

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

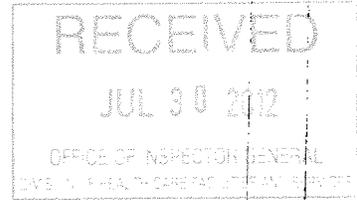
PRINTED: 07/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2012
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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320
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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'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A standard health survey was initiated on 06/19/12 and concluded on 06/21/12. The facility was found not to meet the minimum federal requirements and deficiencies were cited.	F 000	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 161 SS=C	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy it was determined the facility failed to purchase a surety bond to ensure the security of all the funds in the resident trust which exceeded fifty-three thousand (\$3,000) dollars. The facility's surety bond was for thirty-five (35) thousand dollars. The findings include: The facility Admissions Policies included that the facility would secure/protect all resident funds. Review of the Resident Trust Funds, on 06/19/12 at 2:00 PM, revealed a total of fifty-three thousand and twenty-three dollars and ninety-six cents (\$3,023.96).	F 161	F 161 SURETY BOND - SECURITY OF PERSONAL FUNDS ✓ The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. Criteria # 1: The facility purchased a surety bond for the amount of \$ 60,000 on 8/20/12 that covers the current Resident Trust balance of \$30,000 on 7/11/12. Criteria # 2: All residents with money in the facility's resident trust account have the potential to be affected by this alleged deficient practice. Criteria # 3: The Business Manager received in-service education on the requirements of a surety bond for funds of residents deposited with the facility on 7/12/12 as provided by the Administrator. Criteria # 4: The QA indicator tool for the monitoring of Surety Bond and Security of Personal Funds shall be utilized monthly X 2 months and then every 6 months as per established QA calendar under the supervision of the Administrator. Criteria # 5: Target Date 7/27/12	7/26/2012



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE LNHA (X6) DATE 07/30/12

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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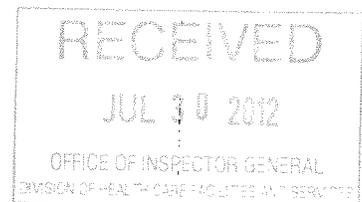
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F 161	Continued From page 1 Review of the surety bond revealed the bond covered resident funds up to thirty-five thousand (35,000) dollars. Interview with the Business Manager, on 06/19/12 at 2:00 PM, revealed she had no idea what the surety bond covered until today. She stated the resident funds were not monitored to ensure the surety bond covered the funds. She stated the surety bond should cover all the resident funds to cover any resident loss. Interview with the Administrator, on 06/19/12 at 5:00 PM, revealed he was not aware the surety bond needed to cover the resident funds managed by the facility. He stated the surety bond was to protect residents from loss of their funds.	F 161			
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	F 167	F 167 RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility shall make the results available for examination and shall post in a place readily accessible to residents and shall post a notice of their availability. Criteria # 1: The facility has posted a sign indicating the survey results are available within ten (10) feet of the front reception desk and in a prominent place easily seen by residents, employees, and visitors. Criteria # 2: All facility residents have the potential to be affected by this alleged deficient practice. Criteria # 3: The Social Services Director received in-service education on 7/12/12 by the Administrator regarding the residents' right to examine survey results and the required posting of such. The facility's survey results book is labeled and securely located in the south lobby making it available and easily accessible to residents. The survey book is secured to the table to ensure proper location at all times. Signage has been posted by the front entrance alerting visitors and residents of the location of the survey results book. Criteria # 4: The QA indicator tool for the monitoring of compliance with survey results being posted shall be utilized monthly X 2 months and then annually under the supervision of the Administrator. Criteria # 5: Target Date 7/27/12	7/26/2012	

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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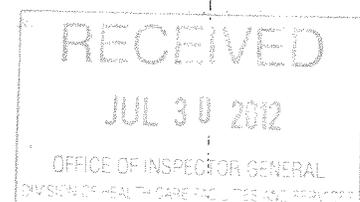
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F 167	<p>Continued From page 2</p> <p>determined the facility failed to post a notice of the availability of the most recent survey results with any plan of correction associated with the results. The binder containing the most recent survey results and the plan of correction could not be located and there was no sign posted to notify residents of the location of the binder.</p> <p>The findings include:</p> <p>The facility had no policy for how residents and families would be notified of the most recent survey results or the location of the binder containing the information.</p> <p>Interview with the Social Services Director, on 06/20/12 at 9:15 AM, revealed the facility should have a sign posted to notify residents and families regarding the location of the survey results binder.</p> <p>Observation of the facility, on 06/19/12 at 9:00 AM, revealed no signage for the location of the most recent survey results or any plan of correction for those survey results.</p> <p>Observation of the facility, on 06/20/12 at 8:30 AM, revealed the survey results binder was located in a small television room off the 400 Wing. Signage regarding the location of the book was not located.</p> <p>Interview with the Social Services Director, on 06/20/12 at 9:15 AM, revealed the facility did not have a sign posted to notify residents and families regarding the location of the survey results binder. She stated the survey binder contained information regarding the facility's</p>	F 167			



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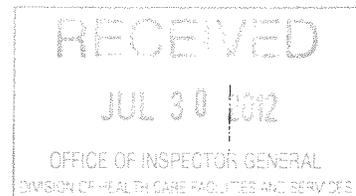
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F 167	Continued From page 3 survey results and residents had the right to know how the facility performed on survey. Interview with Licensed Practical Nurse (LPN) #1, on 06/20/12 at 11:45 AM, revealed she was not aware of the location of the survey results binder and could not find the sign indicating the location of the survey binder.	F 167			
F 203 SS=E	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.	F 203	F 203 NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before the facility transfers or discharges a resident, the facility shall notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Criteria # 1: Residents # 1, #2, #4, #8, #10, #11 and the corresponding family members or legal representatives have received in writing a Notice of Transfer form informing them of their Transfer/Discharge Rights in the event of future need for Transfer/Discharge. Criteria # 2: An audit of clinical records for any resident currently out of the facility to determine that written Transfer/Discharge notification was provided to the resident and family member/legal representative. Criteria # 3: The SSD shall review documentation with each resident transfer/discharge to determine that proper notification was provided to the resident and/or responsible party. Licensed nursing staff members, the Medical records Clerk and the Social Services Director received in-service education 6/28/12-7/26/12 as provided by the DON or designee on the requirements for Notice of Transfer form to be utilized before the facility transfers or discharges a resident. Criteria # 4: The QA indicator tool for the monitoring of Notice of Transfer shall be utilized monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Administrator. Criteria # 5: Target Date 7/27/12	7/26/2012	



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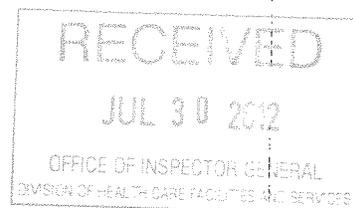
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F 203	Continued From page 4 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide residents with a Notice of Transfer prior to the facility transferring or discharging a resident. The facility failed to notify the resident/family in writing of the reason for the transfer, the effective date of the transfer, the location to which the resident was transferred, a statement that the resident had the right to appeal the action to the state, and the name, address and telephone numbers of appropriate state agencies for six (6) of sixteen (16) sampled residents (Resident #1, #2, #4, #8, #10 and #11). All six residents were transferred	F 203			



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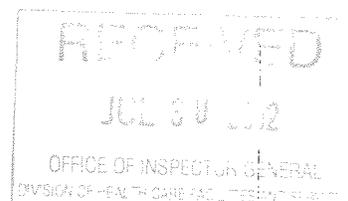
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F 203	<p>Continued From page 5 to acute care hospitals for treatment or for procedures.</p> <p>The findings include:</p> <p>Review of the facility Admission Agreement, undated, revealed the facility may terminate the agreement and transfer or discharge the resident from the facility in accordance with State and Federal law. If the resident was involuntarily discharged from the facility, the facility will notify the resident of their rights, if any, to appeal the discharge under State and Federal law.</p> <p>Review of the facility's policy for Transfer and Discharge Rights, undated, revealed no provision for providing the resident being transferred or discharged with a written Notice of Transfer.</p> <p>Review of the clinical records for Resident #1, revealed the facility admitted the resident with diagnoses of Failure to Thrive and Alzheimer's Disease. On 02/21/12, the facility transferred the resident to the hospital for a low hemoglobin and readmitted the resident on 02/25/12. The facility was not able to provide documentation that the resident received a Notice of Transfer.</p> <p>Further review of the record, revealed the facility transferred Resident #1 to the hospital on 04/18/12 for placement of a feeding tube. The resident was readmitted to the facility on 04/20/12. The facility was not able to provide</p>	F 203			



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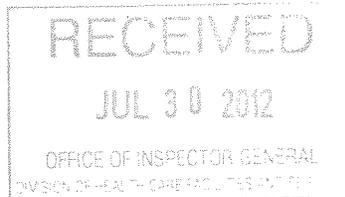
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F 203	<p>Continued From page 6 documentation that the resident received a Notice of Transfer.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/21/12 at 8:45 AM, revealed she was not familiar with a Notice of Transfer and did not recall ever using a form that explained where the resident was going and how to appeal the transfer/discharge.</p> <p>Review of the clinical record for Resident #2, revealed the resident was admitted by the facility with diagnoses of Ischemic Heart Disease and Alzheimer's Disease. On 05/19/12, the facility sent the resident to the hospital with weakness and vomiting. The facility readmitted the resident on 05/23/12. The facility was not able to provide documentation that the resident received a Notice of Transfer.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Congestive Heart Failure and Failure to Thrive. The facility sent the resident to the hospital and readmitted to the facility on 06/07/12. The facility was not able to provide documentation that the resident received a Notice of Transfer.</p> <p>Review of the clinical record for Resident #8, revealed the facility admitted the resident with diagnoses of Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. The facility arranged for the resident to be transferred</p>	F 203		



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F 203	<p>Continued From page 7</p> <p>the hospital for a colonoscopy on 05/23/12. The facility could not provide documentation that the resident received a Notice of Transfer.</p> <p>Review of the clinical record for Resident #11, revealed the facility admitted the resident with diagnoses of Diabetes and Coronary Artery Disease. The facility sent the resident to the hospital for evaluation of cellulitis on 06/12/12. The facility readmitted the resident on 06/14/12. The facility was not able to provide documentation that the resident received a Notice of Transfer.</p> <p>Review of the clinical records for Resident #10, revealed the facility admitted the resident with diagnoses of a Left Hip Fracture and Alzheimer's Disease. On 10/06/11, the facility transferred the resident to the hospital for a possible stroke and readmitted the resident on 10/06/11. The facility was not able to provide documentation that the resident received a Notice of Transfer.</p> <p>Interview with the Medical Records Clerk, on 06/21/12 at 9:00 AM, revealed she was aware of all the forms used by the facility. She stated the facility did not use a Notice of Transfer form and was not aware the form addressed resident rights or was required.</p> <p>Interview with the Administrator, on 06/21/12 at 9:15 AM, revealed he was not aware of residents not receiving Notices of Transfer from nursing</p>	F 203			



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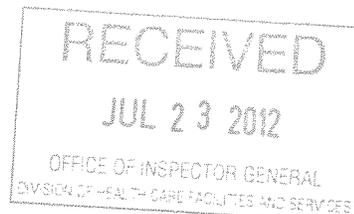
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F 203	Continued From page 8 staff when required.	F 203			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy Resident's Rights-Federal and State, undated, it was determined the facility failed to promote care for residents in a manner that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. The findings include: Review of the provided Resident's Rights-Federal and State, undated, revealed under the section for Resident Dignity, the facility must promote care for residents in a manner that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. Observation, on 06/19/12 at 12:15 PM, revealed in the Main Dining Room Certified Nursing Assistant (CNA) #3 standing while feeding Resident "B".	F 241	F 241 DIGNITY AND RESPECT OF INDIVIDUALITY The facility shall promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Criteria # 1: Staff members are seated while feeding residents A and B. Criteria # 2: Staff members are seated while feeding any resident requiring to be fed part or all of his/her meal by staff. Criteria # 3: Nursing staff members have received in-service education on 6/28/12 - 7/28/12 by the DON or designee to seat themselves close to eye level with residents when feeding them to enhance the resident's dignity during meal consumption. Criteria # 4: The QA indicator tool for the monitoring of dignity during meal service shall be utilized Weekly X 4 weeks, then monthly X 2 months and then quarterly as per established QA calendar under the supervision of the DON. Criteria # 5: Target Date	7/27/12	

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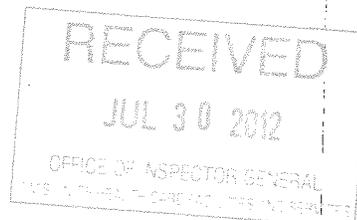
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F 241	<p>Continued From page 9</p> <p>Observation, on 06/20/12 at 12:05 PM, revealed in the Main Dining Room CNA #3 again standing to feed Resident "B". Licensed Practical Nurse (LPN) #3 was also observed standing to feed Resident "A".</p> <p>Interview, on 06/20/12 at 2:15 PM, with CNA #5 revealed you were to sit to feed a resident so you were at the level of the resident and not over the resident. She stated she would not want anyone standing over her to feed her because she would feel rushed and it was degrading. She revealed it would make the resident think they cannot eat independently and feel useless. CNA #5 stated she had been in-serviced not to stand while feeding a resident.</p> <p>Interview, on 06/21/12 at 10:45 AM, with LPN #1 revealed when you fed a resident you were to be at their eye level. She stated this was to make the resident comfortable and not feel intimidated by someone standing over them, which would make them less likely to eat. She had been in-serviced on the feeding of residents, she revealed.</p> <p>Interview, on 06/21/12 at 11:00 AM, with CNA #7 revealed you were not to stand to feed a resident. She stated this was a dignity issue and you needed to be at eye level with the resident, otherwise you would feel threatened. She revealed she had been trained on the feeding of residents.</p>	F 241	



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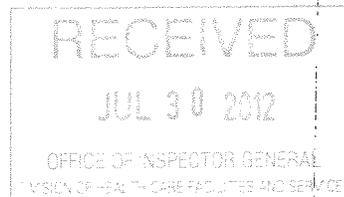
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2012
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1596 US HWY 231 S. BEAVER DAM, KY 42320		
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F 241	Continued From page 10 Interview, on 06/21/12 at 11:05 AM, with CNA #4 revealed you were to sit down in a chair next to the resident to feed. She stated the reason to do that was so you were on the eye level of the resident and it would help the resident not feel that they were less than the person that assisted them. To stand up may make the resident feel like a child, she stated. She revealed she had had no training in the facility on how to feed a resident. She stated she learned it in school. Interview, on 06/21/12 at 3:10 PM, with the Director of Nursing (DON) revealed for the dignity of the resident you were to sit down to feed them. The reason she gave was to make it a more pleasurable dining experience and someone may feel offended if someone was standing over them. She revealed the staff had been trained on how to assist with the feeding of residents. No answer was offered for how the feeding of residents was monitored.	F 241			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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.	F 279	F 279 DEVELOP COMPREHENSIVE CARE PLANS The facility shall use the results of the assessment to develop, review and revise the resident's care plan; Criteria # 1: Resident #8's care plan has been revised to include his/her hoarding behavior and interventions to enhance cleanliness of his/her room. Criteria # 2: A review of all resident behavior monitoring records for the past 30 days was completed on 7/17/12 by the Social Services Director and their findings were compared with their care plans to determine that identified behaviors were addressed and interventions were in place for staff to follow. Criteria # 3: The facility's Care Tracker Kiosk system has been enhanced to notify appropriate administrative staff of any changes in resident behaviors. The report is generated daily (M-F) by the ADON, DON or Administrator and reviewed in the daily CQI meeting to determine that the resident's care plan addressed the identified behaviors. Members of the interdisciplinary team (IDT) received in-service education on 7/17/12 by the Nurse Consultant on the development and implementation of care plans to address residents' identified behaviors and communication of the care plan to the direct care staff. Nursing and housekeeping staff members received in-service education on 7/13/12-7/26/12 by the Administrator, DON, ADON, Staff Development the Weekend RN Supervisor on communication the identified behaviors affecting the cleanliness of resident rooms. Criteria # 4: The QA indicator tool for the monitoring of development and implementation of behavior care plans shall be utilized monthly X 2 months and then every 6 months as per established QA calendar under the supervision of the Director of Nursing. Criteria # 5: Target Date 7/27/12	7/26/2012	



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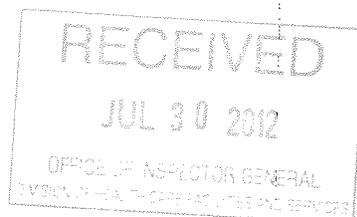
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F 279	<p>Continued From page 11</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services 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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy, it was determined the facility failed to develop a comprehensive care plan for one (1) of sixteen (16) sampled residents (Resident #8) to address the resident's behavior of hoarding to the extent that files were present in the room.</p> <p>The findings include:</p> <p>Review of the facility policy for Comprehensive Care Plans, dated 01/2007, revealed the facility would develop a care plan based on residents' assessed needs. The care plan approaches were communicated to staff for use in providing direction for care.</p> <p>Observation of Resident #8's room, on 06/19/12 at 8:15 AM, 11:10 AM, 12:00 PM, 2:20 PM, 3:00 PM, and on 06/20/12 at 8:15 AM, 9:00 AM and 10:00 AM, revealed opened food, crackers,</p>	F 279			



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F 279	<p>Continued From page 12</p> <p>empty candy bar wrappers, used tissues, socks, papers, a box, and bottles of coke were stored on the floor between the bed and the air conditioning unit. There was no pathway open to get to the head of the bed on the right side. A musty odor was present in the room and flies were on the open food and crawling on the resident and the roommate. There were no observations of this area of the room being cleaned up or picked up by staff.</p> <p>Interview with Resident #8, on 06/19/12 at 4:10 PM, revealed the resident did store belongings on the floor as there were no other places to store these items. The resident indicated snacks and food had to go somewhere so placing them on the floor where they could be watched was the best idea. The resident denied the presence of flies in the room or that the flies were walking on the resident and the roommate. The resident denied the clutter caused difficulty getting around the bed, or that it was not sanitary.</p> <p>Review of the clinical record for Resident #8, revealed the facility admitted the resident with diagnoses of Manic Depression, Bipolar Disease and Anxiety. The facility completed a quarterly Minimum Data Set (MDS) assessment of the resident on 05/28/12 which indicated the resident had no cognitive deficits and was alert and oriented. The resident had behaviors and felt down and depressed frequently.</p> <p>Review of the comprehensive care plan for Resident #8, revealed the resident exhibited</p>	F 279			



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F 279	<p>Continued From page 13</p> <p>behaviors of yelling/screaming out, throwing bowel movements, negative verbalizations, and anxious complaints. The goal was for the resident's behaviors to be managed in collaboration with physician and psychiatric therapy as needed. The facility wrote one (1) intervention for the resident to have time to vent feelings. There were no other interventions. The behavior of hoarding was not addressed on the care plan as an assessed concern.</p> <p>Interview with Certified Nurse Aides (CNA) #3 and #9, on 06/20/12 at 2:00 PM, revealed they were not aware of any special plan to manage Resident #8's behaviors in regards to the state of the resident's room. They stated the resident refused to allow cleaning at times. They stated they moved around the room as able and tried to avoid the flies in the room. They stated the resident had a fly swatter and used it.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/21/12 at 1:20 PM, revealed she was aware of the problems with Resident #8's behavior and the cluttered room with trash piled on the floor. She stated she was not able to find a care plan with interventions to address the resident's behavior, but there should be a care plan to guide staff in the resident's care.</p> <p>Interview with the Director of Nursing, on 06/21/12 at 3:30 PM, revealed all nurses were responsible to develop care plans for residents. She stated the resident should have a care plan to address the cleanliness of the room and the</p>	F 279		



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F 279

Continued From page 14
resident's behaviors for staff to provide the correct care.

F 364
SS=F
483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

F 279

F 364

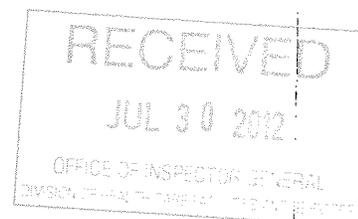
F 364 NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP
Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and the proper temperature.
Criteria # 1: Residents # 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12 are receiving food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and the proper temperature. The Certified Dietary Manager (CDM) interviewed the identified residents by 7/23/12 to determine their preferences regarding temperature of food, texture, and seasoning.
Criteria # 2: All resident have the potential to be affected by this alleged deficient practice. Meal satisfaction is reviewed monthly in resident council meeting; those verbalizing displeasure with meals are referred to the CDM (with resident's permission) for food preference interview. All other residents are interviewed at least quarterly by the CDM or designee in conjunction with each resident's scheduled OBRA MDS.
Criteria # 3: The consulting RD reviewed the facility's menu and made necessary changes to enhance the flavor and appearance of the food on 6/28/12. The current tray line procedure and serving order (hall carts) has been reviewed and revised to promote proper food temperature. Nursing staff members have received in-service education on 6/28/12 - 7/26/12 by the DON or designee that included but was not limited to: offering condiments during meal delivery to enhance flavoring, any changes made to meal delivery protocol to promote proper food temperature, offering of substitutes, reheating or replacing food as indicated.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility policy, it was determined the facility failed to provide residents food that was palatable, attractive, and at the proper temperature. At lunch on 06/19/12, the meal consisted of pinto beans and ham, boiled cabbage, fried potatoes, and cornbread. The meal was not visually appealing. On a test tray, requested on 06/19/12 at lunch, the carrots were served at 100 degrees Fahrenheit. The food was bland, cold, and was not appealing for eleven (11) of eleven (11) sampled residents (Residents #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12) receiving a regular diet (including texture modifications).

The findings include:

The facility did not provide a policy regarding food flavor, appearances, and proper serving temperatures.

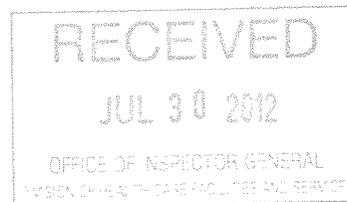
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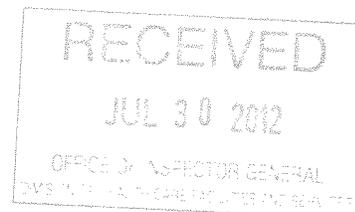
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F 364	<p>Continued From page 15</p> <p>Review of the facility's policy on Food Temperatures, dated 10/2008, revealed if food temperatures were not at acceptable levels and cannot be corrected in time for meal service, the facility should make an appropriate menu substitution. Vegetables should leave the serving line at 140 degrees but preferably at 140-165 degrees. Meat should leave the serving line at 140 degrees but preferably at 140-165 degrees. Tray line should be no longer than one (1) hour. If temperatures cannot be maintained, batch cooking should be utilized.</p> <p>Review of the Quality of Life Assessment Group Interview conducted on 06/19/12, revealed the residents did not like the taste of the food and the food is often served cold.</p> <p>Observation of lunch on the Main Dining Room, on 06/19/12 at 12:20 PM, revealed the foods served were all in the same color tone, brown. The menu consisted of pinto beans and ham, boiled cabbage, fried potatoes, and cornbread.</p> <p>Observation, on 06/20/12 at 12:20 PM, in the Main Dining Room, the last tray on the last tray cart revealed the temperature of the carrots to be cool. The carrots were at 100 degrees Fahrenheit. The roast beef registered at 110 degrees and tasted cool.</p> <p>Interview with Resident #8, on 06/20/12 at 12:15 PM, revealed the resident frequently received</p>	F 364	<p>Criteria # 4: The QA indicator tool for the monitoring of meal service (proper food temps, appearance, resident satisfaction, etc.) shall be utilized weekly X 4 weeks and then monthly as per established QA calendar under the supervision of the Administrator. Resident satisfaction with meals and menu choices shall be reviewed in monthly Resident Council Meetings and reported to the QA team during scheduled QA meetings.</p> <p>Criteria # 5: Target Date</p>	7/27/12	



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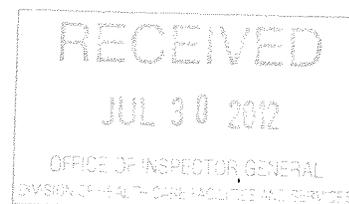
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F 364	Continued From page 16 cold food. She stated staff could warm the food, however, it took time to find staff and get them to take the food and warm it up. She stated the tray carts sit for long periods of time until staff passes the meals. She stated thirty (30) to forty-five (45) minutes was not uncommon. Interview with the Dietary Manager (DM), on 06/20/12 at 12:20 PM, revealed she thought the carrots on the test tray were too cool. She stated the food should be warmer than 100 degrees Fahrenheit to be palatable.	F 364	F 371 FOOD PROCURE, STORE/ PREPARE/ SERVE - SANITARY The facility shall procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. Criteria # 1: The ice machine has been thoroughly cleaned; all dietary staff members are wearing hair nets to fully contain their hair within the nets; unsealed, unlabeled or opened undated food products identified in the walk-in-freezer have been discarded. Criteria # 2: All residents receiving oral nutrition have the potential to be affected by this alleged deficient practice. Criteria # 3: The kitchen equipment cleaning schedule has been reviewed/ revised to determine that routine cleaning of the ice machine is scheduled and documented. Dietary staff members received in-service education on 7/12/12 - 7/26/12 by the CDM that included, but was not limited to: proper donning of hair nets, revised kitchen equipment cleaning schedule, storage and labeling of food. Criteria # 4: The QA indicator tool for the monitoring of dietary sanitation shall be utilized weekly X 4 weeks and then monthly thereafter as per established QA calendar under the supervision of the Administrator. Criteria # 5: Target Date	7/27/12
F 371 SS=F	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, interview, and review of the facility's policy, it was determined the facility failed to ensure food was stored, prepared, and served under sanitary conditions. A rust-like substance was observed on the inside lid and the area surrounding the opening of the ice machine. Five (5) female dietary staff were observed wearing hair nets with their hair not fully	F 371		



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F 371	<p>Continued From page 17</p> <p>contained within the nets. Four (4) food products stored in the walk-in-freezer were found unsealed, opened to air, and not labeled with the opening date. One (1) multi-serving container of liquid eggs was not labeled with the opening date in the walk-in-refrigerator. A package of bacon was observed in the walk-in-refrigerator unsealed, open to air, and not dated with the opening date. These practices affected all residents who received oral nutrition.</p> <p>The findings include:</p> <p>Review of the facility's policy for Food Storage, not dated, revealed all frozen and refrigerated foods should be stored in air tight containers and labeled with the date opened.</p> <p>The facility's policy for Cleaning Ice Machine and Equipment, not dated, noted the ice machine and equipment will be cleaned on a regular basis to maintain a clean, sanitary condition.</p> <p>The facility did not provide a policy on hair restraints.</p> <p>Observation of the walk-in-freezer on 06/20/12 at 8:10 AM, during the initial kitchen tour, revealed one (1) package of frozen beef patties, one (1) package of frozen chicken breasts, one (1) package of frozen carrots, and (1) package of frozen grilled chicken breast unsealed, open to air, and not labeled with open date. Observation</p>	F 371			



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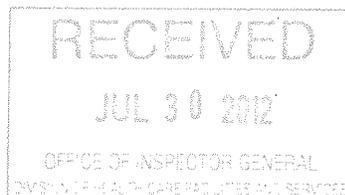
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F 371	Continued From page 18 of the walk-in refrigerator revealed a multi-serving of liquid eggs not labeled with the open date and a package of bacon unsealed, opened to air, and not dated with open date. The area surrounding the opening of the ice machine and the inside lid of the ice machine was observed covered with a rust-like substance. Observation on 06/20/12 at 9:00 AM, revealed five (5) female dietary staff members preparing food in the kitchen with their hair exposed outside of their hair nets. On 6/20/12 at 10:50 AM, four (4) females were observed working on the tray line in the kitchen, with tendrils of hair hanging out of their hair nets, on the nape of their necks, bang areas, and sideburn areas. During interview with the Dietary Manager (DM) on 06/21/12 at 2:00 PM, the DM agreed the hair nets were not restraining the staff's hair properly and that hair could fall into the residents' food. The DM said she would try to purchase larger hair nets. The DM commented that the rusty ice machine could contaminate the ice; and the ice machine did need to be emptied and cleaned thoroughly. The DM said our staff are trained to seal and date any opened items in the freezer and the refrigerator. She said she had discarded the items that were open to air and not dated. It is our policy to seal and date any open items.	F 371			
F 425 SS=F	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425			

FORM CMS-2567(02-99) Previous Versions Obsolete

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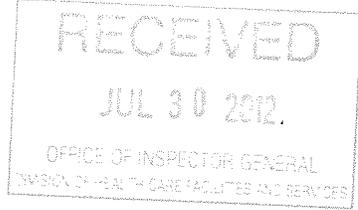


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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2012
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
(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 425	Continued From page 19 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility Pharmacy Services Agreement, agreement terms from 06/01/10 to 05/31/13, review of the facility PharMerica Nursing Drug Handbook, Copyright 2010, and facility policy Medication Administration General Guidelines, Revised 09/10, it was determined the facility failed to address the irregularity in the Medication Regimen Review for four (4) of sixteen (16) sampled residents, Resident #3, #6, #7 and #10, related to the time of medication administration for Levothyroxine. The medication was not administered per manufacturers'	F 425	F 425 PHARMACEUTICAL SVC – ACCURATE PROCEDURES, RPH The facility shall provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. The facility shall provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. The facility shall employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Criteria # 1: Residents # 3, #6, #7 and #10 are receiving their levothyroxine as per manufacturer's specifications and on an administration schedule to maximize the effectiveness of the medication. All opened, undated multi dose vials of Tuberculin Serum, Pneumonia Vaccine and Influenza Vaccine were properly disposed of and replacement vials were obtained from the pharmacy. Criteria # 2: An audit of resident MAR's was completed on 7/18/12 by the consultant pharmacist to determine that all residents are receiving their medications as per manufacturer's specifications and on an administration schedule to maximize the effectiveness of the medication. An audit of all multi-dose medication vials was completed on 7/8/12 by Medication Staff under the supervision of the DON to determine that all were properly labeled in accordance with Federal and State regulations. All undated opened vials were properly disposed of. Criteria 3: The pharmacy regulations have been reviewed by the pharmacy consultant (RPh), DON, and Administrator to determine that the pharmacy services are being provided in accordance with the regulations. The RPh shall review the medication regime on all residents monthly to determine that		

Continued on page 21



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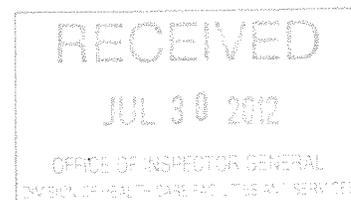
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F 425	Continued From page 20 specifications and was not on an administration schedule to maximize the effectiveness of the medication. In addition, Pharmacy Services failed to monitor the medication rooms for labeling of open multi-dose vials. Two (2) of two (2) medication rooms had open, undated vials of Tuberculin Serum. One (1) of the two (2) medication rooms also had opened, undated Pneumonia Vaccine and two (2) Influenza Vaccine vials. The findings include: Review of the Pharmacy Services Agreement, agreement terms from 06/01/10 to 05/31/13, revealed under Standard Services, a Consultant Pharmacist shall perform a medication regimen review (MRR) for each resident on active facility census on the visit date. When irregularities were noted the MRR report documenting such irregularities would be provided to the Administrator and Director of Nursing (DON). The Agreement stated the Consultant Pharmacist would perform a medication pass observation monthly as part of the MRR. In addition, it stated the Pharmacy would provide up to two (2) educational sessions annually for the facilities staff. Review of the PharMerica Nursing Drug Handbook, Copyright 2010, revealed the medication Levothyroxine was to be administered in the morning on an empty stomach, at least	F 425	medications are being administered in accordance with manufacturer's recommendations and include any suggested changes in a written report provided to the DON. Licensed Nurses (LN) shall verify that the multi-dose vial has a "date opened" written on it and has not expired prior to using it. Any undated or expired multi-dose vials are to be discarded and replaced. A weekly audit of all multi-dose medications shall be conducted by the LNKMA's and recorded on a log in the MAR book to determine that they are properly stored and labeled; any issues identified are reported to the DON/ADON. Licensed nurses and KMA's received in-service education on 7/12/12-7/26/12 by the DON, ADON and Staff Development on medication protocols which included, but was not limited to; dating all multi-dose when opening them for the initial use; checking previously opened multi-dose medications for date opened to determine if expiration has occurred; and proper disposal of undated opened multi-dose medications. Criteria 4: The Pharmacy Consultant reports will be reviewed at least quarterly by the DON, Administrator and Medical Director as part of the QA process, to determine that services are being provided in accordance with the regulations. Criteria # 5: Target Date 7/27/12	7/26/2012	

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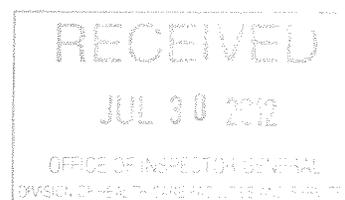
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F 425	<p>Continued From page 21</p> <p>thirty (30) minutes before food. In addition, under Patient Information, it again states to be taken in the morning thirty (30) minutes before breakfast.</p> <p>Review of the policy Medication Administration General Guidelines, Revised 09/10, revealed medications were to be administered in accordance with manufacturers' specifications; however, the Levothyroxine, to be given on an empty stomach was ordered for four (4) of sixteen (16) sampled residents, Residents #3, #6, #7 and #10, at 8:00 AM, after breakfast was served.</p> <p>Review of the Medication Administration Record (MAR) for Residents #3, #6, #7 and #10 revealed the medication Levothyroxine was ordered for and administered at 8:00 AM, which was not the manufacturers recommended time, as noted in the PharMerica Nursing Drug Handbook, Copyright 2010.</p> <p>Review of the Medication Regimen Review for the past five (5) months, January 2012 through May 2012, for Resident #3, #6, #7 and #10 revealed no pharmacist entry to change the time the medication Levothyroxine was administered, which was 8:00 AM for each resident.</p> <p>Observation, on 06/20/12 at 8:00 AM, revealed Resident #7 had just finished eating breakfast. Resident #7 was administered a dose of Levothyroxine 100 mcg, taken orally. The medication was administered by Certified</p>	F 425			



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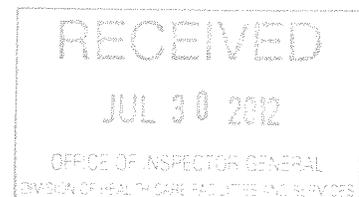
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F 425	<p>Continued From page 22</p> <p>Medication Technician/Certified Nursing Assistant (CMT/CNA) #7.</p> <p>Interview, on 06/20/12 at 8:52 AM, with the facility Nurse Practitioner revealed she signed off on the Physician's Orders. She stated she checked the drugs, not the times they were ordered to be administered. She revealed the time the medication Levothyroxine was ordered affected the potency of the medication. She further revealed the medication was to be administered on an empty stomach early in the morning.</p> <p>Interview, on 06/20/12 at 9:35 AM, with Licensed Practical Nurse (LPN) #1 revealed the drug reference book used in the facility was PharMerica Nursing Drug Handbook, Copyright 2010. She revealed she has had a pharmacy in-service but it was last year. The content was signing off on Physicians Orders and medication administration, she stated.</p> <p>Interview, on 06/20/12 at 3:00 PM, with the Pharmacist revealed the purpose of chart checks and audits was to review state regulations and make sure the facility was in compliance. He stated he looked at drug interaction and duplication. It was revealed, with respect to the time of administration of Levothyroxine to the resident, that sometimes on new orders he tried to recommend the nurse give the medication before breakfast. He stated if the lab work (Thyroid Stability Hormone, TSH) came back stable, the time of administration did not need to change. He stated the medication</p>	F 425		



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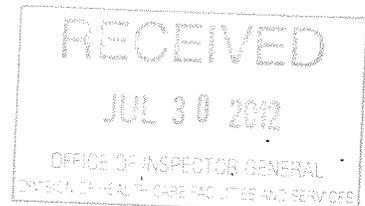
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F 425	<p>Continued From page 23</p> <p>(Levothyroxine) was best absorbed on an empty stomach and to get the "best bang for your buck" the medication would be given on an empty stomach. However, Residents #3, #6, #7 and #10 with the 8:00 AM Levothyroxine medication order had nothing noted during their MMR with respect to changing the administration times.</p> <p>Interview, on 06/21/12 at 11:00 AM, with CMT/CNA #7 revealed she had never witnessed the Pharmacist go through the medication room. She stated she had only observed the Pharmacist at the nursing station. She revealed she had attended an in-service given by pharmacy over a year ago on the topic of how to prepare for a state survey. CMT/CNA #7 stated she had never personally been asked by the Pharmacist any questions about medications or her patients.</p> <p>Interview, on 06/21/12 at 3:10 PM, with the Administrator revealed there were no records or documentation of any pharmacy education, medication cart or medication room review or audit. There were only the resident record reviews.</p> <p>Interview, on 06/21/12 at 3:30 PM, with the Director of Nursing revealed if there were any records of pharmacy education for facility personnel, medication cart or medication room review, the Administrator would have the documentation. She stated the Pharmacist did watch medication pass and the individuals observed had the documentation in their personnel files. The resident medication review</p>	F 425			



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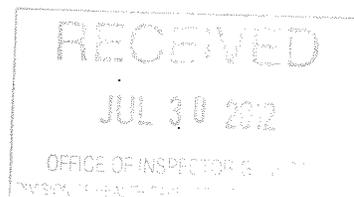
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F 425	<p>Continued From page 24</p> <p>was the only other item she revealed she was aware the pharmacist did for the facility. She stated there was no audit of the medication storage areas done by pharmacy.</p> <p>Observation, on 06/20/12 at 2:00 PM, of the South Medication Room revealed an opened, undated Tuberculin Serum vial, an open, undated Pneumonia vaccine vial and two (2) opened, undated Influenza vials. In addition, found was an opened, dated Tuberculin Serum vial, dated as opened 03/05/12, which was expired.</p> <p>Observation, on 06/20/12 at 3:00 PM, of the North Medication Room revealed one (1) opened, undated vial of Tuberculin Serum.</p> <p>Interview, on 06/20/12 at 9:35 AM, with Licensed Practical Nurse (LPN) #1 revealed a medication multi-dose vial, when opened, was good for thirty (30) days in the refrigerator. Once opened, a multi-dose vial was to be dated and initialed, she revealed. In addition, she gave the reason to date the vial was to keep up with the expiration date, that if the medication was expired, it would not be potent. With an example of the Tuberculin Serum vial she revealed if the medication was expired and you administered it to a resident, you may not know if that resident had active tuberculosis or not. She further revealed if the Pneumonia or Influenza Vaccines were given to a resident with an expired date, you would not know if the resident was protected from the illnesses or not. The Certified Medication Technician (CMT) on second shift was to monitor the medication rooms, she stated.</p> <p>Interview, on 06/20/12 at 9:50 AM, with LPN #2</p>	F 425			



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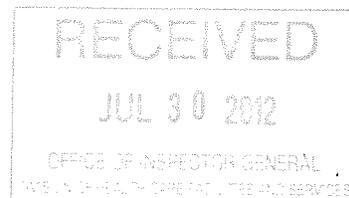
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F 425	Continued From page 25 revealed open multi-dose vials were to be dated when opened because the medication expires. As an example, she revealed the Tuberculin Serum, if expired would not give an accurate reading. She revealed "all of us" were responsible to monitor the medication room, but to her knowledge, no one person monitored the medication room. Interview, on 06/21/12 at 2:55 PM, with LPN #4 revealed medication vials were to be dated when opened and they may be stored for thirty (30) days, and then discarded. She stated there was nothing in place to monitor the medication refrigerator. She revealed the effects on the resident to receive medication from an expired medication vial was you could get a false reading. If Tuberculin Serum, the resident may have an infection and expose all the other residents to tuberculosis because of the false reading. She revealed she had been educated to date a medication vial when opened. Interview, on 06/21/12 at 3:30 PM, with the DON revealed multi-dose medication vials were to be dated when opened and after thirty (30) days, discarded. Failure to do with could result in a false negative reading for a tuberculin skin test. She stated the staff had been trained on dating vials when opened; however, there was nothing in place to monitor the medication rooms. She stated the medication room should be monitored, but the facility has not assigned a specific person. She revealed pharmacy did not monitor the medication rooms where the medication vials were stored.	F 425		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		



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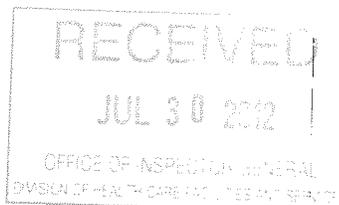
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F 431	<p>Continued From page 26</p> <p>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility policy Storage of Medication, Revised 09/10, it was determined the facility failed to label</p>	F 431	<p>F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>Drugs and biological used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>Criteria # 1: All opened, undated multi dose vials of Tuberculin Serum, Pneumonia Vaccine and Influenza Vaccine were properly disposed of and replacement vials were obtained from the pharmacy.</p> <p>Criteria # 2: An audit of all multi-dose medication vials was completed on 7/6/12 by Medication Nursing Staff under the supervision of the DON to determine that all were properly labeled in accordance with Federal and State regulations. All undated opened vials were properly disposed of.</p> <p>Criteria # 3: LN's shall verify that the multi-dose vial has a 'date opened' written on it and has not expired prior to using it. Any undated or expired multi-dose vials are to be discarded and replaced. A weekly audit of all multi-dose medications shall be conducted by the LN/KMA's and recorded on a log in the MAR book to determine that they are properly stored and labeled; any issues identified are reported to the DON/ADON. Licensed nurses and KMA's received in-service education on 7/12/12 - 7/26/12 by the DON on medication protocols which included, but was not limited to: dating 'all multi-dose medications when opening them for the initial use, checking previously opened multi-dose medication for date opened to determine if expiration has occurred; and proper disposal of undated opened multi-dose medications. The Pharmacy Services Contract has been reviewed by the pharmacy consultant, DON, and Administrator on 7/18/12 to determine that pharmacy services are being provided in accordance with the contract.</p> <p>Continued on next page</p>	



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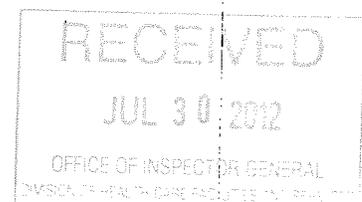
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F 431	<p>Continued From page 27</p> <p>multi-dose vials of medication in accordance with currently accepted professional principles. Two (2) of two (2) medication rooms had open, undated vials of Tuberculin Serum. One (1) of the two (2) medication rooms also had one (1) opened, undated Pneumonia Vaccine and two (2) Influenza Vaccine vials.</p> <p>The findings include:</p> <p>Review of the policy Storage of Medication, Revised 09/10, revealed medications were to be stored properly, following manufacturer's or provider pharmacy recommendation, to maintain their integrity and to support safe effective drug administration. In addition, the policy stated outdated medications were immediately removed from stock.</p> <p>Observation, on 06/20/12 at 2:00 PM, of the South Medication Room revealed an opened, undated Tuberculin Serum vial, an open, undated Pneumonia vaccine vial and two (2) opened, undated Influenza vials. In addition, found was an opened, dated Tuberculin Serum vial, dated as opened 03/05/12, which was expired.</p> <p>Observation, on 06/20/12 at 3:00 PM, of the North Medication Room revealed one (1) opened, undated vial of Tuberculin Serum.</p> <p>Interview, on 06/20/12 at 9:35 AM, with Licensed</p>	F 431	<p>Criteria # 4: In addition to the weekly review of multi-dose vials, the QA indicator tool for the monitoring of Drug Labeling shall be utilized monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Director of Nursing.</p> <p>Criteria # 5: Target Date</p>	7/27/12



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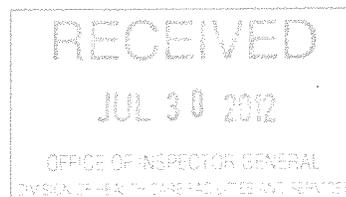
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F 431	<p>Continued From page 28</p> <p>Practical Nurse (LPN) #1 revealed a medication multi-dose vial, when opened, was good for thirty (30) days in the refrigerator. Once opened, a multi-dose vial was to be dated and initialed, she revealed. In addition, she gave the reason to date the vial was to keep up with the expiration date, that if the medication was expired, it would not be potent. With an example of the Tuberculin Serum vial she revealed if the medication was expired and you administered it to a resident, you may not know if that resident had active tuberculosis or not. She further revealed if the Pneumonia or Influenza Vaccines were given to a resident with an expired date, you would not know if the resident was protected from the illnesses or not. The Certified Medication Technician (CMT) on second shift was to monitor the medication rooms, she stated.</p> <p>Interview, on 06/21/12 at 2:55 PM, with LPN #4 revealed medication vials were to be dated when opened and they may be stored for thirty (30) days, and then discarded. She stated there was nothing in place to monitor the medication refrigerator. She revealed the effects on the resident to receive medication from an expired medication vial was you could get a false reading, if Tuberculin Serum, the resident may have an infection and expose all the other residents to tuberculosis because of the false reading. She revealed she had been educated to date a medication vial when opened.</p> <p>Interview, on 06/21/12 at 3:30 PM, with the DON revealed multi-dose medication vials were to be dated when opened and after thirty (30) days, discarded. Failure to do with could result in a false negative reading for a tuberculin skin test.</p>	F 431			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2012
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320	
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F 431	Continued From page 29 She stated the staff had been trained on dating vials when opened; however, there was nothing in place to monitor the medication rooms. She stated the medication room should be monitored but the facility has not assigned a specific person.	F 431		
F 441 SS=E	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.	F 441	F 441 INFECTION CONTROL, PREVENT SPREAD, LINEN The facility shall 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. Criteria # 1: Resident E's urinal was replaced with a new one on 7/11/12 and is being cleaned and properly stored after each use in accordance with facility policy and the resident's Individualized plan of care. Oxygen equipment (i.e., nasal cannula, C-pap face mask, tubing, etc.) in rooms 303, 308-2, 308-1, 314-1, 102 and 112 have been cleaned and/or replaced as indicated, and are properly stored when not in use. The floor in Room 306-2 has been cleaned and resident items have been organized in a way to encourage the resident to store personal items off of the floor. The soiled linen cart on the 300 Hall is not parked next to the water fountain. Criteria # 2: All resident urinals were replaced with new ones on 7/11/12 and are being cleaned and properly stored after each use in accordance with facility policy and the residents' individualized plans of care. All resident oxygen equipment (i.e., nasal cannulas, O2 tubing, C-pap face mask, Neb masks, etc.) have been cleaned and/or replaced as indicated, and are properly stored when not in use. The Administrator completed an audit of all resident rooms on 7/16/12 to determine if there were other resident rooms with personal items stored improperly on the floor; and any room identified as in this audit has been clean and organized. All soiled linen barrels are being 'parked' away from water fountains while in use. Continued on next page (pg. 31)	



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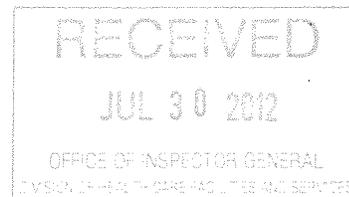
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2012
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
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F 441	<p>Continued From page 30</p> <p>(c) Linens 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 facility policies it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe and sanitary environment and help prevent the development and transmission of disease and infection. One (1) of five (5) unsampled residents, Resident "E" had a urinal with urine in it stored on his/her overbed table on three (3) separate occasions. During the tour of the facility three (3) of eight (8) resident rooms, Rooms 306-2, 308-1 and 314-1, had oxygen equipment improperly stored. One (1) of eight (8) resident rooms, Room 306-2, on tour had belongings and food stored on the floor of their room with numerous flies present. The ice machine in the kitchen, one (1) of one (1), which services the entire facility was noted to have a black substance on the inside. Additionally, a staff member was noted to sit directly on the linen of an unmade resident's bed while assisting the resident.</p> <p>The findings include:</p> <p>Review of the Cleaning and Disinfecting Resident Care Equipment, undated, revealed a urinal shall</p>	F 441	<p>Criteria # 3: Urinals shall be rinsed after each use and replaced as needed; O2 tubing is routinely replaced weekly and as needed; storage bags are kept on oxygen equipment to allow for proper storage of tubing/mask/cannula when not in use. Resident storage needs shall be determined by the Housekeeping Supervisor and/or SSD; and the facility shall provide assistance in acquiring proper storage/organizational containers to promote a clean and pest free environment. Soiled linen barrels are stored in designated storage areas away from water fountains. Nursing and housekeeping staff members received in-service education on 7/12/12 - 7/26/12 by the DON or designee on Infection Control Issues, which included, but was not limited to: sanitation and storage of urinals; storage of oxygen equipment when not in use; proper storage of resident personal items off of the floor; and keeping soiled linen barrels away from water fountains. Charge nurses and administrative nurses monitor during routine rounds to determine compliance.</p> <p>Criteria # 4: The QA indicator tool for the monitoring of infection control shall be utilized monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Director of Nursing.</p> <p>Criteria # 5: Target Date</p>	7/27/12	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 810011

Facility ID: 100353

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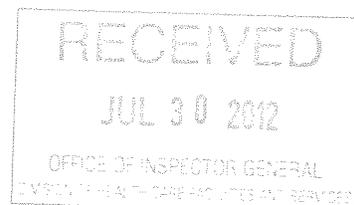
PRINTED: 07/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2012
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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320
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F 441	<p>Continued From page 31 be cleaned and/or disinfected to prevent and control infection. Also stated was after sanitizing, urinals were to be returned to the bedside table in the resident's room.</p> <p>Observation, on 06/19/12 at 8:45 AM, revealed in the room of unsampled Resident "E", a urinal on the overbed table with urine inside.</p> <p>Observation, on 06/20/12 at 11:25 AM, revealed a urinal with urine in it on the overbed table in the room of unsampled Resident "E". Lunch was being served at the time. The server removed the urinal, emptied it and wiped the overbed table with a wet washcloth dampened with water. The urinal was not observed to be cleaned or disinfected.</p> <p>Observation, on 06/21/12 at 8:45 AM, revealed a urinal on the overbed table in front of unsampled Resident "E". The call light was within reach.</p> <p>Interview, on 06/21/12 at 8:48 AM, with Licensed Practical Nurse (LPN) #1 revealed unsampled Resident "E" was reminded frequently to have the urinal emptied and to use his/her call light. She stated the staff was to empty the urinal hourly.</p> <p>Review of the facility Oxygen Therapy Concentrator Set-Up, Clinical Practice Guidelines, 01/01/2007, revealed nasal cannula, masks or other delivery devices not in use should be stored in a plastic bag or container to</p>	F 441		
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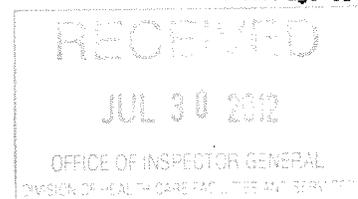
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F 441	<p>Continued From page 32 decrease risk of contamination.</p> <p>Observation, on 06/19/12 during the tour of the facility which began at 8:45 AM, revealed in Room 306-2 oxygen tubing and a nasal cannula on the bed, uncovered and undated. Room 308-1 had a C-Pap facemask sitting out uncovered. Additionally, oxygen tubing was on the floor in Room 308-1. Room 314-1 revealed a nebulizer mask with tubing out and uncovered.</p> <p>Observation, on 06/20/12 at 8:50 AM, revealed oxygen tubing with areas of brown semi solid substances around it and an uncovered nasal cannula on the floor in Room 306-2, that of Resident #8.</p> <p>Interview, on 06/21/12 at 2:40 PM, with Certified Nursing Assistant (CNA) #6 revealed oxygen equipment was to be stored in a plastic bag when not in use. She stated this was for the prevention of contamination. She revealed oxygen equipment not stored properly could cause cross contamination. She had not been trained in the facility on the storage of oxygen equipment she said.</p> <p>Interview, on 06/21/12 at 2:40 PM, with Licensed Practical Nurse (LPN) #1 revealed nasal cannulas, tubing and nebulizer masks were to be stored in a plastic bag with the name of the resident on the bag. She stated the person responsible to ensure the storage was the nurse that administered the oxygen. She stated the</p>	F 441			

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Event ID: 810011

Facility ID: 100353

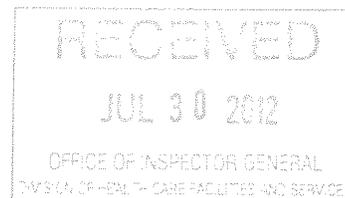
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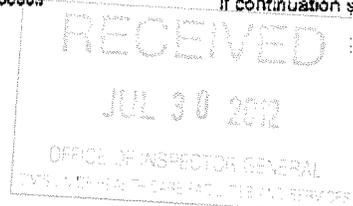
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2012
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F 441	<p>Continued From page 33</p> <p>reason for appropriate storage was for infection control issues, that there was a risk of bacteria and infections. LPN #1 revealed she had been in-serviced on oxygen equipment storage and it was the nurses who monitor the equipment when they go in and out of the resident's room. There was no documentation for the monitoring of the oxygen equipment.</p> <p>Interview, on 06/21/12 at 3:10 PM, with the Director of Nurses (DON) revealed oxygen equipment was to be stored in bags when not in use. She offered no specific training the staff received, but revealed they (the staff) all know oxygen equipment was to be stored in bags. The equipment was monitored by the nurse caring for the resident, she revealed. In addition, she revealed the nurse daily checks the oxygen for the concentrator delivery and storage of equipment. Inappropriate storage of oxygen equipment could be an infection control issue, she revealed, and could possibly make the resident ill.</p> <p>Review of the Housekeeping Services Policy, 02/2002, revealed the facility was to provide housekeeping services to maintain a sanitary, orderly and comfortable environment for residents, staff and visitors.</p> <p>Observation, on 06/19/12 at 8:45 AM, revealed in Room 306-2 the storage of small boxes, food, drinks, and empty containers against the wall under the window. The area on the floor was</p>	F 441			



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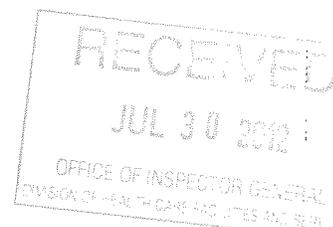
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F 441	<p>Continued From page 34</p> <p>discolored and unclear. Flies were noted above the items and flying about the resident's bed.</p> <p>Interview, on 06/19/12 at 8:45 AM, with Licensed Practical Nurse (LPN) #3 revealed the resident did not allow the staff to touch anything on the floor when asked how does housekeeping clean the floor and the resident's room to maintain a sanitary environment.</p> <p>Observation of the facility, on 06/19/12 at 8:15 AM, revealed oxygen tubing directly on the floor in Room 303.</p> <p>Observation of the facility, on 06/20/12 at 11:00 AM, revealed the C-PAP machine face mask was uncovered in Room 308. The oxygen tubing and nasal cannula were on the floor in Rooms 314-1 and 112. In addition, the mininebulizer face mask was uncovered in Room 112.</p> <p>Observation of the facility, on 06/21/12 at 1:00 PM, revealed the oxygen tubing was directly on the floor in Rooms 112, 306-2, 102, and 303. The mini-nebulizer face masks were uncovered in Rooms 112 and 314 and the C-PAP machine face mask was uncovered in Room 308. In addition, the soiled linen cart was pushed up against the water fountain on the 300 Wing for fifteen (15) minutes before being moved down the hallway.</p> <p>Interview with CNA #3, on 06/21/12 at 2:00 PM, revealed the soiled linen cart should not have</p>	F 441			



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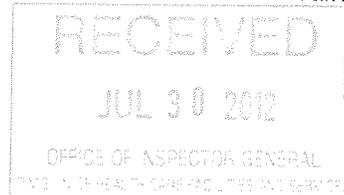
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F 441	Continued From page 35 been parked next to the water fountain as the fountain was clean and the cart was not clean. She stated this could contaminate the fountain and spread infection. She stated the oxygen tubing used by residents should not be stored on the floor as the floor was soiled and the tubing goes around the resident's face and into their nose. She indicated this could cause an infection in the resident.	F 441		
F 465 SS=E	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, interview, and facility policy, it was determined that the facility failed to provide a safe and comfortable environment for residents. Rooms were noted to have dull, soiled floors, cubicle curtains and window curtains were missing hooks and dangling from rods, ceiling tiles were stained, a vent in the dining room was soiled, rooms were cluttered that prevented adequate cleaning, room doors and door frames were scuffed and chipped, baseboard was missing and flies were present in a room. The findings include: Review of the policy for Reporting Maintenance Needs, undated, revealed staff were to enter	F 465	F 465 SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRON The facility shall provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Criteria # 1: Room 306 has been cleaned and the facility has been treated appropriately for flies. The dining room ceiling vent has been cleaned. Ceiling tiles in the 100 and 300 halls have been cleaned, repaired and/or replaced as indicated. The broken window blinds in rooms 306 and 315 have been replaced/repared as indicated. Cubicle curtains in rooms 301, 302, 303, 305, 306, 313, 318 and 402 are properly hanging from hooks; missing hooks were replaced. The closet doors in room 307 have been repaired. The built-in cabinet in room 402 has been repaired. The door frames and doors to rooms 101, 102, 103, 104, 108, 310 and the double doors to the 100 Hall have been repaired. The floors in rooms 303, 306, 308, 309, 315 and 403 have been cleaned and/or stripped and waxed as indicated to remove the dullness and dried substances. Room 301 has been reorganized to provide storage for items listed off of the floor. The water fountain on the 300 Hall has been cleaned. Criteria # 2: An audit of all resident rooms has been completed on 7/12/12 by the Administrator to identify repair needs (i.e., window blinds, cubicle curtains, doors/door frames, furniture) and cleaning/storage needs. A facility wide audit was completed to identify dusty ceiling vents, soiled/broken ceiling tiles, doors/door frames in need of repair, floors needing cleaning and/or stripped and waxed, and water fountain cleanliness. All repairs/needs identified through these audits have been repaired. Continued on page 37	



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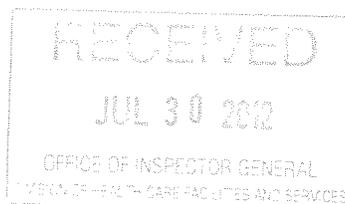
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F 465	<p>Continued From page 36</p> <p>repair needs into the computer program. The Maintenance Director checked the computer daily for needs and documented in the computer when repairs were completed.</p> <p>Review of the facility's policies for Housekeeping Services, dated 2/2002, revealed housekeepers will be available in adequate numbers to provide all aspects of housekeeping in the facility. No daily cleaning schedule was available. Extra cleaning tasks were planned for each day. No cleaning procedures or supervisor oversight were noted in the policy.</p> <p>Observation of the facility on 06/19/12 at 8:15 AM, revealed there were flies in Room 308 where candy wrappers, paper, opened crackers, cokes, used tissues, fly swatters and other papers were covering the floor between the bed and the air conditioning unit. Flies were observed to be present and landing on the resident and the roommate. The ceiling vent in the dining room was covered with a brown fuzzy substance. The ceiling tiles in the halls of the 100 and 300 halls were stained, broken, and had holes. The window blinds in Rooms 308 and 315 were broken. The cubicle curtains in Rooms 301, 302, 303, 305, 306, 313, 315, 318, and 402 were missing hooks and dangling from the cubicle tracks.</p> <p>Observation of the facility, on 06/21/12 at 1:25 PM, revealed the window curtains in Room 306, 308, 309 and 403 lacked hooks and were dangling from the curtain rods. The closet doors</p>	F 465	<p>Criteria # 3: The Care Tracker Kiosk has been enhanced to provide all staff with the ability to notify the Maintenance Director and Housekeeping Supervisor of issues/concerns. The Maintenance and Housekeeping Care Tracker reports shall be printed out M-F and reviewed during the daily CQI meeting to determine issues are addressed and resolved. Nursing and housekeeping staff members, the Housekeeping Supervisor and the Maintenance Supervisor received in-service education on 7/12/12 - 7/26/12 by the DON or designee on the facility's protocol for identifying and reporting environmental repair needs and housekeeping needs. The Housekeeping Supervisor and Maintenance Supervisor received in-service education on 7/20/12 as provided by the Administrator on proper monitoring of facility for a safe, functional, sanitary and comfortable environment.</p> <p>Criteria # 4: The QA indicator tool for the monitoring of Environmental Services shall be utilized monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Administrator.</p> <p>Criteria # 5: Target Date</p> <p>Also see exhibit A</p>	7/27/12



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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
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F 465	<p>Continued From page 37</p> <p>in Room 307 were broken and off the track. The built-in cabinet in Room 402 was scuffed, chipped and the drawers were not able to open smoothly. The room doors and door frames to Rooms 101, 102, 103, 104, 105, 108, 310 and the double doors to the 100 Wing were scuffed, gouged and heavily chipped. The floors in Rooms 303, 306, 308, 309, 315 and 403 were dull and had dried substances on the floors. Room 301 had wheel chair footrests, boxes, and a clothing hamper stored on the floor under the sink.</p> <p>Observation of the facility, on 06/21/12 at 1:25 PM, revealed the water fountain on the 300 Wing was noted to have a white substance inside the bowl.</p> <p>Interview with the Housekeeping Supervisor, on 06/21/12 at 2:00pm, revealed she functioned as the supervisor, however, she also functioned as a full time housekeeper and was not able to supervise the work until she finished cleaning her assigned areas. She stated there was no daily cleaning schedule and rooms were not stripped, waxed, or buffed until terminally cleaned. She stated she was also responsible for the laundry department. She stated the floors were mopped daily with a neutral germicide.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/21/12 at 1:20 PM, revealed staff used the computer to send work requests to maintenance. She stated she had not sent any work requests to maintenance regarding curtains, ceiling tiles, or cubicle curtains.</p>	F 465			



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2012
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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320
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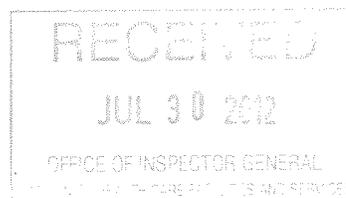
F 465	Continued From page 38	F 465		
F 497 SS=E	<p>Interview with the Maintenance Director, on 06/21/12 at 2:00 PM, revealed the facility was old and required many repairs, however, he did not receive any assistance in keeping up with all the facility needs. He indicated he did make rounds of the facility daily. He stated none of the staff reported the need to repair the curtains, cubicle curtains, doors or ceiling tiles.</p> <p>483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure Certified Nurse Aides (CNA) received twelve (12) hours of regular in-service education per year for three (3) of seven (7) sampled CNAs (CNA #5, 6 and 7).</p>	F 497	<p>F 497 NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</p> <p>The facility shall complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>Criteria # 1: CNA's #5, 6 and 7 received additional in-service education hours to accommodate for the hours missed last year prior to reporting back to work after this alleged deficient practice was identified.</p> <p>Criteria # 2: An audit of all CNA in-service records was completed on 6/21/12 & 6/22/12 by Administrative Nursing Team to determine compliance with CNA yearly in-servicing requirements. Any identified to be out of compliance were not allowed to report back to work until additional required in-service hours were met.</p> <p>Continued on next page 9 (pg. 40)</p>	

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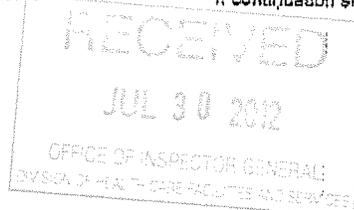
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F 497	Continued From page 39 The findings include: The facility did not provide a policy for providing CNAs with twelve (12) in-service hours per year. Review of the in-service education records revealed Employee #5, hired by the facility on 05/28/08, attended 8.5 hours of in-service training in the last year. Review of the in-service education records revealed Employee #6, hired by the facility on 03/29/96, attended 8.5 hours of in-service training in the last year. Review of the in-service education records revealed Employee #7, hired by the facility on 02/09/10, attended 9.0 hours of in-service training in the last year. Interview with the Director of Nursing, on 06/21/12 at 3:30 PM, revealed she did not have time to review the CNA training records to ensure staff received 12 hours per year. She stated all the CNAs worked the day shift and had worked on all units in the facility. She stated CNAs not obtaining the required hours would not be able to work, however, they had been working in the facility.	F 497	Criteria # 3: The in-servicing calendar has been reviewed (and revised if indicated) to determine that the required in-servicing hours for CNA's is being provided. The Staffing Coordinator and CNA's received in-service education on 7/11/12 - 7/26/12 by the DON or designee on the requirements for annual in-servicing hours for CNA's and that failure to meet annual in-servicing requirement may result in an inability to work. The Staffing Coordinator (or designee) shall be responsible for tracking CNA in-servicing hours and identifying needs prior to their anniversary date. Criteria # 4: Each month, the Staffing Coordinator (or designee) shall review CNA in-servicing hours for CNA's that are within 1-2 months of their anniversary date to determine that in-service requirements were met and report findings to the QA team. Criteria # 5: Target Date	7/27/12	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520			



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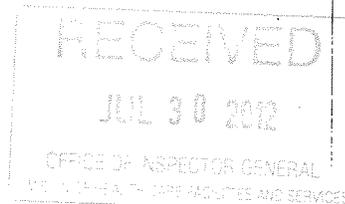
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F 520	Continued From page 40 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality 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 observation, interview, record review and review of facility policy, it was determined the facility failed to identify pharmacy issues and infection control issues and develop and implement plans of action to correct quality deficiencies. The facility failed to identify and develop a plan of action to address the pharmacy's failure to monitor the medication rooms and medication storage. The facility failed to identify and develop plans of action to address	F 520	F 520 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS The facility shall maintain a quality assessment and assurance (QA) committee consisting of the Director of Nursing Services (DON); a physician designated by the facility; and at least 3 other members of the facility's staff. Criteria # 1: The QA committee (consisting of the DON, ADON's, Administrator, SDC, Hsk Supervisor, HR, BOM, CDM, MRC, SSD, Maintenance Director, Medical Director and Pharmacist Consultant), along with the nurse consultant, has developed and implemented plans of action to correct all alleged deficient practices identified in this statement of deficiency (including, but not limited to: pharmacy and infection control issues) by the designated target dates. A policy for the QA program has been implemented and the QA team in-serviced (see Criteria # 3). Regarding Pharmacy Issues: Residents # 3, #6, #7 and #10 are receiving their levothyroxine as per manufacturer's specifications and on an administration schedule to maximize the effectiveness of the medication Regarding Infection Control Issues: Resident E's urinal was replaced with a new one on 7/11/12 and is being cleaned and properly stored after each use in accordance with facility policy and the resident's individualized plan of care. Oxygen equipment (i.e., nasal cannula, C-pap face mask, tubing, etc.) in rooms 303, 306-2, 308-1, 314-1, 102 and 112 have been cleaned and/or replaced as indicated, and are properly stored when not in use. The floor in Room 306-2 has been cleaned and resident items have been organized in a way to encourage the resident to store personal items off of the floor. The soiled linen cart on the 300 Hall is not parked next to the water fountain. Continued on next page		



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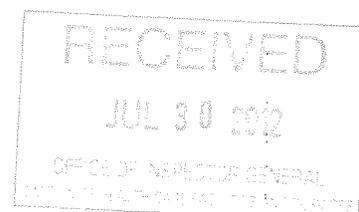
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F 520	<p>Continued From page 41</p> <p>the facility's infection control concerns with oxygen tubing and nasal cannulas being in contact with the floor, storage and protection from bacteria of mini-nebulizer machines and C-PAP machines. The facility failed to ensure resident rooms were clear of clutter causing the presence of pests. The facility failed to ensure urinals were emptied and disinfected between uses. The facility failed to ensure the ice machine (used for all residents) was clean.</p> <p>The findings include:</p> <p>The facility did not provide a policy for Quality Assurance.</p> <p>Review of the Cleaning and Disinfecting Resident Care Equipment, undated, revealed a urinal shall be cleaned and/or disinfected to prevent and control infection. After sanitizing, urinals were to be returned to the bedside table in the resident's room.</p> <p>Observation, on 06/19/12 at 8:45 AM, revealed in the room of unsampled Resident "E", a urinal on the overbed table with urine inside.</p> <p>Observation, on 06/20/12 at 11:25 AM, revealed a urinal with urine in it on the overbed table in the room of unsampled Resident "E". Lunch was being served at the time. The server removed the urinal, emptied it and wiped the overbed table with a wet washcloth dampened with water. The</p>	F 520	<p>Regarding Environmental Issues: Room 306 has been cleaned and treated appropriately for flies. The dining room ceiling vent has been cleaned. Ceiling tiles in the 100 and 300 halls have been cleaned, repaired and/or replaced as indicated. The broken window blinds in rooms 306 and 315 have been replaced/repared as indicated. Cubicle curtains in rooms 301, 302, 303, 305, 306, 313, 318 and 402 are properly hanging from hooks; missing hooks were replaced. The closet doors in room 307 have been repaired. The built-in cabinet in room 402 has been repaired. The door frames and doors to rooms 101, 102, 103, 104, 108, 310 and the double doors to the 100 Hall have been repaired. The floors in rooms 303, 306, 308, 309, 315 and 403 have been cleaned and/or stripped and waxed as indicated to remove the dullness and dried substances. Room 301 has been reorganized to provide storage for items listed off of the floor. The water fountain on the 300 Hall has been cleaned.</p> <p>Criteria # 2: All residents have the potential to be affected by this alleged deficient practice.</p> <p>Criteria # 3: The QA committee received in-service education on 07/11/12 by the facility's nurse consultant on the QA process; this included, but was not limited to: identifying potential deficient practices; developing and implementing plans of action for identified concerns; and evaluating effectiveness of plans of action.</p> <p>Criteria # 4: The QA indicator tool for the monitoring of, and the effectiveness of, the QA process shall be utilized monthly until compliance is achieved, and then every 6 months thereafter under the supervision of the Administrator. The Administrator shall oversee scheduling the frequency of QA monitoring tools, determine if thresholds are met, assist in development of action plans (as needed), and determine if further corrective action is needed.</p> <p>Criteria # 5: Target Date</p>	7/27/12



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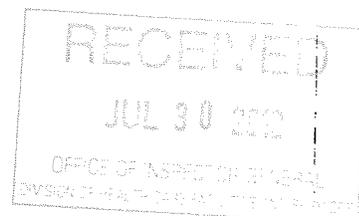
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F 520	<p>Continued From page 42</p> <p>urinal was not observed to be cleaned or disinfected.</p> <p>Observation, on 06/21/12 at 8:45 AM, revealed a urinal on the overbed table in front of unsampled Resident "E".</p> <p>Interview, on 06/21/12 at 8:48 AM, with Licensed Practical Nurse (LPN) #1 revealed unsampled Resident "E" was reminded frequently to have the urinal emptied and to use his/her call light. She stated the staff was to empty the urinal hourly.</p> <p>Review of the facility Oxygen Therapy Concentrator Set-Up, Clinical Practice Guidelines, 01/01/2007, revealed nasal cannula, masks or other delivery devices not in use should be stored in a plastic bag or container to decrease the risk of contamination.</p> <p>Observation, on 06/19/12 during the tour of the facility which began at 8:45 AM, revealed in Room 306-2 oxygen tubing and a nasal cannula on the bed, uncovered and undated. Room 308-1 had a C-Pap facemask sitting out uncovered. Additionally, oxygen tubing was on the floor in Rooms 308-1. Room 314-1 revealed a nebulizer mask with tubing out and uncovered.</p> <p>Observation, on 06/20/12 at 8:50 AM, revealed oxygen tubing with nasal cannula on the floor in Room 306-2, the room of Resident #8, with</p>	F 520			



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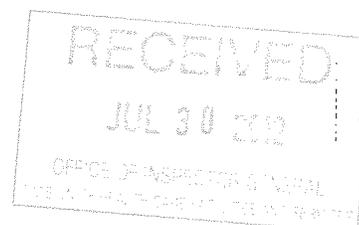
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F 520	<p>Continued From page 43</p> <p>several areas of a brown semi solid substance around it.</p> <p>Interview, on 06/21/12 at 2:40 PM, with Certified Medication Technician (CMT) #6 revealed oxygen equipment was to be stored in a plastic bag when not in use. She stated this was for the prevention of contamination. She revealed oxygen equipment not stored properly could cause cross contamination. She had not been trained in the facility on the storage of oxygen equipment she said.</p> <p>Interview, on 06/21/12 at 2:40 PM, with Licensed Practical Nurse (LPN) #1 revealed nasal cannulas, tubing and nebulizer masks were to be stored in a plastic bag with the name of the resident on the bag. She stated the person responsible to ensure the storage was the nurse that administered the oxygen or the respiratory company that came to the facility weekly. She stated the reason for appropriate storage was for infection control issues, that there was a risk of bacteria and infections.</p> <p>Interview, on 06/21/12 at 3:10 PM, with the Director of Nurses (DON) revealed oxygen equipment was to be stored in bags when not in use. She offered no specific training the staff received, but revealed they (the staff) all know oxygen equipment was to be stored in bags. The equipment was monitored by the nurse caring for the resident, she revealed. In addition, she revealed the nurse daily checks the oxygen for</p>	F 520		



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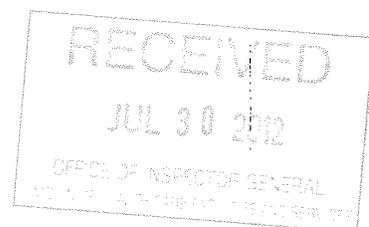
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F 520	<p>Continued From page 44</p> <p>the concentrator delivery and storage of equipment. Inappropriate storage of oxygen equipment could be an infection control issue, she revealed, and possibly make the resident ill.</p> <p>Review of the Pharmacy Services Agreement, agreement from 06/01/10 to 05/31/13, revealed as part of the Standard Services in the Agreement, a Pharmacy Representative would serve on the Facility's Quality Assurance (QA) Committee and/or Pharmaceutical Services Committee. However, the Pharmacist which serviced the facility was not a member of either committee. In addition, the Agreement stated the Pharmacist would perform random quarterly audits of medication carts or audit medication storage areas. The medication storage areas were not monitored by pharmacy. Medication vials of Tuberculin Serum, Pneumonia Vaccine and Influenza Vaccine were found opened and undated in two (2) of two (2) medication rooms.</p> <p>Review of the medication regimen review (MRR) revealed the administration for the medication Levothyroxine did not follow the manufacturer's recommendations and was not noted as a concern during the MRR. This medication was ordered for Residents # 3, #6, #7 and #10. The MRR was not brought up before the QA Committee as an area of concern.</p> <p>Interview, on 06/21/12 at 3:30 PM, with the Director of Nursing (DON) revealed it had not been identified by the QA Committee that the</p>	F 520			



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F 520	<p>Continued From page 45 Pharmacist job was not conducted according to the Pharmacy Services Agreement.</p> <p>Continued interview with the DON revealed there were no audits of the medication storage areas by pharmacy or any other person. She revealed nothing was in place to monitor the medication rooms. She stated using expired Tuberculosis Serum could give false and inaccurate testing results. She stated the pharmacy had not been contacted regarding not following the contract for auditing medication storage and medication rooms.</p>	F 520		



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964, 1975, 1984</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 06/20/12. Beaver Dam Nursing and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for fifty eight (58) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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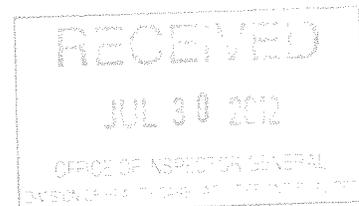
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *XO [Signature]* TITLE *YLANHA* (X6) DATE *X 7/27/12*

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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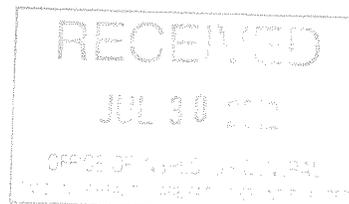
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2012
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
(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	
K 000	Continued From page 1	K 000	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.		
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for fifty eight (58) beds with a census of fifty eight (58) on the day of the survey.</p>	K 018	<p>K 018 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1% inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Criteria #1: The privacy curtains in rooms 106, 301, 302 and 404 are secured by a tie-back hook when not in use to prevent blockage of the resident room doors. Resident rooms 302, 306, 314 and 403 doors have been adjusted to resist passage of smoke. The bedside floor mats in resident rooms 307, 311 and 313 have been size adjusted to allow for door closure without blockage.</p> <p>Criteria #2: An audit of resident rooms was completed on 7/16/12 by the Administrator and Maintenance Director to determine that all resident room doors close without blockage, and are resistant to passage of smoke.</p> <p style="text-align: center;">Continued on page 2</p>		



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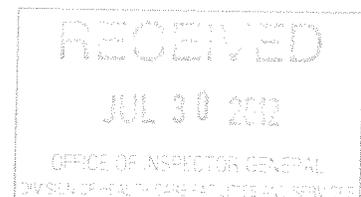
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K 018	Continued From page 2 The findings include: Observations, on 06/20/12 between 11:30 AM and 3:00 PM, with the Director of Maintenance revealed some of the corridor doors to resident rooms were blocked from closing by the privacy curtain hanging in the doorway. The doors affected by this were rooms #106, 301, 302, 404. Interviews, on 06/20/12 between 11:30 AM and 3:00 PM, with the Director of Maintenance confirmed the observation of the doors not closing due to the privacy curtains hanging into the doorway. Observations, on 06/20/12 between 11:30 AM and 3:00 PM, with the Director of Maintenance revealed corridor doors to resident rooms would not resist the passage of smoke. The rooms affected are rooms # 302, 306, 314, and 403. Interviews, on 06/20/12 between 11:30 AM and 3:00 PM, with the Director of Maintenance revealed he was not aware the doors would not resist the passage of smoke. Observations, on 06/20/12 between 11:30 AM and 3:00 PM, with the Director of Maintenance revealed corridor doors to resident rooms would not close due to a padded mat on the floor blocking the door from closing. The rooms affected are rooms # 307, 311, and 313.	K 018	Criteria #3: The Care Tracker Kiosk has been enhanced to provide all staff with the ability to notify the Maintenance Director and Housekeeping Supervisor of issues/concerns. The Maintenance and Housekeeping Care Tracker reports shall be printed out M-F and reviewed during the daily CQI meeting to determine issues are addressed and resolved. The Maintenance Director has received in-service education on 7/16/12 by the Administrator on Life Safety Code Standard, including, but not limited to doors protecting corridor openings: (1) are required to resist the passage of smoke, (2) there is to be no impediment to the closing of the doors. Nursing and housekeeping staff members received in-service education on 7/13/12-7/26/12 as provided by the Administrator or designee on Life Safety Code Standard including, but not limited to: there is to be no impediment to the closing of doors protecting corridor openings. Criteria #4: The QA monitoring tool for the monitoring of Life Safety Code Standards in regards to doors protecting corridor openings shall be utilized monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Administrator. Criteria #5: Target Date	8/2/12



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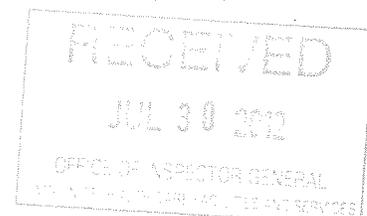
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K 018	<p>Continued From page 3</p> <p>Interviews, on 06/20/12 between 11:30 AM and 3:00 PM, with the Director of Maintenance revealed he was not aware the doors were hitting the padded mats and unable to close properly.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is</p>	K 018		



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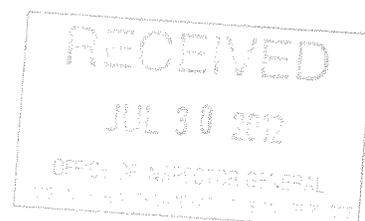
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K 018	Continued From page 4 applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke	K 025	K 025 NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Criteria #1: Penetrations in the smoke compartments have been filled with a material rated equal to the partition and can resist the passage of smoke. Criteria #2: The Maintenance Director performed an inspection 6/21/12 – 7/26/12 of all smoke compartments to determine that all penetrations are filled with a material rated equal to the partition and resists the passage of smoke. Any penetrations identified were filled (as described above) by 7/26/12. Criteria #3: The Maintenance Director has received in-service education on 7/16/12 by the Administrator on Life Safety Code Standard, including, but not limited to: penetrations in smoke compartments must be filled with a material rated equal to the partition and resists the passage of smoke. The Maintenance will inspect smoke compartments after any outside vendors have performed any work that might hinder the smoke compartment and make the necessary repairs in a timely manner. Criteria #4: The QA indicator for the monitoring of physical plant specific to penetrations in smoke barriers/partitions will be utilized monthly x 2 and then every 6 months per the QA schedule under the supervision of the Administrator Criteria #5: Target Date	8/2/12



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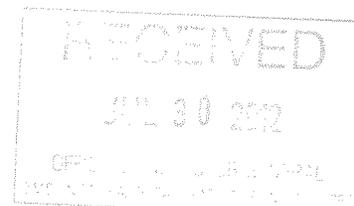
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K 025	<p>Continued From page 5</p> <p>barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for fifty eight (58) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 06/20/12 between 10:00 AM and 11:00 AM, with the Director of Maintenance revealed the smoke partitions, extending above the ceiling had multiple penetrations due to the original drywall ceiling having holes from former fixtures being removed when the suspended ceiling was installed for an updated look. All five (5) smoke compartments were penetrated in sporadic locations above the suspended ceiling. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview, on 06/20/12 between 10:00 AM and 11:00 AM, with the Director of Maintenance revealed he was not aware of the penetrations.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and</p>	K 025		



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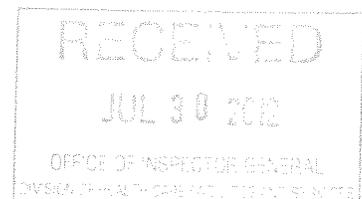
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K 025	Continued From page 6 the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	K 027 NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Criteria #1: The North Med Room door and frame were replaced 7/18/12 with fire rated materials. The T-astragal on the cross-corridor door, located on the 100 Hall, has been replaced with a smoke barrier strip to ensure the doors will close properly in the event of an emergency on 7/20/12 by the maintenance supervisor. Criteria #2: An audit of all corridor doors was done to ensure that (1) all doors and frames are fire rated as indicated; and (2) any doors with a t-astragal would close first after the initial close and closed properly on 7/13/12 by the Maintenance Supervisor. No other residents were found to be affected by this alleged deficient practice. Criteria #3: Maintenance Director was in-serviced on the necessity of corridor doors closing properly in the event of an emergency and that doors with the t-astragal requiring a door coordinator to ensure the door closes properly after the initial close on 7/16/12 by the Administrator Criteria #4: The QA indicator for the monitoring of corridor doors will be utilized monthly x 2 months and then quarterly as per the QA schedule under the supervision of the Administrator Criteria #5: Target Date	8/2/12
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure access doors in smoke barriers were installed in	K 027		



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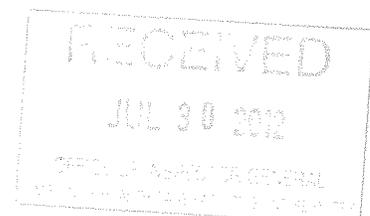
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K 027	<p>Continued From page 7</p> <p>accordance with NFPA Standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty eight (58) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/20/12 at 10:50 AM, with the Director of Maintenance revealed one (1) unrated door and frame in the smoke barrier. The door is to the North Med Room and is part of the smoke barrier.</p> <p>Interview, on 06/20/12 at 10:50 AM, with the Director of Maintenance revealed he was not aware the door was part of the smoke barrier, and must be rated for use.</p> <p>Observation, on 06/20/12 at 2:35 PM, with the Director of Maintenance revealed the cross-corridor doors, located in the 100 Hall by the North Lobby, would not close completely when tested. This was due to the doors not having a coordinator to ensure the door without the t-astragal would close first.</p> <p>Interview, on 06/20/12 2:35 PM, with the Director of Maintenance revealed they were unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p>	K 027		



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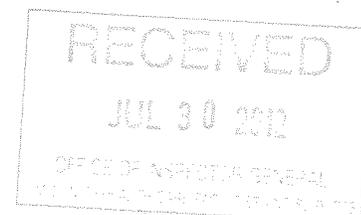
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K 027	Continued From page 8 NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Reference: NFPA 101 (2000 Edition) Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027			
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029			



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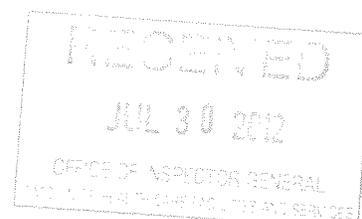
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K 029	Continued From page 9 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for fifty eight (58) beds and the census was fifty eight (58) on the day of the survey. The findings include: Observation, on 06/20/12 between 2:00 PM and 2:55 PM, with the Director of Maintenance revealed doors to hazardous area did not have a self-closing device. The doors are located in the following; 1) Biohazard Room located in the 400 Hall. 2) Central Supply Room located in the 400 Hall. 3) Medical Records Office located in the Front Hall. 4) Dry Storage Room located in the Kitchen.	K 029	K 029 NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door permitted. 19.3.2.1 Criteria #1: A door closer has been installed on the following doors: (1) Biohazard Room located in the 400 Hall; (2) Central Supply Room located in the 400 Hall; (3) Medical Records Office located in the Front Hall; and (4) Dry Storage Room located in the Kitchen by the Maintenance Supervisor on 7/9/12. Criteria #2: An audit was completed of hazardous areas to ensure door closures were in place and ceilings were sealed by the Maintenance Supervisor on 6/28/12. Criteria #3: The Maintenance Director was in-serviced on what hazardous areas are and the importance of having a door, a self-closer, and separation, by the Administrator on 7/16/12. Criteria #4: The QA indicator for the monitoring of hazardous areas will be utilized monthly X 2 months then every 6 months as per QA schedule under the supervision of the Administrator Criteria #5: Target Date	8/2/12



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OMB NO. 0938-0391

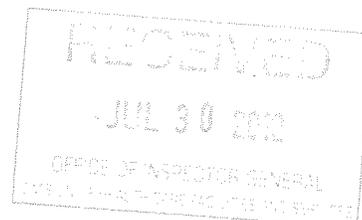
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2012
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
(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	
K 029	Continued From page 10 Interview, on 06/20/12 at 2:00 PM and 2:55 PM, with the Director of Maintenance revealed he was not aware the doors were required to be self-closing. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	K 029			



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K 029	Continued From page 11 Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for fifty eight (58) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 06/20/12 at 10:53 AM, with the Director of Maintenance revealed an emergency exit sign light with battery backup located in the North Lobby, did not function when tested. Interview, on 06/20/12 at 10:53 AM, with the Director of Maintenance revealed he was unaware the light was not functioning properly. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure	K 046	K 046 NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9. 19.2.9.1. Criteria #1: The emergency exit sign light with battery backup located in the North Lobby was replaced by the Maintenance Supervisor on 7/3/12. Criteria #2: An audit was done to ensure all other emergency lights with battery backup were functioning, by the Maintenance Supervisor on 7/16/12. Criteria #3: The Maintenance Director was in-serviced on the importance of ensuring emergency lights with battery backup are functioning properly, by the Administrator on 7/16/12. Criteria #4: The QA tool for the monitoring of emergency lighting will be utilized monthly x 2 months and then quarterly as per the QA schedule under the supervision of the Administrator Criteria #5: Target Date	8/2/12



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K 046	Continued From page 12 of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.	K 046			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for fifty eight (58) beds and the census was fifty eight (58) on the day of the survey.	K 050	K 050 NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Criteria #1 and #2: Fire drills are conducted quarterly at unexpected times under varied conditions. Criteria #3: The Maintenance Director has received in-service education on the need to conduct fire drills quarterly at unexpected times under varied conditions, as provided by the Administrator on 7/16/12. Criteria #4: The QA indicator for the monitoring of fire drills will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the Administrator. Criteria #5: Target Date	8/2/12	

