comprehensive assessment; prepared by an interdisciplinary team and revised when necessary. Resident #1 is a 91 year old female admitted to Berea Health Care Center on February 2, 2006 with diagnoses of Alzheimer's (dementia), anxiety, paranoia, psychosis, vertigo, degenerative joint disease and glaucoma. Since admission, she has developed several other medical conditions such as diabetes. Numerous interventions had been attempted during the resident's stay	

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F 280	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to periodically review and revise the comprehensive care plan for one (1) of nineteen (19) sampled residents (resident #1) after the resident sustained a fall in the facility on October 31, 2009, which resulted in a wrist fracture. The facility failed to evaluate newly identified fall risk factors for resident #1 after the fall on October 31, 2009, and failed to develop/implement resident-specific interventions to prevent additional falls for this resident. The resident sustained another fall in the facility on December 14, 2009, resulting in a fracture to the right hip. The findings include: Review of the medical record for resident #1 revealed the resident was admitted to the facility on February 2, 2009, with diagnoses of Alzheimer's Disease, Dementia, Depression, Anxiety, Paranoia, Psychosis, Degenerative Joint Disease, Diabetes Mellitus, Hypertension, and Osteoporosis. A review of a Minimum Data Set (MDS) for significant change for resident #1 dated January 3, 2010, revealed the resident had experienced a fall with a hip fracture in the past 30 days, and a fall with another fracture in the past 31 to 180 days. According to the assessment, the resident had also experienced decline in the activities of daily living and bowel/bladder incontinence. Review of the Resident Assessment Protocol (RAP) Summary	F 280	Continued From page 44 such as a toileting program, pressure alarm to bed and self-releasing seatbelt to wheelchair. In the three years prior to October 31, 2009, the resident had not sustained an injury related to a fall. On October 31, 2009, Resident #1 got up out of bed unattended and fell causing a laceration to her forehead and a fractured left wrist. A bed alarm was in place and functioning properly. The staff member heard the alarm and responded but the resident fell before the staff member could reach the resident. Resident #1 was reviewed by the Interdisciplinary Team on November 3, 2009 and it was felt that the interventions currently in place were appropriate and no changes were made at the time. Resident #1 did not experience another fall until December 14, 2009 when resident #1 was found lying on the floor on her right side with the alarm sounding. Resident #1 was immediately sent to the Emergency Room and returned to the facility two hours later. On December 14, 2009, the bed was moved along the wall and a half rail was applied to the left side of the bed, the bed alarm continued and the bed was placed in low position. On December 15, 2009 an order was obtained to x-ray the resident's right pelvis, right hip, right knee and right femur to rule out fractures. 1. On April 7, 2010, a Fall Assessment was completed by the MDS Coordinator	

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F 280	Continued From page 45 dated January 4, 2010, revealed resident #1 was assessed to be at high risk for falls due to having a history of falls, receiving psychotropic medications, and diagnoses of Anxiety, Depression, Arthritis, and Osteoporosis. A review of an incident/accident report for resident #1 dated October 31, 2009, revealed the resident attempted to get out of bed unattended at 4:40 p.m., and was found lying on the floor beside the bed by facility staff. Resident #1 sustained a laceration to the forehead, and the resident complained of pain to the left arm and leg. Resident #1 was transferred to the hospital for further evaluation and treatment and was diagnosed with a fracture to the left wrist. A review of the occurrence investigation report dated November 3, 2009, revealed after the facility investigation of this incident no new interventions were implemented to prevent additional falls for the resident due to the staff's determination that interventions were already in place to prevent future falls for this resident. However, the occurrence investigation dated November 3, 2009, revealed facility staff identified that resident #1 attempted to get out of bed unassisted to transfer to the wheelchair whenever the wheelchair was left in the room and was visible to the resident. Additionally, staff determined leaving the wheelchair outside the resident's room could decrease the resident's risk for future falls. Review of the comprehensive care plan for resident #1 revealed the facility had identified resident #1 to be at risk for falls and had developed interventions to address this risk. However, the facility failed to develop/implement new interventions to prevent additional falls for	F 280	Continued From page 45 on Resident #1 indicating that she continued to be at high risk for falls. Currently the following interventions are in place: Hi/low bed in low position, bed against wall, front side rails up times two (half-rails) with soft bed bolder between rails, floor mat on floor beside bed. When she is up in the wheelchair she has an early warning self-releasing seat belt due to leaning and throwing her right arm up and forward without purpose. 2. All residents who experience a fall will be reviewed daily by the Director of Nursing to ensure risk factors and interventions have been implemented on an ongoing basis. 3. Daily, the Director of Nursing, MDS Coordinator and Unit Coordinator will meet to review any falls as well as other clinical indicators, focusing on ensuring risks are identified and approaches indicated. In addition, an inservice was conducted on April 16, 2010 by the Director of Nursing with all licensed staff to review the importance of immediately updating the plan of care to be reflective of the residents' current needs and risks. 4. As part of the facility's ongoing Quality Assurance Program, the Director of Nursing will audit ten percent of all resident care plans to ensure they reflect the residents' needs and risks.	

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F 280	Continued From page 46 the resident after resident #1 sustained a fall with injury on October 31, 2009. The plan of care did not include the intervention of leaving the resident's wheelchair outside the resident's room, although the wheelchair being in the resident's room while the resident was in bed had been identified as a fall risk factor for this resident. Review of an incident/accident report for resident #1 dated December 14, 2009, at 12:25 a.m., revealed staff heard an alarm sounding and found resident #1 lying on the floor upon entering resident #1's room. The resident was transported to the Emergency Room (ER) of the local hospital for evaluation and treatment. Review of the ER report dated December 14, 2009, revealed no pain or tenderness to the resident's bilateral hips and no x-rays were performed. The resident was returned to the facility where the resident was examined by the Nurse Practitioner (NP) at 9:30 a.m. on December 15, 2009. The NP documented that resident #1 had facial grimacing and pain when passive range of motion was performed to the right leg. The resident was also unable to bear weight since the fall according to documentation by the NP. Review of the x-ray report dated December 17, 2009, revealed resident #1 had sustained a fracture of the proximal right femur which required surgical intervention to repair. Review of the facility fall policy (not dated) revealed facility staff was required to review, evaluate, and develop/implement interventions to address a resident's assessed risk for falls in an effort to prevent further falls for the resident. Observation of resident #1 at 3:05 p.m. on March 29, 2010, revealed the resident was sitting in a	F 280	Continued From page 46 This audit will continue for the next three month. 5. April 16, 2010	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185384	A. BUILDING _____ B. WING _____	04/05/2010

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F 280	Continued From page 47 wheelchair with a waist restraint in place. The resident's bed was observed to be a low bed with the right side of the bed placed against the wall. The left side of the bed contained two half side rails with a soft bolster pillow placed between the two rails. A mat was observed on the floor of the left side of the bed. Interview with the Administrator, DON, Unit Coordinators, and MDS Nurse on April 1, 2010, at 7:38 p.m., revealed that the facility had investigated the cause of resident #1's fall on October 31, 2009. The facility determined that all needed interventions to prevent additional falls for this resident were already in place and decided there was no need to revise the resident's care plan interventions. However, administrative staff was unable to give details or specifics as to how this determination was made. The administrative staff explained since the resident did not usually roll out of bed it was not expected that the resident would roll out of bed a second time and therefore, the care plan interventions for this resident were not revised.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services were provided by the facility to meet professional standards of quality for two (2) of nineteen (19) sampled residents (residents #9 and #19). Resident #9 had physician's orders for	F 281	**F 281** It is and was on the days of survey the policy of Berea Health Care Center that services provided or arranged by the facility meet professional standards of quality. 1. The nurse in charge of overseeing Resident #9 was counseled on April 8, 2010 for not ensuring that medical/assistive devices that were ordered by the physician were on Resident #9 on March 29,2010. The nurse that was administering	

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F 281	Continued From page 48 medical/assistive devices to be utilized by the resident; however, there was no evidence these devices were provided for resident #9. An evaluation conducted by the facility determined resident #19 was not able to self-administer medications; however, resident #19 was observed to be self-administering a nebulizer treatment during the medication administration observation conducted on March 30, 2010. The findings include: 1. Resident #9 was admitted to the facility on October 23, 2002, and had diagnoses including Alzheimer's Disease, Aphasia, Macular Degeneration, and Osteoporosis. A review of physician's orders dated February 2010 and March 17, 2010, for resident #9 revealed the staff was to apply TED hose to resident #9 every morning and remove the hose at bedtime, the resident's wheelchair lap tray was to have Ali-fleece to the inside of the tray to decrease skin tear risk, and have palm protectors bilaterally to maintain palm integrity. Observations of resident #9 on March 29, 2010, at 3:00 p.m., 3:50 p.m., 4:05 p.m., 4:35 p.m., and 6:05 p.m., and on March 30, 2010, at 9:45 a.m., 11:10 a.m., and 5:15 p.m., revealed the resident was not provided the TED hose or palm protectors, or had fleece applied to wheelchair tray. A review of resident #9's Nursing Assistant Care Plan and Flow Record revealed the TED hose, palm protectors, and fleece were included on the form. An interview was conducted on March 30, 2010, at 5:15 p.m., with the CNA caring for	F 281	Continued From page 48 medication on March 30, 2010 received counseling on ensuring nebulizer treatments are administered correctly and per facility protocol. She was also counseled regarding allowing Resident #19 to self-administer medication when assessment indicated Resident #19 was not a candidate to self-administer her own medications. 2. Physician orders and care plans were reviewed by Unit Managers and the Director of Nursing to ensure all residents had in place all medical/assistive devices that were ordered. All nursing staff were inserviced on April 16, 2010 to educate the staff of ensuring medical/assistive devices were being applied to residents as ordered by the physician Also, on April 16, 2010, the nurses were inserviced on not allowing residents to self-administer medication unless they were determined to be able to self-administer and a physician order was in place indicating they were able to do so. 3. Daily, the Unit Coordinator will monitor resident care to ensure all devices are applied as ordered and care planned. The Director of Nursing will monitor at least one medication pass per week to ensure residents who are not safe to self-administer	

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F 281	Continued From page 49 resident #9. The CNA stated he/she had assumed the Geri-legs worn by resident #9 were the same as TED hose. The CNA thought the resident wore the palm protectors during day shift only. The CNA did not know where the fleece padding for the tray was located and stated, "It may be in the wash." An observation of resident #9 and an interview with the Unit Manager (UM) was conducted on March 30, 2010, at 5:30 p.m. The UM confirmed resident #9 did not have the palm protectors, TED hose, or fleece applied to the wheelchair tray as ordered by the resident's physician. The UM stated he/she did conduct rounds "from time to time" in an effort to ensure that residents received physician-ordered treatments, but stated, "I can't check every day." 2. A review of the medical record revealed resident #19 was admitted to the facility on January 26, 2010, with diagnoses including Dementia, Anxiety, and Alzheimer's Disease with Behavioral Disturbances. A review of the current physician's orders dated March 3, 2010, revealed resident #19 had a physician's order to receive Ipratropium/Albuterol 3 ml Duoneb treatment four times a day. An evaluation was conducted on January 26, 2010, to assess resident #19's ability to safely self-administer medication. The evaluation revealed resident #19 did not have knowledge of what the medication was used for, did not have the knowledge of the correct time to take the medication, or the ability to store all medications properly. The evaluation further stated the resident got medications "mixed-up" at home and preferred that the facility staff administer the	F 281	Continued From page 49 medications are not permitted to do so. 4. As part of the facility's ongoing Quality Assurance Program, the Pharmacy Consultant will watch one medication pass monthly. The Director of Nursing will audit 10% of residents' care plans and care provided monthly to ensure physician's orders are being followed as ordered. 5. April 16, 2010	

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F 281	Continued From page 50 resident's medications. During the medication administration observation conducted on March 30, 2020, at 4:12 p.m., the nurse was observed to obtain one ampule of Ipratropium Bromide and one ampule of Albuterol Sulfate from the medication cart. The nurse took the medications into resident #19's room. Resident #19 was observed to be sitting on the side of the bed with the nebulizer placed in the resident's mouth. The nebulizer was nearly filled with a clear liquid. The nurse told the resident, "You're already giving yourself a treatment," and the resident stated, "I forget sometimes." The nurse proceeded to remove the nebulizer from the resident's mouth and poured the liquid into the trash can at the resident's bedside. The nurse then poured the ampules of Ipratropium Bromide and Albuterol Sulfate into the nebulizer and administered the medications to resident #19. An interview conducted with the nurse on March 30, 2010, at 4:45 p.m., revealed the resident was not assessed to safely self-administer medications. The nurse stated resident #19 had received a nebulizer treatment earlier that day at 12:00 p.m. The nurse stated he/she stayed with the resident during the 12:00 p.m. treatment to ensure the resident took the treatment as ordered. The nurse stated the nurse was not able to identify the liquid substance in the nebulizer during the 4:12 p.m. administration.	F 281		
F 323 SS=G	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	F 323	**F 323** It is and was on the days of survey the policy of Berea Health Care Center to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance device to	

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F 323	Continued From page 51 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a safe environment to include adequate supervision to prevent accidents for one (1) of nineteen (19) sampled residents (resident #1). The facility failed to evaluate newly identified fall risk factors for resident #1 and develop/implement resident-specific interventions in an attempt to prevent further falls. Resident #1 sustained a fall on October 31, 2009, resulting in a left wrist fracture, and resident #1 sustained a second fall on December 14, 2009, resulting in a right hip fracture. The findings include: 1. Resident #1 was admitted to the facility on February 2, 2009, with diagnoses of Alzheimer's Disease, Dementia, Depression, Anxiety, Paranoia and Psychosis, Degenerative Joint Disease, Diabetes Mellitus, Hypertension, and Osteoporosis. Observation of resident #1 at 3:05 p.m. on March 29, 2010, revealed the resident was sitting in a wheelchair with a waist belt restraint, and an alarm in place. In addition, the resident had a low bed with the right side of the bed placed against the wall. The left side of the bed had two half side rails with a soft bolster pillow placed between the two side rails. A mat was also on the floor on the left side of the bed.	F 323	Continued From page 51 prevent accidents. Resident #1 is a 91 year old female admitted to Berea Health Care Center on February 2, 2006 with diagnoses of Alzheimer's (dementia), anxiety, paranoia, psychosis, vertigo, degenerative joint disease and glaucoma. Since admission, she has developed several other medical conditions such as diabetes. Numerous interventions had been attempted during the resident's stay such as a toileting program, pressure alarm to bed and self-releasing seatbelt to wheelchair. In the three years prior to October 31, 2009, the resident had not sustained an injury related to a fall. On October 31, 2009, Resident #1 got up out of bed unattended and fell causing a laceration to her forehead and a fractured left wrist. A bed alarm was in place and functioning properly. The staff member heard the alarm and responded but the resident fell before the staff member could reach the resident. Resident #1 was reviewed by the Interdisciplinary Team on November 3, 2009 and it was felt that the interventions currently in place were appropriate and no changes were made at the time. Resident #1 did not experience another fall until December 14, 2009 when resident #1 was found lying on the floor on her right side with the alarm sounding. Resident #1 was immediately sent to the Emergency	

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F 323	Continued From page 52 A review of a significant change Minimum Data Set (MDS) comprehensive assessment for resident #1 dated January 3, 2010, revealed the resident had experienced a fall with a hip fracture in the past 30 days, and a fall with other fracture in the past 31 to 180 days. In addition, resident #1 experienced a decline in activities of daily living, and bowel/bladder incontinence. Review of the Resident Assessment Protocol (RAP) Summary dated January 4, 2010, revealed resident #1 was assessed to be at high risk for falls due to having a history of falls, psychotropic medications, anxiety, depression, arthritis, and osteoporosis. A review of an incident/accident report dated October 31, 2009, for resident #1 revealed the resident attempted to get out of bed unattended at 4:40 p.m., and staff found resident #1 lying on the floor by the bed. Resident #1 sustained a laceration to the forehead, and the resident was complaining of pain in the left arm and leg. Resident #1 was sent to the hospital and was diagnosed with a left wrist fracture. A review of the occurrence investigation report dated November 3, 2009, revealed after the facility's investigation no new interventions were implemented because staff felt interventions were already in place to prevent the resident from having future falls. However, the occurrence investigation dated November 3, 2009, revealed facility staff identified that resident #1 attempted to get out of bed unassisted to get into the wheelchair whenever the wheelchair was left in the room and visible to the resident. Additionally, facility staff determined that leaving the wheelchair outside the resident's room could	F 323	Continued From page 52 Room and returned to the facility two hours later. On December 14, 2009, the bed was moved along the wall and a half rail was applied to the left side of the bed, the bed alarm continued and the bed was placed in low position. On December 15, 2009 an order was obtained to x-ray the resident's right pelvis, right hip, right knee and right femur to rule out fractures. 1. An updated Fall Risk Assessment was completed for Resident #1 on April 7, 2010 indicating that she continued to be at high risk for falls although her last fall was noted to have been in December of 2009. She continues to require extensive assistance of two with transfers and is unable to ambulate. When Resident #1 is in bed, she continues to be in a hi/low bed in low position with the bed against the wall, half rails times two up on the front of the bed, bed bolder between rails and a floor mat in the floor beside the bed. Resident #1 is to have a self-releasing early warning seat belt when in wheelchair. 2. A Fall Risk Assessment will continue to be completed on individual residents after a fall with interventions put into place. For residents who have not had a fall, Fall Risk Assessments will be completed on a quarterly basis.	

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F 323	Continued From page 53 decrease the resident's risk for future falls. Review of the comprehensive plan of care revealed the facility had identified resident #1 to be at risk for falls and developed interventions to address this risk. However, the facility failed to develop new interventions after the resident sustained a fall with injury on October 31, 2009. The plan of care did not include the intervention of leaving the resident's wheelchair outside the resident's room, even though the wheelchair being in the resident's room while the resident was in bed had been identified as a fall risk factor for this resident. Review of an incident/accident report for resident #1 revealed staff heard an alarm sounding at 12:25 a.m. on December 14, 2009, and upon entering resident #1's room, staff found the resident lying on the floor on the resident's right side. The resident was sent to the Emergency Room (ER) for evaluation. A review of the ER report dated December 14, 2009, revealed the bilateral hips were non-tender, and the range of motion was painless. There was no x-Ray performed. The resident returned to the facility where the resident was examined by the Nurse Practitioner (NP) at 9:30 a.m. on December 15, 2009. The NP documented that resident #1 had facial grimacing and pain when passive range of motion was performed to the right leg. In addition, the resident was unable to bear weight since the fall. A review of the x-Ray report dated December 17, 2009, revealed resident #1 had sustained a fracture of the proximal right femur that resulted in surgery. Review of the facility fall policy (not dated) revealed facility staff was to review, evaluate and	F 323	Continued From page 53 3. Any resident that has a fall will immediately be assessed by a nurse. At that time, the nurse will also review risks and put interventions in place to assist in preventing future falls. The nurse will notify the Director of Nursing via a written occurrence report. The Director of Nursing will review the occurrence reports daily during the week and review falls that have occurred on weekends on Monday to ensure interventions are in place to assist in preventing future falls. All falls will then be reviewed each Wednesday during the facility's Quality of Care Meeting. 4. As part of the facility's ongoing Quality Assurance program, the Director of Nursing will audit the care plan of any resident who falls to identify that risk factors have been addressed and interventions have been implemented which are appropriate for the resident. 5. April 16, 2010	

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F 323	Continued From page 54 develop/implement interventions to address residents' assessed risk for falls in an effect to prevent further resident falls. Interview with the Administrator, Director of Nursing, Unit Coordinators, and MDS nurse at 7:38 p.m. on April 1, 2010, revealed the facility staff had researched the cause of the resident's fall on October 31, 2009. They stated the facility staff thought all needed interventions were in place and decided there was no need to revise the resident's care plan interventions. However, administrative staff was unable to give details or specifics as to how this determination was made. They explained since the resident did not usually roll out of bed they did not expect her to roll out of bed a second time.	F 323		
F 371 SS=D	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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was stored, prepared, distributed, and served under sanitary conditions. The confectioner's oven was dirty and in need of cleaning.	F 371	**F 371** It is and was on the days of survey the policy of Berea Health Care Center to – (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. 1. The convection oven had been in use the day it was found unclean. The oven is cleaned on a daily basis as needed and also on a weekly cleaning schedule for a more detailed cleaning. The cook who failed to clean the oven as scheduled received counseling on April 2, 2010. 2. The Dietary Manager has placed the convection oven on a schedule to be cleaned daily. A thorough cleaning of	

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F 371	Continued From page 55 The findings include: Observation on April 1, 2010, revealed the confectioner's oven was dirty and in need of cleaning. Interview with dietary staff on April 1, 2010, at 3:00 p.m., revealed the ovens were scheduled for weekly cleaning on Wednesday; however, the staff person stated he/she was unable to clean the oven the day before on Wednesday due to the workload.	F 371	Continued From page 55 the convection oven will remain on the weekly cleaning schedule. 3. The Dietary Manager and/or day shift Cook will check the convection oven daily to ensure it is clean. 4. As part of the Quality Assurance Program, the Administrator and Environmental Team Leader will periodically monitor to ensure the convection oven is maintained to acceptable standards of cleanliness. 5. April 2, 2010	
F 441 SS=D	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, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	**F 441** It is and was on the days of survey the policy of Berea Health Care Center to establish and maintain and Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. Resident #3's charge nurse was educated and counseled on Berea Health Care Center's Hand Washing Policy on April 8, 2010. 2. The Director of Nursing inserviced all nurses on April 16, 2010 regarding the Hand Washing Policy. Hand sanitizers may be used between residents when administering medications, however hands must be	

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F 441	Continued From page 56 direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff conducted handwashing during medication administration for one (1) of nineteen (19) sampled residents (resident #3). The nurse was observed during the medication administration pass on March 30, 2010, at 4:05 p.m., to touch resident #3's oral medication with the nurse's hands without conducting proper handwashing techniques. The findings include: A medication administration observation was conducted on March 30, 2010, at 4: 05 p.m. The nurse was observed to clean his/her hands with an antiseptic gel located on the medication cart and remove a Flector Pain Patch from an unsampled resident's left shoulder with the nurse's bare hands. The nurse was then observed to open/prepare resident #3's oral medication. The nurse was observed to touch resident #3's Oxycodone 5/325 mg tablet with the nurse's bare fingers and administer the medication to resident #3 without performing	F 441	Continued From page 56 washed with soap and water between every third residents. Hands are to be washed with soap and water after applying or removing a topical patch. 3. The Director of Nursing will monitor at least one medication pass per month to ensure the Hand Washing Policy is being followed on an ongoing basis. 4. As part of the Quality Assurance Program, the Pharmacy Consultant will monitor one medication pass per month to ensure that the Hand Washing Policy is being followed on an ongoing basis. 5. April 16, 2010	

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BEREA HEALTH CARE CENTER	601 RICHMOND ROAD, P O BOX 40 BEREA, KY 40403

(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 441	Continued From page 57 hand sanitizing/washing after having direct contact with the unsampled resident. An interview conducted with the nurse on March 30, 2010, at 4:15 p.m., revealed the nurse "forgot" to perform handwashing after having direct contact with the unsampled resident's shoulder. The nurse stated handwashing was required to be conducted before and after any direct contact with a resident.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The first floor medication room contained two (2) refrigerators with freezer compartments that were in need of cleaning/defrosting. The findings include: An observation of the first floor medication room revealed a heavy buildup of ice inside both the medication refrigerator, and the laboratory refrigerator freezer compartments. The laboratory freezer was observed to have a plastic "bag" of unknown contents frozen inside the ice buildup, and unable to be removed from the freezer compartment.	F 465	**F 465** It is and was on the days of survey the policy of Berea Health Care Center that the facility provides a safe, functional, sanitary and comfortable environment for residents, staff and the public. 1. The refrigerators in the medication room on the first floor were defrosted on March 31, 2010. 2. On April 1, 2010, the Director of Nursing updated the job duties of the Second Shift Nurse adding the defrosting of refrigerators in the medication room to be done weekly. 3. The Director of Nursing and Unit Coordinator will monitor weekly for six months to ensure the refrigerators are free of ice build-up. 4. As part of the Quality Assurance Program, the Administrator and Clinical and Environmental Team Leaders will monitor all of the refrigerators in the medication rooms monthly for twelve	

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F 465	Continued From page 58 An interview conducted with the Director of Nursing on April 1, 2010, at 11:05 a.m., revealed nursing staff was responsible to clean/defrost the refrigerator freezer compartments weekly on Sundays, however, it had not been done.	F 465	Continued From page 58 months to ensure they are free of ice build-up. 5. April 1, 2010.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have an effective	F 520	**F 520** It is and was on the days of survey the policy of Berea Health Care Center to maintain a Quality Assurance Committee. 1. The restraint portion of the Quality Assurance process has been reviewed. The Clinical Team Leader has been instructed to educate staff to the importance of completing the entire restraint forms as they are assigned to specific disciplines to ensure the process is complete and accurate. 2. The Administrator reviewed the restraint portion of the Quality Assurance process noting that the restraint process had not been completed thoroughly. The Administrator has informed all of the Quality Assurance Team Leaders of the importance of completing the restraint and all other portions of the Quality Assurance process completely and accurately. 3. Weekly, the facility will conduct a Quality of Care meeting which will serve as an adjunct to the every other month Quality Assurance. During the weekly meetings, key areas such as restraints	

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F 520	Continued From page 59 Quality Assurance (QA) Committee structured to identify quality concerns, and develop action plans to correct the concerns. The QA Committee failed to ensure residents were free from physical restraints not required to treat medical symptoms and failed to have an effective system to evaluate/monitor residents for possible restraint reduction. (Refer to F221 and F272.) The findings include: An interview conducted with the Administrator/Quality Assurance (QA) Coordinator on April 1, 2010, at 5:30 p.m., revealed QA audits were conducted routinely by each Department Manager. The Administrator/QA Coordinator explained the Nursing Department was responsible for conducting a clinical review of restraints. The Administrator/QA Coordinator explained the review/audit consisted of a review of the physician's order to determine the presence of a medical symptom for the restraint use, the risks/benefits of the restraint, evidence of quarterly restraint meetings conducted to evaluate for possible restraint reduction, informed consent for the restraint, correct application of the restraint, monitoring to ensure the restraint is maintained per facility protocol, and to ensure a plan of care had been developed for the restraint use. The Administrator/QA Coordinator stated a restraint audit had been conducted on February 25, 2010; however, the QA committee did not identify any concerns related to restraint use in the facility. A review of the facility's policy/procedure Restraints-Physical, dated January 9, 2003, revealed the facility would use restraints only for	F 520	Continued From page 59 and restraint reduction will be reviewed by the interdisciplinary team. 4. As part of the facility's ongoing Quality Assurance Program, the Administrator will audit any Quality Indicator which is above the 75th percentile monthly to ensure appropriate actions and follow-up have been completed. 5. April 16, 2010	

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F 520	Continued From page 60	F 520		

medically related symptoms and only after other alternatives have been tried unsuccessfully. Additionally, the policy/procedure indicated that restraints should be used only as a last resort, and the medical record must indicate the events leading up to the necessity of the restraint. The policy/procedure stated an evaluation would be conducted by an interdisciplinary team to assure the least restrictive device is used. Furthermore, the policy/procedure revealed the restraint would be re-evaluated quarterly to determine continued need, and every effort would be made to eliminate its use.

An interview conducted on March 31, 2010, at 1:45 p.m., with the Administrator and the restraint team (consisting of the DON, MDS Coordinator, and Occupational Therapist) revealed the nurse caring for the resident completed a "Pre-restraining Assessment Form" when the nurse determined the resident needed to be restrained. The Administrator explained criteria for application of a restraint device was considered to be if a resident had experienced two or more falls, was having trouble with balance, or the nurse suspected a restraint was needed for the safety of a resident. The restraint team stated the floor nurse and "ultimately the physician" decided if and what type of restraint would be placed on the resident at the time the order was received. The MDS Coordinator and OT stated that the assessment and physician's order would be reviewed, and if the ordered restraint did not appear to be appropriate for a resident the restraint team would discuss other options. However, the restraint team members and the Administrator stated no formalized individualized interdisciplinary team meeting was conducted to discuss the risk/benefits, safety

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F 520	Continued From page 61 concerns for the resident, or to determine the specific medical symptom that warranted the use of the restraint prior to initiating the restraint. In addition, the Administrator and restraint team stated no formalized team meeting was conducted to discuss continued need for the restraint, if a less restrictive device would be appropriate, or if a restraint reduction could be attempted. According to the Administrator and restraint team, the facility failed to have a system in place to gradually reduce restraint use.	F 520		

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	185384	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/31/2010

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on March 31, 2010, for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	K 000		

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

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.