

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

PRINTED: 04/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETED 03/22/2012
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NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD, P O BOX 40 BEREA, KY 40403
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER RESPONSE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
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F 000	INITIAL COMMENTS A standard health survey was conducted on 03/20-22/12. Deficient practice was identified at "D" level.	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 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 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	F 441	F 441 It is and was on the days of survey, the policy of Berea Health Care Center to establish and maintain an Infection Control Program designed to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dicki Adams</i>	TITLE Adm.	(X6) DATE 4-20-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD, P O BOX 40 BEREA, KY 40403
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F 441	<p>Continued From page 1</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection for one of sixteen sampled residents (Resident #2). The facility failed to ensure staff changed gloves and washed/sanitized hands in accordance with facility policy during incontinence care for Resident #2 on 03/21/12.</p> <p>The findings include:</p> <p>A review of the facility policies titled "Using Gloves" and "Hand Hygiene" (dated 2007) revealed gloves must be replaced as soon as practical when contaminated. Additional review of the facility's Nurse Aide Training Manual, Sixth Edition, page 193 revealed that gloves were required to be changed and hands washed/sanitized during care when moving from a contaminated body site to a clean site.</p> <p>Observations of incontinence care conducted for Resident #2 on 03/21/12, at 9:30 AM, revealed Certified Nurse Aide (CAN) #1 used gloved hands and wipes to clean stool from Resident #2's perineal area. CNA #1 did not change gloves or</p>	F 441	<p>provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <ol style="list-style-type: none"> 1) The Certified Nurse Aide on duty on 03/21/12 who provided perineal care to Resident #2 was inserviced by the RN Unit Coordinator on this date and again on 03/28/12 by the RN Staff Coordinator and Director of Nursing regarding the proper technique of glove usage and hand hygiene while administering perineal care. 2) All Certified Nursing Assistants have been inserviced by the Director of Nursing on hand hygiene, washing hands aseptically and proper usage of gloves while administering perineal care to all residents. <p>On 04/27/12, all Nurses will be inserviced by the Quality Assurance Nurse on hand hygiene, washing hands aseptically and proper usage of gloves.</p> <p>The Housekeeping Department will also be inserviced by the Quality Assurance Nurse on hand hygiene, washing hands aseptically and proper usage of gloves on or before 04/27/12.</p> <ol style="list-style-type: none"> 3) The Quality Assurance Nurse will do ongoing and random audits of ten 	

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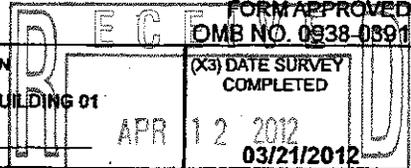
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD, P O BOX 40 BEREA, KY 40403
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F 441	<p>Continued From page 2 .</p> <p>wash/sanitize hands after providing the incontinence care to the resident and proceeded to position the resident, adjust the resident's clothing, and replace a bolster pillow cover before removing the contaminated gloves and washing hands.</p> <p>An interview conducted with CNA #1 on 03/21/12, at 9:35 AM, revealed the CNA was aware gloves were required to be changed and hands washed/sanitized after providing incontinence care. However, the CNA stated she was "nervous" and "forgot to change gloves" after cleaning the resident's perineal area and before continuing with care of the resident.</p> <p>A review of training and in-service documentation revealed the Director of Nursing (DON) had provided CNA #1 in-service training related to handwashing on 02/04/11. However, there was no documented evidence of an audit related to the CNA's competency for handwashing since 2006.</p> <p>An interview with the Unit Coordinator conducted on 03/22/12, at 3:35 PM, revealed the Unit Coordinator monitored/audited staff weekly to ensure staff was competent and had not identified concerns related to hand washing and/or glove use. Further interview revealed the Unit Coordinator did not document the audits.</p>	F 441	<p>percent of the facility's Certified Nursing Assistants, Nurses and Housekeepers on a weekly basis to observe and ensure that proper technique of glove usage and hand hygiene is being performed per facility policy while administering perineal care.</p> <p>4) As a part of the Quality Assurance Program, the Director of Nursing will randomly monitor ten percent of the facility's Certified Nursing Assistants and Nurses on a monthly basis for six months to ensure that proper technique of glove usage and hand hygiene is being performed per facility policy while administering perineal care to residents.</p> <p>5) 04/27/12.</p>	

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NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD, P O BOX 400 of Health Care BEREA, KY 40403 Southern Enforcement Branch
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1962</p> <p>Facility type: SNF/NF</p> <p>Type of structure: 2 story Type II protected with partial basement under kitchen</p> <p>Smoke Compartments: 1st Floor - 3 2nd Floor - 3</p> <p>Fire Alarm: Complete Fire Alarm Smoke detectors in corridors Heat detectors in kitchen/laundry/maintenance and resident rooms 101-107</p> <p>Sprinkler System: Complete sprinkler system (wet)</p> <p>Generator: Natural gas installed 1997</p> <p>A standard Life Safety Code survey was conducted on 03/21/12. Berea Health Care Center was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The census on the day of the survey was 78. The facility is licensed for 84 beds.</p> <p>Deficiencies were cited with the highest</p>	K 000	<p>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.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Wicki Shaw

TITLE

Adm.

(X6) DATE

4-12-12

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NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD, P O BOX 40 BEREA, KY 40403	
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K 000	Continued From page 1	K 000		
K 051 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>This STANDARD is not met as evidenced by. Based on observation, interview, and record review, it was determined the facility failed to ensure the fire alarm system was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the</p>	K 051	<p>K 051 It is and was on the days of survey the policy of Berea Health Care Center to establish and maintain a safe environment according to National Fire Protection Association (NFPA) standards for this facility.</p> <ol style="list-style-type: none"> 1) All heat detectors that were located in resident rooms 101,102,103, 104, 105, 106 and 107 were removed and capped off on 03/23/12. 2) After being removed and capped off on 03/23/12, the deficient practice no longer exists. 3) See above. 4) See above. 5) 03/23/12. 	

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K 051	Continued From page 2 potential to affect one smoke compartment, fourteen residents, staff, and visitors. The findings include: Observation on 03/21/12, at 11:21 AM, revealed heat detectors were located in resident rooms 101, 102, 103, 104, 105, 106, and 107. The observation was confirmed with the Maintenance Director. Record review of the facility fire alarm inspection records performed by an outside contractor on 03/21/12, at 11:25 AM, revealed only three heat detectors, two in the kitchen and one in the laundry area, were being checked on a quarterly basis. Interview on 03/21/12, at 11:25 AM, with the Maintenance Director, revealed he thought the heat detectors in the resident rooms were not being checked by the outside contractor because the heat detectors did not work anymore. Reference: NFPA 101 (2000 Edition). 4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.	K 051		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	K 064 It is and was on the days of survey the policy of Berea Health Care Center to establish and maintain a safe environment according to National Fire Protection Association (NFPA) standards for this facility. 1) The fourteen fire extinguishers	

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K 064

Continued From page 3

This STANDARD is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to ensure fourteen of fifteen fire extinguishers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six smoke compartments, eighty-four residents, staff, and visitors.

The findings include:

Record review on 03/21/12, at 3:00 PM, revealed the facility could not produce documentation for the six-year maintenance procedure for fourteen fire extinguishers located in the facility. The observation was confirmed with the Maintenance Director. Further observation revealed only one extinguisher (found at the nursing station) was new and did not require the six-year maintenance procedure at the time of the Life Safety Code survey. Fire extinguishers must be maintained to ensure their reliability.

Interview on 03/21/12, at 3:00 PM, with the Maintenance Director, revealed he was unaware the fire extinguishers lacked the six-year maintenance procedure.

Reference: NFPA 10 (1998 Edition).

4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using

K 064

- located in the facility which had not received six-year maintenance preformed on them were replaced on 04/05/12.
- 2) The fourteen fire extinguishers located in the facility which had not received six-year maintenance preformed on them were replaced on 04/05/12.
 - 3) The Maintenance Department will monitor dates of each extinguisher bi-monthly to ensure that each extinguisher receives the six-year maintenance per the NFPA requirements.
 - 4) As part of the Quality Assurance program, the Assistant Administrator will monitor all fire extinguishers yearly to ensure their compliance.
 - 5) 04/05/12.

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K 064	<p>Continued From page 4</p> <p>a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.</p> <p>Exception: Nonrechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3.</p> <p>4-4.4.2* Verification of Service (Maintenance or Recharging). Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.</p> <p>Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999.</p> <p>Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.</p>	K 064		